Audit Report

Department of Health and Mental Hygiene
Health Regulatory Commissions

January 2013

OFFICE OF LEGISLATIVE AUDITS
DEPARTMENT OF LEGISLATIVE SERVICES
MARYLAND GENERAL ASSEMBLY

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DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF LEGISLATIVE AUDITS
MARYLAND GENERAL ASSEMBLY

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January 7, 2013

Senator James C. Rosapepe, Co-Chair, Joint Audit Committee
Delegate Guy J. Guzzone, Co-Chair, Joint Audit Committee
Members of Joint Audit Committee
Annapolis, Maryland

Ladies and Gentlemen:

We have audited the Health Regulatory Commissions of the Department of Health and Mental Hygiene for the period beginning May 1, 2008 and ending May 15, 2011. The Health Regulatory Commissions consists of the following independent commissions:

- Maryland Health Care Commission (MHCC)
- Health Services Cost Review Commission (HSCRC)
- Maryland Community Health Resources Commission (MCHRC)

These three independent commissions are responsible for health-related functions, including directing and administering the State's health planning functions, developing health care cost-containment strategies, reviewing and approving hospital rates, and increasing health care access for low-income, underinsured, and uninsured Marylanders.

Our audit disclosed control deficiencies that resulted in a lack of assurance that the billings processed by the 53 hospitals regulated by HSCRC, with combined annual regulated revenues totaling more than $13 billion, were in accordance with HSCRC's established rates. HSCRC did not have a process to determine if hospitals had implemented adequate controls over the maintenance, updates, and management of their billing systems. Additionally, HSCRC did not fully investigate hospital billing overcharges identified through required annual agreed-upon procedures reviews. The fiscal year 2009 reviews disclosed that four hospitals charged significantly higher rates for certain procedures. Based on records obtained by HSCRC upon our request from these four hospitals, we estimated these overcharges totaled at least $13.2 million, dating in some cases back to 2001, including at least $3.7 million to the State's Medicaid program. Furthermore, we noted that the calculations supporting annual hospital billing

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rates prepared by HSCRC staff were not independently reviewed and approved by supervisory personnel. Finally, HSCRC did not periodically review documentation to support the reasonableness of billing rates determined directly by hospitals for certain unique medical procedures that HSCRC permitted hospitals to establish unilaterally. HSCRC's periodic review of the reasonableness of these hospital-determined rates is necessary to ensure the billing rates are consistent with comparable procedures as required by HSCRC policy.

MHCC did not verify the propriety of disbursements from the Maryland Trauma Physician Services Fund, which awards reimbursements to trauma physicians that provided uncompensated trauma care.

The Department of Health and Mental Hygiene's response to this audit, on behalf of the Commissions, is included as an appendix to this report. We wish to acknowledge the cooperation extended to us during the course of this audit by the Commissions.

Respectfully submitted,

Thomas J. Barnickel III, CPA
Legislative Auditor

Table of Contents

Executive Summary

Legislative Audit Report on the
Department of Health and Mental Hygiene
Health Regulatory Commissions
January 2013

The Health Regulatory Commissions is a budgetary unit of the Department of Health and Mental Hygiene that comprises three independent commissions established by law: the Maryland Health Care Commission, the Health Services Cost Review Commission, and the Maryland Community Health Resources Commission.

- **The Health Services Cost Review Commission (HSCRC) did not have a process to periodically review hospital billing systems to determine if hospitals had implemented adequate controls over the maintenance, updates, and management of the systems to ensure that hospital bills were proper. The HSCRC is responsible, in part, for establishing and approving hospital billing rates and monitoring hospital compliance with approved billing rates.**

  HSCRC should establish procedures to ensure hospitals have implemented proper controls over the maintenance, updates, and management of hospital billing systems.

- **HSCRC did not adequately investigate the impact of hospital billing overcharges identified through annual agreed-upon procedures reviews that it requires be performed. Our review of the fiscal year 2009 agreed-upon procedures reviews (the most recent completed at the time of our audit) disclosed that four hospitals charged rates ranging from 67 to 1,880 percent higher than allowed by HSCRC for certain medical procedures (one at each hospital). As of June 30, 2011, we estimated that related past overcharges at the four hospitals totaled at least $13.2 million, of which at least $3.7 million was overcharged to the State's Medicaid program. These overcharges dated back to 2001 or 2004.**

  HSCRC should fully investigate overcharges to determine their extent and impact. Based on these investigations, HSCRC should determine the appropriate action to be taken, including adjusting future rates to account for the full extent of the overcharges, requiring repayment of the specific overcharges, and/or assessing penalties. HSCRC should also expand these

annual reviews as necessary to determine if overcharges occurred in additional medical procedures.

- **HSCRC did not periodically review documentation to support the reasonableness of the billing rates established directly by the hospitals. For certain unique inpatient and outpatient medical procedures, hospitals are permitted to establish the billing rates which are not set by HSCRC. HSCRC's periodic review of the reasonableness of these hospital-determined rates is necessary to ensure the billing rates are consistent with comparable procedures, as required by HSCRC policies. HSCRC estimated that revenue from medical procedures in which the hospitals assign the billing rates accounts for approximately 10 to 20 percent of total hospital revenue.**

  HSCRC should establish procedures to review, at least on a test basis, the documentation supporting the reasonableness of hospital-assigned billing rates for unique medical procedures.

