Department of Legislative Services
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Department of Health and Mental Hygiene

Medical Care Programs Administration

Presentation to
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Joint Audit Committee

Bruce A. Myers, CPA
Brian S. Tanen, CPA, CFE
Mark S. Hagenbuch, CPA

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Background

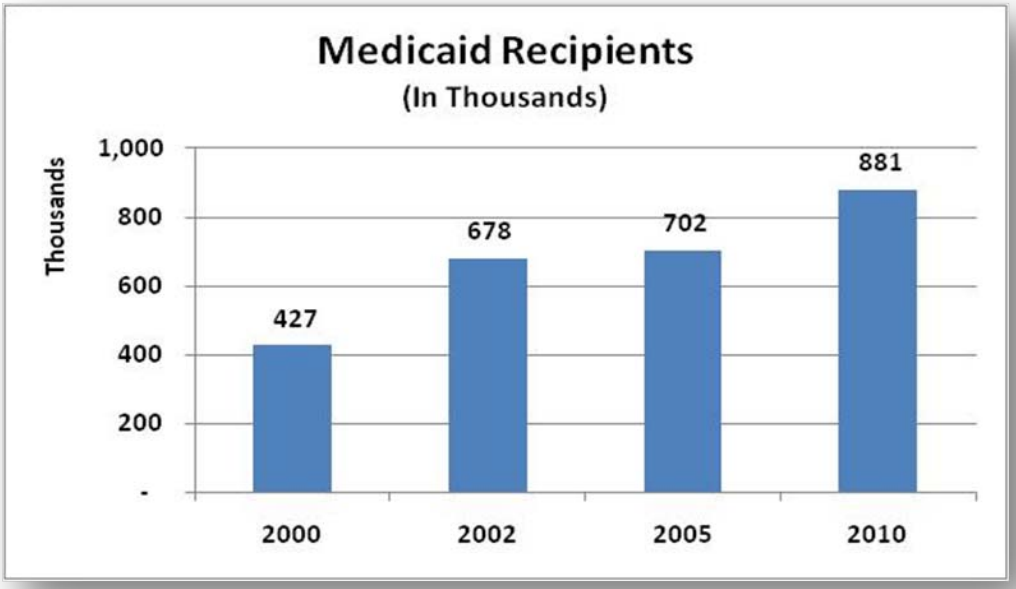
- Medical Care Programs Administration (MCPA), through the Medical Assistance Program, provides access to a broad range of health care benefits to eligible Maryland residents.

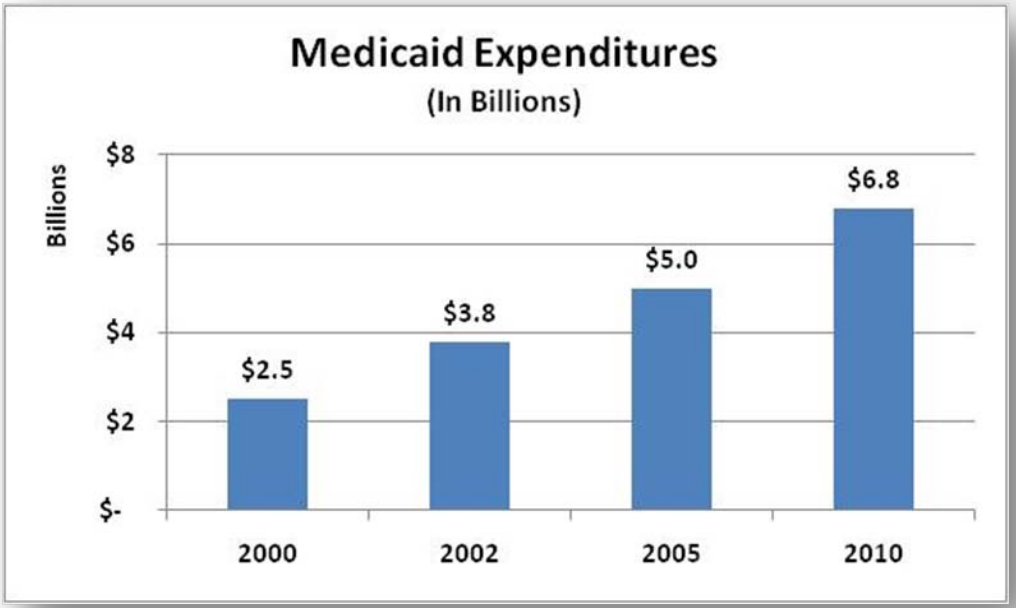
- MCPA served 881,000 individuals as of 6/30/10, through over 40,000 providers.

