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Department of Health and Mental Hygiene

Processing of Certain Medicaid Claims

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Presentation to Joint Audit Committee

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Background

- Medicaid is joint federal and state program that provides medical care to low-income citizens.
- The DHMH's Medical Care Program Administration primarily administers the program. The Federal government generally funds 50% of program costs.
- During FY 2009, Medicaid claims totaling $6.28 billion were processed. As of June 30, 2009, 802,000 individuals were enrolled in the program.
- The audit focused on claims totaling $2.68 billion during FY 2009 consisting of fee-for-service payments and eligible claims for DDA and MHA services.
- Under the fee-for-service system, providers (e.g., hospitals, physicians) are paid for each service or supply provided.

Audit Objectives

1. To evaluate the effectiveness of the claims edit process, particularly the appropriateness of disabling edits.

2. To assess the effectiveness of DHMH's procedures performed to review the propriety of claims after payment.

3. To evaluate the effectiveness of the voucher claim processes to obtain federal Medicaid reimbursements for services provided through the Mental Hygiene Administration (MHA) and the Developmental Disabilities Administration (DDA).

Audit Methodology

Our work included:

- Obtaining a computer file of all fee-for-service claims paid between July 1, 2007 and March 31, 2008. From this file, we isolated the $978 million of claims that were flagged as having not been processed through one or more of the 81 disabled system edits.
- Evaluating the propriety of disabling 55 of the 81 edits that accounted for 99% of the transactions that bypassed disabled edits during the period.
- Reviewing procedures over the post-payment review processes, including certain hospital claims.
- Evaluating the processes used by MHA and DDA to obtain federal Medicaid funds for their previously paid claims.

Key Audit Issues

- Nine automated edits should not have been disabled; consequently, claims valued at $98 million, which should have been suspended and subject to manual reviews, were allowed to be processed for payment during the nine-month period tested.

- Certain employees could change edit settings without independent authorization, and certain claims were improperly paid due to a programming error involving one system edit.

- The post-payment review processes used to identify improperly paid claims needed more structure and formal procedures to help ensure that the reviews were effective, efficient, fully carried out, and fully documented.

- There was no systematic process to analyze the causes of rejected federal fund reimbursement claims submitted by DDA and MHA.

Objective 1 –System Edit Process

- There were valid reasons for not using most MMIS edits that were disabled, but 9 of the 51 edits we tested should not have been disabled. These 9 edits applied to claims totaling in excess of $98 million during the nine-month period ended March 31, 2008. Had these edits been used, the claims would have been suspended and subject to further review before being paid. (Finding 1)

- Controls over changes to edit settings were inadequate. Four employees could deactivate edits without any approvals. A record of setting changes and written justifications as to why edit settings were changed were not maintained. (Finding 2)

- Detailed written descriptions of the various automated edits were often brief and vague. MCPA staff did not always have a clear understanding of the purpose of certain edits. (Finding 3)

Objective 1 – System Edit Process (cont'd)

- During our testing of claims, we determined that certain claims were improperly processed for payment due to a temporary change in edit settings. (Finding 4)

  - These claims were paid rather than suspended for subsequent manual review. After we advised MCPA about these claims, its research disclosed that claims totaling $5.3 million should have been manually reviewed before payment.

  - MCPA also determined that $1.4 million of these claims were paid in error and should be recovered from the providers.

Objective 1 – System Edit Process (cont'd)

- Excessive MMIS system access capabilities were inadvertently granted to allow 532 users to pay claims that were suspended due to edits. (Finding 5)

- Although certain claim processing functions had backlogs, no formal studies of staffing requirements had been performed to determine if its existing resources should be reallocated. Approximately 60 of the over 600 MCPA employees are responsible for claims processing. (Finding 6)

- MCPA does not have a training program for employees performing critical claims processing functions, including those responsible for evaluating claims suspended due to edits. (Finding 7)

Objective 2 – Post Payment Review

- The post-payment review process is vital for helping to ensure that payments to providers were for necessary services that were rendered. A critical component is the use of computer data analysis (Surveillance and Utilization Review – SURS).

  - DHMH's post payment review process was not formally structured or adequately documented. There were no specific requirements as to the type and frequency of computer analyses of claims data to identify potentially improper paid claims.

  - Comprehensive records of data analysis reports, specific claims reviewed, and any related recoveries were not maintained. This information could be used to more effectively direct future data analyses. (Finding 8)

Objective 2 – Post Payment Review (cont'd)

- Certain data analysis reports deemed to be useful by the federal government and other states designed to identify potentially improper payment patterns were not routinely produced. (Finding 9)

  For example, there were no comprehensive reports to identify:

  - payments made for deceased persons.
  - providers performing services outside of their specialties.
  - spike payments made to providers that submitted large amounts of claims over a short period.

Objective 2 – Post Payment Review (cont'd)

- The vendor MCPA hired to audit in-state paid hospital claims did not complete audits timely. (Finding 12)
  - As of December 31, 2008, no claims paid since January 1, 2004 had been subject to audit by the vendor.
  - MCPA advised that certain claims for services provided during calendar year 2003 can no longer be audited since the period hospitals are required to maintain records has lapsed.
- Rates paid for services rendered by out-of-state hospitals were not always verified. Such payments totaled $21 million over a three-year period. (Finding 13)

Objective 3 – DDA and MHA Claims

DDA and MHA providers are paid outside of the computer system (MMIS II) used to process Medicaid claims. To obtain federal funds for clients enrolled in Medicaid, paid DDA and MHA claims are subsequently processed through MMIS and are submitted to the federal government.

- There was no systematic process among DDA, MHA, and MCPA to determine the causes for the rejected claims so that procedures and processes could be modified to minimize future rejected claims. (Finding 15)

- The difficulties of MHA and DDA in obtaining federal Medicaid funds for their previously paid claims has been a longstanding issue, for at least 10 years.

Objective 3 – DDA and MHA Claims (cont'd)

- Numerous claims for federal reimbursement from DDA and MHA were rejected by MMIS II. For example, 116,000 DDA claims submitted during August 2008 totaling $12.2 million were rejected by MMIS II.

- As of January 2009, outstanding MHA rejected claims for federal reimbursement totaled $14.5 million, including $6.3 million of rejected claims that had been outstanding for more than 1 year.

- Since these claims were previously determined to be legitimate and were paid by these Administrations, the amount of claims rejected by MMIS II for federal reimbursement purposes should be minimal.

Objective 3 – DDA and MHA Claims (cont'd)

- Rejected claims for federal reimbursement were not investigated and resolved promptly. (Finding 16)
  - For example, as of December 2008, DDA claims paid for services provided in calendar year 2006, totaling approximately $8.4 million, were submitted and denied for federal reimbursement and remained outstanding.
  - If these claims were not successfully processed through MMIS II, federal fund reimbursements of up to $4.2 million (50 percent of $8.4 million) may have been lost.
- Records for rejected DDA claims were not maintained in a manner that facilitated a complete and timely resolution of the claims.

Conclusion

DHMH needs to:

- Process claims through all appropriate edits, improve controls over changes to edit settings, and develop clear descriptions of edits;
- Recover identified improper payments;
- Periodically review MMIS access, and study staffing needs and develop training for claims processing;
- Develop comprehensive procedures for the post-payment review process and use a risk-based approach to select areas for review;
- Ensure that hospital claims are audited timely and verify that payments to out-of-state hospitals are based on appropriate rates; and
- Improve the process for obtaining federal funds for DDA and MHA Medicaid claims and ensure that all rejected claims are promptly pursued.