- **The calculations used by HSCRC to determine the annual hospital rate order agreements were not independently reviewed by supervisory personnel. The rate order agreements establish the allowable billing rates for hospital services as well as broad revenue thresholds for HSCRC monitoring purposes.**

  HSCRC should establish procedures to perform a documented independent supervisory review of hospital rate order agreements on a test basis.

- **The Maryland Health Care Commission (MHCC) did not require its contractor, which processes claims from the Maryland Trauma Physician Services Fund, to confirm that trauma patients on reimbursement claims were listed on the Maryland Trauma Registry, as required by the contract and State law. The MHCC administers this Fund to reimburse trauma physicians for services rendered to uncompensated care patients. Our match of the contractor's claims records to the Maryland Trauma Registry disclosed 1,357 approved claims, totaling approximately $290,000, for which the patient trauma registry numbers did not exist in the Maryland Trauma Registry.**

  MHCC should require its contractor to confirm trauma patients listed on reimbursement claims to the Maryland Trauma Registry to determine eligibility, investigate the aforementioned 1,357 claims identified, and take appropriate action to recover amounts paid for ineligible claims.

Background Information

Agency Responsibilities

The Health Regulatory Commissions is a budgetary unit of the Department of Health and Mental Hygiene that comprises three independent commissions established by law: the Maryland Health Care Commission, the Health Services Cost Review Commission, and the Maryland Community Health Resources Commission.

The Maryland Health Care Commission (MHCC) is responsible for directing and administering the State's health planning functions, developing health care cost-containment strategies, and maintaining a database on all non-hospital health care services. The Health Services Cost Review Commission (HSCRC) is responsible for establishing, reviewing, and approving hospital billing rates, monitoring hospital compliance with approved billing rates, collecting data on hospital utilization, and administering the Hospital Uncompensated Care Fund, which compensates hospitals for services provided to individuals unable to pay. The MHCC and HSCRC are jointly responsible for administering the Maryland Trauma Physician Services Fund. The Maryland Community Health Resources Commission (MCHRC) is responsible for increasing health care access for low-income, underinsured, and uninsured Marylanders by providing support to community health resources.

According to the State's records, fiscal years 2011 and 2012 operating expenditures for the Commissions totaled approximately $36 million and $44 million, respectively, and were primarily funded by user fees assessed to hospitals and other entities. Additionally, approximately $111 million and $120 million, respectively, were paid to hospitals from the Hospital Uncompensated Care Fund during those same years.

See Exhibit A for definitions of terms used throughout this report.

Medicare Waiver Compliance

In 1977, the federal government granted Maryland a Medicare Waiver, whereby the federal government agreed that Medicare and Medicaid payments to hospitals would be made based on the rates established by the Health Services Cost Review Commission (HSCRC) instead of based on national federal payment principles. This Waiver allows Maryland to establish an all-payer system (including Medicare, Medicaid, private insurers, and uninsured individuals) which pays hospitals based on the rates set by HSCRC, regardless of the payer. The purpose

of the all-payer system is to reduce disparities in hospital payments that normally exist between payer groups in non-regulated systems and makes it possible for the State to operate its uncompensated care program that pays for medical services provided to patients who are unable to pay. Maryland is the only state that has this Medicare Waiver. As of September 2011, HSCRC's rate-setting authority applied to 47 acute hospitals, 3 specialty hospitals, and 3 psychiatric hospitals; combined annual regulated revenues total more than $13 billion.

To maintain the Medicare Waiver, Maryland must comply with the following two requirements:

1. The rate of growth in Medicare payments to Maryland hospitals per inpatient hospital admission (average cost) from 1981 to the present must be no greater than the rate of growth in Medicare payments nationally over the same period.
2. All payers must pay based on the same rates.

If the federal government determines that Maryland is not in compliance with the Medicare Waiver requirements, the Waiver provides for a three-year correction period before the Waiver would be lost. According to the Department of Legislative Services in its 2011 analysis of HSCRC's budget, the annual monetary impact of losing the Medicare Waiver to the State's hospitals is approximately $1 billion in lost Medicare reimbursements.

HSCRC projections indicate significant potential difficulties in the State's ability to maintain compliance with the aforementioned first Medicare Waiver requirement. Specifically, according to May 2012 documents, HSCRC estimates that the "waiver cushion" (that is, the amount Medicare payments to Maryland hospitals could grow before the State failed to meet its waiver requirement) was approximately 3.08 percent as of December 2011.[1] HSCRC projects the waiver cushion will continue to decrease. HSCRC's goal is to maintain a minimum 10 percent waiver cushion to minimize the risk of failing to comply with the requirement. This waiver cushion was achieved as recently as June 2010.