- FY 2010 Medicaid expenditures totaled approximately $6.8 billion:
  - $2.6 billion - capitation payments to managed care organizations
  - $1.1 billion - long-term care expenditures
  - $3.1 billion - fee-for-service expenditures

  At least 50 percent of the expenditures was recovered from the federal government

Background


Medicaid Recipients
(In Thousands)
Thousands
1,000
800
600
400
200
-
427
678
702
881
2000
2002
2005
2010


Medicaid Expenditures
(In Billions)
Billions
$8
$6
$4
$2
$-
$2.5
$3.8
$5.0
$6.8
2000
2002
2005
2010

Audit Overview

- The audit report included 14 findings, two of which were repeated from our preceding audit report.
- The preceding audit report noted that MCPA's accountability and compliance level was unsatisfactory. This audit, MCPA improved its fiscal operations and its accountability and compliance level is no longer unsatisfactory.
- In November 2009, we issued a performance audit report on the processing of certain Medicaid claims. OLA identified a number of enhancements to the claims payments and edits areas, and during our current audit we did not follow-up on certain prior fiscal compliance audit report findings addressed in the performance audit and limited our review in these areas.

Key Audit Issues

- Lack of comprehensive policies and procedures to monitor the eligibility process and to correct certain long-term deficiencies associated with that process.
- Managed Care Organization provider/enrollee encounter data which impact amounts paid to MCOs were not properly verified, nor were third-party recovery/cost avoidance efforts.
- Inadequate procedures over claims for Medicaid recipients with Medicare coverage, adjustments to claim amounts, and the data entry of sensitive claims information.
- Lack of proper controls over other areas including cost settlements, pharmacy drug costs, the Kidney Disease and Transportation Grant programs, provider applications and web based information technology applications.

Recipient Eligibility

Background:

- DHMH and DHR maintain a longstanding memorandum of understanding (MOU) which assigns responsibility to DHR for determining applicants' eligibility for participation in the Medical Assistance Program.
- Applicant eligibility is primarily determined by the various local departments of social services (LDSS) under the supervision of DHR.
- DHMH is responsible for establishing regulations, guidelines, and procedures to be used by DHR for Medical Assistance applicants.

Recipient Eligibility (continued)

Deficiencies with the eligibility process and related monitoring have been commented upon in MCPA audit reports dating back to 1992 and in our audit reports of several DHR units. (Finding 1) During this audit, we noted that:

- 6,737 active recipients were missing social security numbers as of June 17, 2009.
- 424 individuals had two or more recipient numbers on MMIS II. Our test of 11 of these individuals disclosed that, for 9, MCPA paid capitation fees (that is, a per-person payment) totaling $137,000 under both recipient numbers, resulting in overpayments of $63,000.
- Most of the 802,271 fiscal year 2009 recipients did not have an eligibility ending date recorded in MMIS II.

Recipient Eligibility (continued)

These conditions occurred, at least in part, due to shortcomings in the MOU, which:

- Did not provide MCPA with sufficient responsibility for monitoring eligibility determinations.
  - MCPA did not independently monitor the eligibility process using available data.
  - MCPA monitoring was generally limited to reviews of DHR's quality control efforts.
- Did not establish specific responsibilities to ensure deficiencies were corrected.
  - MCPA notified DHR of deficiencies but did not address DHRs failure to correct the problems.
- Has not been updated since the MOU's inception in July 1985 and several provisions are no longer accurate or applicable.

HealthChoice (Managed Care Organizations)

Background:

- Under HealthChoice, qualified recipients are required to enroll in one of seven managed care organizations (MCOs).
- As of June 30, 2009, 70% of all Medicaid recipients (555,000) were enrolled in MCOs.
- MCPA pays the MCOs a fixed monthly payment (capitation), for which the MCOs are generally expected to pay the recipients' medical costs regardless of the number or nature of services provided.
- Each MCO must report all provider-enrollee (medical) encounters which is one of the factors used in the determination of the capitation rates.

Health Choice (continued)

- MCPA did not verify encounter data submitted by the MCOs for calendar years 2005 through 2007 (which was a factor used in developing the CY 2008 to 2010 capitation rates) and did not follow up on errors noted during its review of calendar year 2004 encounter data. (Finding 2) The lack of verification was commented upon in our two preceding audit reports.