According to HSCRC, one significant reason for the eroding waiver cushion is a requirement, established in the State's budget starting in fiscal year 2010, for annual assessments on hospitals, intended to help support Maryland's Medicaid budget. These assessments have been a significant factor contributing to

[1] The 3.08 percent estimate is based on the assumption that there will be no growth in Medicare payments nationally.

increases in hospital rates and have grown from $45.7 million in fiscal year 2010 to $389.8 million in fiscal year 2012.[2]

The viability and impact of these assessments has been questioned, since all payers are ultimately subsidizing one payer (Medicaid), potentially violating the second waiver requirement. On March 17, 2011, members of the Maryland General Assembly requested the U.S. Department of Health and Human Services Office of the Inspector General (OIG) to perform a compliance review to determine whether legislation requiring such assessments could impact the State's continued compliance with the second waiver requirement. As of September 2012, the OIG had not responded.

In the April 2012 *Joint Chairmen's Report*, the budget committees of the Maryland General Assembly expressed concern about the eroding waiver cushion and stated that the projected waiver cushion for fiscal year 2013 is .77 percent. The *Report* also cited budget actions contemplated by the fiscal year 2013 Medicaid budget as further deteriorating this situation. Accordingly, the *Report* required the Department of Health and Mental Hygiene (DHMH), in consultation with HSCRC, to inform the budget committees immediately if DHMH takes any budgetary actions not identified in the fiscal year 2013 budget that further reduce the waiver cushion or that will have a negative impact on the HSCRC approved hospital financial thresholds (such as the charge per case which establishes a maximum average charge per hospital inpatient case). The *Report* further required the submission of a report to the committees by December 1, 2012, on the specific impact any proposed fiscal year 2012 and 2013 budget action has, or will have, on the waiver cushion or HSCRC approved hospital financial thresholds, as well as the cumulative impact that the hospital Medicaid budget funding assessment has had on the waiver cushion or HSCRC approved hospital financial thresholds.

Status of Findings From Preceding Audit Report

Our audit included a review to determine the status of the one finding contained in our preceding audit report dated November 6, 2008. We have determined that the Commissions had satisfactorily addressed the finding.

[2] While a portion of these assessments is paid by hospitals out of their profits, the vast majority is generated through increases in hospital rates. For example, according to HSCRC records, for fiscal year 2012, $333.3 million of the $389.8 million was paid through increases in hospital rates.

Findings and Recommendations

Hospital Monitoring

Background

The Health Services Cost Review Commission (HSCRC) was established to regulate hospital billing rates and is responsible for maintaining the Medicare Waiver (as described on page 7 of this report). HSCRC's primary mandates are to establish, review and approve reasonable hospital rates and publicly disclose information on the costs and financial performance of Maryland's 53 regulated hospitals. In setting hospital rates, HSCRC's goal is to assure the following requirements are met, which helps ensure the State complies with the Medicare Waiver:

- The total costs of all services offered by a hospital are reasonable.
- Aggregate hospital rates are reasonably related to its aggregate costs.
- Rates are set equitably among all purchasers of hospital services.

Specifically, HSCRC establishes hospital-specific and service-specific rates for all inpatient, hospital-based outpatient, and emergency services based on various data (such as revenue, volume, cost, and discharge data), resulting in unique rates for each hospital. In the annual rate setting process, the reasonableness of each hospital's underlying costs and revenues is considered as well as the combined impact all hospitals' rates will have on the Medicare Waiver.

HSCRC enters into annual written agreements, called rate orders, with each of its regulated hospitals. In general terms, the rate orders establish broad-based revenue thresholds that are used by HSCRC to monitor hospital revenues. Since fiscal year 2000, the primary revenue threshold for inpatient care billings has been the charge per case (CPC), which establishes a maximum average charge per inpatient case for the hospital. Although HSCRC implemented a threshold on outpatient charges in fiscal year 2011, as of May 2012, this threshold had not been used by HSCRC for monitoring purposes. The rate orders also establish allowable inpatient and outpatient unit rates (expressed in dollars) for the service-specific areas (such as labor and delivery services and electrocardiography services) provided by the hospitals. The number of service-specific areas varies among the hospitals depending on the types of services provided but, generally, each hospital has 25 to 35 different service-specific areas, each including various medical procedures. For medical procedures billed under certain service-specific areas, the allowable unit rate is one of the two factors contributing to the ultimate billing rate. The other factor is the unit level, which is a multiplier that, in most cases, is established by HSCRC and is the same for all hospitals. Specifically, for

these service-specific areas, the unit rate is multiplied by the unit level for each medical procedure to determine the total billing rate for that procedure.[3]

HSCRC monitors hospital compliance with rate orders using hospital-reported data and annual independent audits. Specifically, each hospital submits operational and financial data (such as, revenue, volume, cost, and discharge data) to HSCRC throughout the year. HSCRC analyzes the data to determine if hospitals are within acceptable variances of approved unit rates and revenue thresholds established by that year's rate orders. HSCRC also requires each hospital to obtain an annual independent financial statement audit and mandates that the independent auditor also perform an agreed-upon procedures review to provide assurances over the reliability of the aforementioned reported data. As a result of the monitoring process, HSCRC may assess penalties for non-compliance with rate orders and adjust future rates for variances from approved rates (which could result from both undercharges and overcharges) or established revenue thresholds.

Finding 1
HSCRC did not have a process to determine if hospital billing systems were accurately maintained to provide assurance that billing rates were in accordance with HSCRC's rate orders.

Analysis
HSCRC had not established procedures to determine if hospitals had implemented adequate controls over the maintenance, updates, and management of their billing systems to ensure that hospital bills were proper. Furthermore, HSCRC's annual agreed-upon procedures reviews did not include an evaluation of the hospital's billing system or related controls. Each regulated hospital uses an electronic billing system to generate hospital bills. These electronic billing systems contain a database (known as the charge master) that stores the hospital's billing rates for each unique hospital service, medical procedure, and medical supply, as well as the medical procedure code (a universally recognized medical coding value), a description of the medical procedure, and other data used to generate hospital bills.

Specifically, HSCRC did not perform any reviews of hospital billing systems and did not require hospitals to maintain control procedures. Control procedures should be in place to provide reasonable assurance that the systems are properly maintained, that regulated services and billing rates are properly recorded in the

[3]For example, if a hospital with an approved unit rate of $3 for a service-specific area includes a medical procedure with a unit level of 30, the billing rate for the medical procedure would be $90 (the $3 unit rate times the 30 unit level).

system, that proper controls are in place over data entry and edits, and that the billing system is functioning properly. Our discussions with two large payers, including the State's Medicaid program, disclosed that the payers do not verify the accuracy of hospital billing rates since they rely on HSCRC for this purpose.

Furthermore, State law requires that facilities under the jurisdiction of HSCRC charge for services at the rates established by HSCRC. Inadequate controls over hospital billing systems could allow billing errors to occur and remain undetected. For example, as noted in Finding 2, the use of improper billing rates at four hospitals for certain medical procedures resulted in overbillings for extended periods.

HSCRC may be able to use or expand current monitoring mechanisms to ensure hospitals have implemented proper controls over their billing systems. For example, HSCRC may be able to enhance its requirements for the annual agreed-upon procedures reviews of each hospital to also include assurances over the adequacy of each hospital's billing system controls and related database.

Recommendation 1

We recommend that HSCRC establish procedures to ensure hospitals have implemented adequate controls over the maintenance, updates, and management of hospital billing systems. These controls should provide reasonable assurance that the systems are properly maintained, that hospital-regulated services and billing rates are properly recorded in the systems, that proper controls are in place over data entry and edits, and that the billing systems are functioning properly.

Finding 2

HSCRC did not adequately investigate the impact of hospital billing overcharges identified through annual agreed-upon procedures reviews.

Analysis

HSCRC did not adequately investigate hospital billing charges in excess of approved rates that were identified during the annual agreed-upon procedures reviews. Specifically, HSCRC did not determine how long overcharges had been occurring, the extent of prior year overcharges, and the patients and payers that may have been overcharged, nor did HSCRC expand the annual reviews to determine if overcharges occurred in additional medical procedures not originally selected for testing. Rather, HSCRC only requested that the hospitals correct their billing systems for identified errors going forward. Based on the full extent of overcharges, HSCRC could determine additional actions to be taken against the hospitals, including adjusting future rates to account for the full extent of the

overcharges, requiring repayment of the specific overcharges, and/or assessing penalties. State regulations allow HSCRC to assess penalties for noncompliance with approved unit rates and provide that, when a flagrant disregard of approved rates is detected, HSCRC can require hospitals to repay patients who were overcharged.

According to the agreed-upon procedures reviews, selected medical procedures were subject to specific testing to determine if the related billing rates were proper based on the rate orders. HSCRC recommended testing one month of billing data based on a selection of certain medical procedures accounting for high annual volume or revenue in two pre-selected service-specific areas. For example, for one hospital, six procedures were selected for testing.

We reviewed the results of the agreed-upon procedures reviews for all hospitals for fiscal year 2009 (the most recent year reviewed by HSCRC at the time of our audit) to identify instances of overcharges. Our review disclosed four hospitals that charged for certain procedures (one at each hospital) at rates ranging from 67 to 1,880 percent higher than allowed by HSCRC. At our request, HSCRC obtained available billing records from these four hospitals, dating as far back as 2001. As of June 30, 2011, we estimated that hospital overcharges totaling at least $13.2 million occurred, of which at least $3.7 million was overcharged to the State's Medicaid program. (Refer to the table on page 15.)

Based on our discussions with HSCRC management, we were advised that the overall impact of overcharges on a specific hospital's revenue threshold (charge per case) could be minimized by the extent of undercharges for other medical procedures. However, comparing overcharges to undercharges does not consider the impact that documented overcharges have on individual payers. Consequently, while the agreed-upon procedures reviews also disclosed instances of hospital undercharges, our review focused on overcharges, which are of greater significance to payers. Furthermore, although State regulations allow for HSCRC, under certain conditions, to require repayment to patients for overcharges, there is no requirement allowing hospitals to bill patients for undercharges identified during the reviews.