- MCPA did not ensure that the MCOs were maximizing their efforts to help reduce expenditures through third-party recoveries and cost avoidance efforts, and did not ensure that the MCOs were properly reporting the related results. (Finding 3) The reduction of these expenditures through recoveries and cost avoidance efforts could lower future capitation rates.

Claims Processing

- MCPA did not verify the propriety of the Medicaid claims submitted for Medicaid recipients who also had Medicare coverage to ensure that payments for these claims were proper. (Finding 5) From 7/1/08 to 5/30/09, MCPA processed more than 2 million claims totaling $135 million for such dual coverage Medicaid recipients.

  Also, there were no system edits to prevent overpayments based on incorrect claims data entry, such as payments in excess of billed amounts. Our analysis of claims data for such recipients from 7/1/08 to 5/30/09 found that MCPA paid providers more than the amount billed for at least 372 claims totaling $231,000.

- MCPA did not verify the propriety of claim adjustments. (Finding 7) During FY 2009, 152,485 adjustments were processed without independent supervisory approval.

Claims Processing (Policy Issue)

The confidentiality of certain sensitive recipient information may not have been adequately safeguarded. (Finding 6) MCPA contracted with the Department of Public Safety and Correctional Services – Maryland Correctional Enterprises (MCE) and data entry contractor to process claims data which contained social security numbers and other sensitive information.

- MCPA did not determine the nature of the crimes committed by MCE inmates used to enter claims data.
- MCPA did not obtain documentation from the data entry contractor that the required criminal background checks had been conducted for its personnel.

Other Issues

Maryland Medicaid Pharmacy Program

MCPA did not ensure that pharmacy reimbursements (which totaled $271 million during FY 2009) were reasonable. (Finding 9) MCPA's vendor was responsible for processing and authorizing pharmacy claims using the most current drug prices. MCPA did not verify the drug pricing used by the vendor with independent sources.

Long-Term Care Cost Settlements

MCPA did not maintain a comprehensive listing of all long-term care facilities to account for due dates and receipt of cost settlements. MCPA also did not ensure that all annual cost settlements were completed by its contractor. (Finding 10)

- Throughout the year, MCPA pays facilities using interim rates and identifies over and underpayments via the settlement process.
- 246 settlements were not issued within 1 year.
- 40 settlements dating back to 2002 were outstanding.

Other Issues (continued)

Provider Applications

Certain healthcare provider applications were not subject to supervisory review and approval to ensure that the proper verification procedures were performed. (Finding 8)

Information Technology

Adequate authentication, access, and monitoring controls did not exist over a critical Internet web-based IT application that allows health care providers to electronically submit claims (Finding 13). Certain security settings were not activated to identify, for management review, modifications made to critical databases. (Finding 14)

Other Issues (continued)

Kidney Disease Program

- MCPA did not implement certain procedures and controls to fully address deficiencies that enabled certain fraudulent activities to occur in the Kidney Disease Program over a ten-year period. In February 2009, a KDP employee was convicted of misappropriating $1.8 million by processing fictitious KDP claims. (Finding 11)
- Other procedural deficiencies over KDP pharmaceutical claims resulted in overpayments of at least $161,744 to one pharmacy and the referral of this provider to the Office of Attorney General – Criminal Division.
- During FY 2009, KDP expended $12.5 million to provide financial assistance to eligible end-stage renal disease patients.

Other Issues (continued)

Transportation Grant Program

- Numerous deficiencies were noted with MCPA's oversight of the Program which provides grants to local jurisdictions to provide Medicaid recipients with non-emergency transportation to and from providers rendering Medicaid-covered services. MCPA paid the 24 local jurisdictions $32.5 million during FY 2009 under the program. (Finding 12)
- Local jurisdictions were not prohibited from hiring the same vendor to perform the functions of screening and transporting of applicants. This situation existed in 11 jurisdictions that received $6.3 million in FY 2009.
- Vendors were not required to maintain sufficient documentation to support the propriety of the transport.
- MCPA site visits to monitor the local jurisdictions were not comprehensive or timely. One jurisdiction that received about 30% of all grants in FY 2009 had not been visited for over 4 years.

Conclusion

MCPA should:

- Update the MOU with DHR and establish comprehensive policies and procedures to monitor the eligibility process and to correct long-term deficiencies.
- Verify MCO encounter data and better monitor third-party recovery/cost avoidance efforts.
- Improve procedures over Medicaid payments for recipients with Medicare coverage, claims adjustments and sensitive claims information.
- Implement adequate controls to address the other deficiencies noted in the report including Pharmacy drug costs, Cost Settlements, Kidney Disease and Transportation Grant programs, provider application processing and IT systems.