These overcharges, which dated back to at least 2001 or 2004, resulted from each hospital including an incorrect unit level for the specific procedure in its billing system. Since HSCRC's ongoing rate order monitoring process did not include obtaining unit level information in sufficient detail from the hospitals, these types of overcharges would not be readily detected; therefore, the agreed-upon procedures reviews are a necessary component of the monitoring process. Furthermore, since the agreed-upon procedures include only a limited number of

medical procedures, expanding the reviews to include additional medical procedures should be considered, depending on the results, to see if there is broader impact.

OLA Estimated Hospital Overcharges

Hospital	Medical Procedure	Percentage Difference Between HSCRC Approved Rate and Billed Rate	OLA Estimated Overcharge		
			Total Overcharge	Period of Overcharge	Amount of Overcharge Paid by State Medicaid
Hospital 1	Doppler Color Flow	1,880%	$3.7 million	July 2001 to March 2010	$400,000
Hospital 2	Doppler Color Flow	300%	$1.2 million	July 2004 to April 2010	Hospital unable to provide data
Hospital 3	EKG Single	67%	$1.6 million	July 2004 to April 2010	Hospital unable to provide data
Hospital 4[1]	OB Ultrasound	67%	$6.7 million	July 2004 to June 2011	$3.3 million
Totals			**$13.2 million[2]**		**$3.7 million**

[1] After bringing these overcharges to HSCRC's attention, Hospital 4 provided HSCRC with a written explanation for the higher billed charges. Although HSCRC agreed with the hospital, HSCRC did not assess the reasonableness of the explanation based on a comprehensive review or audit of hospital bills.

[2] The outpatient portion of the $13.2 million in overcharges totaled approximately $7.5 million.

Based on our review, penalties specific to the overcharges identified were not assessed against the aforementioned hospitals and the hospitals were not required to make repayment.

Recommendation 2

We recommend that HSCRC

a. fully investigate overcharges to determine the extent and impact;

b. based on the results of the investigations, determine the appropriate action to be taken, including adjusting future rates to account for the full extent of the overcharges, requiring repayment of the specific overcharges, and/or assessing penalties; and

c. establish a policy to expand agreed-upon procedures reviews to additional medical procedures as necessary.

Finding 3
HSCRC did not periodically review documentation to support the reasonableness of billed unit levels assigned by hospitals for certain medical procedures.

Analysis
HSCRC did not periodically review documentation to support the reasonableness of the billed unit levels established by hospitals. While most unit levels are determined by HSCRC, the hospitals have the authority to determine their own billed unit levels for certain unique, non-routine inpatient and outpatient medical procedures (such as certain eye exams, specialized reproductive procedures, and molecular biology procedures), subject to HSCRC review to determine if the billing rates are consistent with comparable procedures. The billed unit level assigned by a hospital to a medical procedure directly impacts the amount that is charged by the hospital for the related procedure. Specifically, the unit level is applied to the unit rate to determine the billing rate of the procedure. Therefore, reviewing the documentation supporting the reasonableness of the hospital's assigned unit levels is critical and is not specifically reviewed during the annual agreed-upon procedures reviews.

HSCRC management advised us that, while it is not specifically tracked, HSCRC estimated that revenue from medical procedures in which the hospital determines the billed unit level is approximately 10 to 20 percent of total hospital revenue from all medical procedures.

Recommendation 3
We recommend that HSCRC establish procedures to review the documentation to support billed unit levels assigned by hospitals, at least on a test basis.

Finding 4
The calculations used to determine the annual hospital rate orders were not independently reviewed by supervisory personnel.

Analysis
Although HSCRC's process to prepare hospital rate orders involves multiple internal meetings and reviews by the hospitals, the formal calculations used to

determine the underlying data (including unit rates and levels) prepared by HSCRC staff were not subject to an independent documented supervisory review.

The preparation of the rate order for each hospital is complex and includes numerous components and calculations during which HSCRC staff members update and manipulate various spreadsheets with pre-defined complex formulas.

While the annual update factor[4] is approved by the HSCRC commissioners and each hospital's rate order is signed by the HSCRC Executive Director, neither of these reviews ensures the underlying preparation and calculation of the rates and thresholds prepared by HSCRC staff were proper. HSCRC advised that, due to limited staff, it had not established a process whereby the rate order preparation was subject to documented independent review to ensure that the rates and thresholds were properly prepared and accurate prior to being submitted to the Executive Director for approval. Consequently, any errors affecting each hospital's rate order may not be detected.

Recommendation 4
We recommend that HSCRC establish procedures to perform a documented independent supervisory review of hospital rate orders on a test basis.

Trauma Physician Reimbursements

Background
The Maryland Health Care Commission (MHCC) administers a program that provides reimbursements from the Maryland Trauma Physician Services Fund to trauma physicians for services rendered to uncompensated care patients treated at Maryland trauma centers. The Fund is financed by a $5 surcharge on all Maryland vehicle registrations. According to State law and regulations, to qualify for reimbursement, the trauma patient must be listed on the Maryland Trauma Registry beginning on or after July 1, 2006. The Maryland Trauma Registry is maintained by the Maryland Institute for Emergency Medical Services Systems (MIEMSS) and is used to monitor and evaluate major trauma care, outcome, cost, and to assess how designated trauma centers comply with trauma standards, regulations, and protocols. Patients are added to the Maryland Trauma Registry by MIEMSS based on trauma patient admission data for trauma patients submitted periodically by Maryland's Trauma Centers. During the twelve-month

[4] The Annual Update Factor is applied to all hospital rate structures under the jurisdiction of the HSCRC. It is meant to adjust each hospital's approved rates for various factors, such as inflation and changes in the intensity of care and/or patient severity of illness, and provides a mechanism for HSCRC to recognize cost, control growth, and achieve policy objectives.

period ending in May 2010, more than 21,000 patients (including patients covered by insurance and uncompensated care patients) were added to the Maryland Trauma Registry.

Beginning December 2007, MHCC entered into a $1.9 million contract with a contractor, through September 2012, to process the reimbursement claims. The contractor's responsibilities include receiving claims from trauma physicians, verifying eligibility of the claims, and submitting to MHCC periodic reports denoting the claims and related amounts that met eligibility requirements for reimbursement. Based on these reports, MHCC processes the reimbursement payments to the trauma physicians. According to MHCC's records, during fiscal years 2009 to 2011, approved reimbursement claims totaled approximately $16.2 million.

Finding 5
MHCC did not require its contractor to comply with State law and its contract by confirming that trauma patients on reimbursement claims were listed on the Maryland Trauma Registry.

Analysis
Although MHCC's contract required the contractor to confirm the trauma patients were listed on the Maryland Trauma Registry when determining claims eligibility, MHCC advised us that the contractor was not performing these confirmations since the beginning of the contract. Furthermore, we were advised by MHCC that, beginning January 2010, it granted verbal approval at the contractor's request not to perform this confirmation even though the contract states the Maryland Trauma Registry is the definitive source for determining eligibility. Furthermore, according to contract procurement documents, the contractor specifically indicated that a component of its fee was for "eligibility/enrollment verification with interface to Trauma Fund Registry information."

We performed an automated match of the contractor's approved claims processed from January 2009 through March 2011 (which we determined reliable for our purposes) to the Maryland Trauma Registry. The match disclosed 1,357 claims totaling approximately $290,000 for which the patient trauma registry numbers in the contractor's claims records did not exist in the Maryland Trauma Registry dating back to July 1, 2006. Our test of 20 of these claims, totaling $54,000, disclosed that, for 16 claims totaling $36,000, the related patient was not listed on the Maryland Trauma Registry on or after July 1, 2006, including 7 for which the actual dates of service, according to the claims forms, were two to three years prior to dates reflected in the contractor's records. This is significant since, in all 7 of these instances, the actual dates of service were prior to July 1, 2006, rendering them ineligible for Fund reimbursement. For the remaining 4 claims

totaling $18,000, there were minor differences in the trauma numbers between the two records; therefore, the patients appeared to be eligible.

As of June 30, 2011, according to State records, MHCC had paid the contractor approximately $1.3 million since the contract began.

Recommendation 5
We recommend that MHCC

a. require its contractor to confirm trauma patients listed on reimbursement claims to the Maryland Trauma Registry to determine claims eligibility, and

b. investigate the aforementioned 1,357 claims identified and take appropriate action to recover amounts paid for ineligible claims.

Audit Scope, Objectives, and Methodology

We have audited the Health Regulatory Commissions of the Department of Health and Mental Hygiene (DHMH) for the period beginning May 1, 2008 and ending May 15, 2011. The Commissions consists of the Maryland Health Care Commission, the Health Services Cost Review Commission, and the Maryland Community Health Resources Commission. The audit was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

As prescribed by the State Government Article, Section 2-1221 of the Annotated Code of Maryland, the objectives of this audit were to examine the Commissions' financial transactions, records and internal control, and to evaluate its compliance with applicable State laws, rules, and regulations. We also determined the status of the finding included in our preceding audit report.

In planning and conducting our audit, we focused on the major financial-related areas of operations based on assessments of materiality and risk. The areas addressed by the audit included hospital rate monitoring, Maryland Trauma Physician Services Fund disbursements, grant programs, and hospital uncompensated care. Our audit procedures included inquiries of appropriate personnel, inspections of documents and records, and observations of the Commissions' operations. We also tested transactions and performed other auditing procedures that we considered necessary to achieve our objectives. Data provided in this report for background or informational purposes were deemed reasonable, but were not independently verified.

Our audit did not include certain support services provided to the Commissions by DHMH – Office of the Secretary. These support services (such as payroll, purchasing, maintenance of accounting records, and related fiscal functions) are included within the scope of our audit of DHMH's Office of the Secretary and Other Units.

The Commissions' management is responsible for establishing and maintaining effective internal control. Internal control is a process designed to provide reasonable assurance that objectives pertaining to the reliability of financial records, effectiveness and efficiency of operations including safeguarding of assets, and compliance with applicable laws, rules, and regulations are achieved.

Because of inherent limitations in internal control, errors or fraud may nevertheless occur and not be detected. Also, projections of any evaluation of internal control to future periods are subject to the risk that conditions may change or compliance with policies and procedures may deteriorate.

Our reports are designed to assist the Maryland General Assembly in exercising its legislative oversight function and to provide constructive recommendations for improving State operations. As a result, our reports generally do not address activities we reviewed that are functioning properly.

This report includes findings that we consider to be significant deficiencies in the design or operation of internal control that could adversely affect the Commissions' ability to maintain reliable financial records, operate effectively and efficiently, and/or comply with applicable laws, rules, and regulations. Our report also includes findings regarding significant instances of noncompliance with applicable laws, rules, or regulations. Other less significant findings were communicated to the Commissions that did not warrant inclusion in this report.

DHMH's response, on behalf of the Commissions, to our findings and recommendations is included as an appendix to this report. As prescribed in the State Government Article, Section 2-1224 of the Annotated Code of Maryland, we will advise DHMH regarding the results of our review of its response.

Exhibit A
Definition of Terms

1. **Billing Rates** – the actual rates that are charged by hospitals for regulated hospital services. The Billing Rates must be in accordance with the hospital's HSCRC approved Unit Rates after applying the appropriate Unit Level.
2. **Charge Master** – the database within each automated hospital billing system that stores the hospital's price for every hospital service, medical procedure, and medical supply provided by the hospital, and that is used to generate hospital bills.
3. **Charge per Case (CPC)** – a primary constraint, or threshold, that is established by HSCRC to control hospital revenues on a weight-adjusted per-case basis for inpatient cases. HSCRC establishes a CPC threshold for most hospitals and monitors hospital compliance with that threshold.
4. **Rate Order** – an annual agreement between the State and each hospital detailing HSCRC's established billing rates and revenue thresholds specific to the hospital.
5. **Unit Level** – the quantity of units applied to the Unit Rate for hospital services within service-specific areas to determine the amount to be charged for a specific hospital procedure. In effect, this is a multiplier that is applied to the Unit Rate for a specific hospital procedure within a service-specific area.
6. **Unit Rates** – the rates established by HSCRC for each hospital that are to be the basis of payment for regulated hospital services (for example, operating room charge per minute, admission charge per day). Individual unit rates are established for each service-specific area (for example, labor and delivery services, electrocardiography services).

APPENDIX

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein M.D., Secretary

December 17, 2012

Mr. Thomas J. Barnickel III, CPA
Acting Legislative Auditor
Office of Legislative Audits
301 West Preston Street
Baltimore, MD 21201

Dear Mr. Barnickel:

Thank you for your letter regarding the draft audit report for the Health Regulatory Commissions. Enclosed you will find the Department's response and plan of correction that addresses each audit recommendation. The Commissions have already begun to address many of the recommendations. I will work with the Regulatory Commissions to promptly address the audit exceptions. In addition, the Office of Inspector General's Division of Internal Audits will follow up on the recommendations to ensure compliance.

If you have any questions or require additional information, please do not hesitate to contact Thomas V. Russell of my staff at (410) 767-5862.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: Patrick Redmon, Executive Director, HSCRC
Patrick D. Dooley, Chief of Staff, Office of the Secretary, DHMH
Thomas V. Russell, Inspector General, DHMH
Ellwood L. Hall, Jr., Assistant Inspector General, DHMH
Lisa J. Ellis, Chief Administrative Officer, DHMH
Ben Steffen, Executive Director, MHCC

Finding 1
HSCRC did not have a process to determine if hospital billing systems were accurately maintained to provide assurance that billing rates were in accordance with HSCRC's rate orders.

Auditor's Recommendations:

We recommend that HSCRC establish procedures to ensure hospitals have implemented adequate controls over the maintenance, updates, and management of hospital billing systems. These controls should provide reasonable assurance that the systems are properly maintained, that hospital-regulated services and billing rates are properly recorded in the systems, that proper controls are in place over data entry and edits, and that the billing systems are functioning properly.

Administration's Response:

The Administration concurs with the recommendation. When billing errors occur currently, hospitals may be required to pay back any overcharges if such overcharges result in the hospital exceeding its charge per case target established by the Commission. In addition, hospitals may be subject to significant fines for inaccurate reporting. Despite the fact that hospitals are keenly aware of the substantial penalties associated with incorrect or erroneous billing, the HSCRC agrees that additional procedures to ensure maintenance, updates, and management of billing systems (including charge masters) can be effective to reduce errors in the future. Therefore, the Commission has mandated that hospitals review and keep their billing systems (or charge masters) updated on at least an annual basis, and has required hospitals to attest to such under its Special Audit Procedures. In addition, HSCRC will initiate annual audits of several hospitals' charge masters each year to be conducted by independent audit firms.

Finding 2
HSCRC did not adequately investigate the impact of hospital billing overcharges identified through annual agreed-upon procedures reviews.

Auditor's Recommendations:

We recommend that HSCRC

a. fully investigate overcharges to determine the extent and impact;

b. based on the results of the investigations, determine the appropriate action to be taken, including adjusting future rates to account for the full extent of the overcharges, requiring repayment of the specific overcharges, and/or assessing penalties; and

c. establish a policy to expand agreed-upon procedures reviews to additional medical procedures as necessary.

Administration's Response:

a. The Administration concurs with the recommendations, and the Commission has investigated both the overcharges and undercharges to determine the overall extent and impact.

b. The Commission will require the hospitals, as appropriate, to repay net amounts of overcharges to undercharges dating back to when the error occurred by adjusting future rates. Additionally, those hospitals will be fined in accordance with HSCRC regulations for reporting inaccurate data on their monthly and annual HSCRC reports. The Commission determined that one of the hospitals cited in the Legislative auditor's report charged appropriately for procedures for which Commission policy allows hospitals to charge for services on a "By Report" basis (see Administration's Response to Finding #3). In this case, the hospital followed HSCRC "By Report" procedures by producing documentation justifying the greater resource use for more comprehensive procedures. In this example, the Relative Value Unit (RVU) amount for the common "quick look" ultrasound procedure was 3 RVUs. The hospital justified the assignment of 5 RVUs for the more comprehensive ultrasound procedure.

It is important to note that the Commission discovered these errors, and hospitals will be required to repay overcharge amounts in addition to penalties. This will ensure that hospitals do not financially benefit from overcharges at any point. It is important to the Commission that all revenue be properly accounted for and therefore agrees with the Legislative Auditor's recommendation.[1]

c. When errors were identified by the Special Audit Procedures, HSCRC staff assumed that the error occurred in the fiscal year being audited. The HSCRC Special Audit Procedures have now been changed to include the following question for all medical procedure RVUs: "When were incorrect RVUs entered into the hospital's charge master." This will permit the Commission to determine when the error occurred and to apply appropriate repayments (net of overcharges and undercharges) and penalties.

[1] **Auditor's Comment:**

Although HSCRC's response indicates its concurrence with the recommendation, the response also states that HSCRC subsequently determined that one of the four hospitals cited for billing overcharges was justified in charging a rate higher than the rate established in the rate order for the specific procedure. However, as noted in the audit report, this billing error was disclosed during the 2009 agreed-upon procedures review and HSCRC took no action until this issue was questioned by us during the audit. Consequently, our finding—that HSCRC did not fully investigate hospital overcharges, determine the appropriate action to be taken, and establish a policy to expand agreed-upon procedures reviews—remains valid.

Finding 3
HSCRC did not periodically review documentation to support the reasonableness of billed unit levels assigned by hospitals for certain medical procedures.

Auditor's Recommendations:

We recommend that HSCRC establish procedures to review the documentation to support billed unit levels assigned by hospitals, at least on a test basis.

Administration's Response:

The Administration concurs with the recommendation. This recommendation refers to what is known as the "By Report" procedures. "By Report" procedures are new procedures and those that are not common enough to have specifically published Relative Value Units (RVUs) in Appendix D of the HSCRC Manual. Special Audit Procedures require that the audit provide a list of all "By Report" procedures, where the hospital has assigned RVUs to procedures/tests for which RVUs are not assigned in Appendix D of the HSCRC Manual, including the CPT Code, description, and the RVUs assigned for review by HSCRC staff. The HSCRC "By Report" procedures require hospitals, upon request, to produce documentation justifying the greater resource use for the more comprehensive "By Report" procedures. However, there is no standard for the routine review of the reasonableness of the RVUs assigned.

As a result of the findings of the Legislative Audit, the HSCRC has established procedures to review the list of "By Report" procedures/tests and require that hospitals provide the documentation for a sample of procedures/tests to support the RVUs assigned.

Finding 4
The calculations used to determine the annual hospital rate orders were not independently reviewed by supervisory personnel.

Auditor's Recommendations:

We recommend that HSCRC establish procedures to perform a documented independent supervisory review of hospital rate orders on a test basis.

Administration's Response:

The Administration concurs that the Commission has not documented independent supervisory review of hospital rate orders. However, the Commission asserts that supervisory reviews have taken place both by supervisory HSCRC staff and senior finance officers at hospitals. The Commission has implemented a process to document the independent supervisory review of rate orders for FY2013 and beyond.

Finding 5
MHCC did not require its contractor to comply with the State law and its contract by confirming that trauma patients on reimbursement claims were listed on the Maryland Trauma Registry.

Auditor's Recommendations:

We recommend that MHCC

a. Require its contractor to confirm trauma patients listed on reimbursement claims to the Maryland Trauma Registry to determine claims eligibility, and
b. Investigate the aforementioned 1,357 claims identified and take appropriate action to recover amounts paid for ineligible claims.

Administration's Response:

a. The Administration concurs with the recommendation. The Commission has already contacted its contractor, and put in writing, that verification of claims paid by the fund are to be matched with the Trauma Registry.

b. The MHCC has begun the process of investigating not only the 1,357 claims that were identified but all claims payments from January, 2009 to present. The Commission has already notified trauma physicians that we are in the process of auditing these claims and will recover funds for claims that are not on the registry.

AUDIT TEAM

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