

Audit Report

**Department of Health and Mental Hygiene
Mental Hygiene Administration**

May 2008



OFFICE OF LEGISLATIVE AUDITS
DEPARTMENT OF LEGISLATIVE SERVICES
MARYLAND GENERAL ASSEMBLY

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Karl S. Aro
Executive Director

DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF LEGISLATIVE AUDITS
MARYLAND GENERAL ASSEMBLY

Bruce A. Myers, CPA
Legislative Auditor

May 21, 2008

Senator Verna L. Jones, Co-Chair, Joint Audit Committee
Delegate Steven J. DeBoy, Sr., Co-Chair, Joint Audit Committee
Members of Joint Audit Committee
Annapolis, Maryland

Ladies and Gentlemen:

We have audited the Mental Hygiene Administration of the Department of Health and Mental Hygiene (MHA) for the period beginning July 1, 2004 and ending June 30, 2007.

Our audit disclosed that federal reimbursement for provider claims did not correspond to the related rates paid to the providers in all cases, and MHA had not adequately investigated why or the extent to which this occurred. Based on our analysis, approximately \$1.15 million in federal reimbursements were not requested for claims paid in calendar year 2006.

We also noted certain deficiencies relating to the oversight of the administrative service organization (ASO) hired by MHA to provide benefit management services, such as authorizing patient services and paying provider claims. For example, MHA lacked adequate procedures for systematically reviewing the ASO's service authorization decisions as required by State regulations, and did not ensure that the ASO performed the number of claim audits required by its contract. Furthermore, as of June 2007, interest totaling approximately \$1.8 million earned on a bank account used by the ASO to pay provider claims since October 2004 had not been transferred to the State's General Fund.

In addition, independent reviews of provider claims processed by the ASO did not include certain critical attributes, such as ensuring that claims were received within the required timeframe. The ASO paid provider claims totaling approximately \$475 million and received approximately \$14.4 million for its services during fiscal year 2007.

Finally, sufficient action had not been taken to recover provider advances totaling approximately \$737,000, adequate controls had not been established over certain cash receipts, and MHA had not formally analyzed and documented the feasibility of expanding the capitation program.

Respectfully submitted,

Bruce A. Myers, CPA
Legislative Auditor

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Executive Summary

Legislative Audit Report on the Department of Health and Mental Hygiene Mental Hygiene Administration May 2008

- **Based on our analysis, approximately \$1.15 million in federal reimbursements were not requested for claims paid during calendar year 2006. MHA had not adequately investigated why or the extent to which this occurred. In addition, provider claims were not always submitted for reimbursement within the timeframe required by federal regulations.**

MHA should ensure that federal reimbursement for provider claims is received to the fullest extent possible, and that provider claims are submitted within the required timeframe.

- **MHA did not adequately develop and document its procedures for selecting authorization decisions made by the administrative service organization (ASO) for review. State regulations require MHA to regularly and systematically review decisions relating to patient services. Furthermore, the ASO did not perform the number of inpatient facility claim audits required by its contract with MHA.**

MHA should develop and document procedures for selecting a sufficient and comprehensive sample of authorization decisions to be reviewed. In addition, MHA should ensure that the ASO performs the required number of inpatient facility claim audits.

- **Interest income totaling approximately \$1.8 million earned on funds used to pay providers was not transferred to the State's General Fund.**

MHA should ensure that interest income earned on funds used to pay providers is periodically transferred to the General Fund.

- **Reviews of paid provider claims conducted by an independent contractor did not include certain critical procedures, such as ensuring that claims paid entirely from the State General Fund were not actually eligible for federal reimbursement, and verifying that claims were submitted by providers within nine months of service as required by State regulations. In addition, MHA did not ensure that all deficiencies and discrepancies reported by the contractor were properly investigated and resolved.**

MHA should ensure that claim reviews conducted by the independent contractor are sufficiently comprehensive, and that deficiencies and discrepancies reported by the contractor are adequately investigated and resolved.

- **Documentation was not always obtained and verified to support patient eligibility for services paid entirely from the State's General Fund (not eligible for federal reimbursement). During calendar year 2006, claims paid in this manner totaled approximately \$46 million.**

MHA should ensure that documentation of patient eligibility is obtained and verified, at least on a test basis.

- **Sufficient action was not taken to recover provider advances totaling approximately \$737,000 due from three providers. The advances have been outstanding for a number of years. Two of the providers continued to receive claim payments which MHA may have been able to offset against their outstanding advances.**

MHA should take steps to recover the outstanding advances.

- **MHA did not formally analyze and document the potential cost benefits and feasibility of expanding its capitation program in spite of significant potential cost savings. The program pays providers a fixed fee for rendering all mental health services for certain high-cost recipients (in lieu of the fee-for-service method). The program is currently capped at 351 recipients and serves only the adult population in Baltimore City.**

MHA should analyze and document the potential cost benefits and feasibility of expanding the capitation program by compiling relevant cost reports and other data that would help support its decisions to expand or not expand the capitation program.

Background Information

Agency Responsibilities

The Mental Hygiene Administration (MHA) is responsible for developing comprehensive treatment and rehabilitation services for individuals with mental illness. MHA's mission is to promote the creation and management of a coordinated, comprehensive, accessible, culturally and age-appropriate system of publicly-funded services and to support individuals who have mental disorders. In addition, MHA oversees the provision of publicly-funded services that provide for the care and treatment of individuals who have mental disorders. Finally, MHA supervises State mental health facilities and reviews and approves the local government plans for the treatment of the mentally ill. According to the State's records, MHA expenditures totaled approximately \$575 million during fiscal year 2007, and were primarily for mental health services.

Claim Edits

Paid provider claims that are eligible for federal reimbursement are submitted by MHA's administrative service organization to the Department of Health and Mental Hygiene's Medical Care Programs Administration (MCPA) for processing on a federally certified automated system (MMIS II). Claims data must be processed on this system in order to be approved for federal reimbursement, which is generally 50 percent of the claim amount paid. In this regard, MMIS II has certain edit functions, such as a check for duplicate payments and claims not submitted timely, through which the claim data must pass prior to being approved for reimbursement. However, at MHA's request, MCPA periodically bypassed certain edits in the system in order to process claims for reimbursement that otherwise, in the opinion of MHA and MCPA, would have been improperly rejected by the system.

This situation was first commented upon in our audit report on MCPA dated July 28, 2006, which stated that, during fiscal year 2005, MCPA submitted MHA claims totaling approximately \$145 million through a separate batch process that bypassed MMIS II edits in order to obtain federal reimbursement. In that report, we recommended that MCPA process all claims through standard system edits unless approval to override the edits is obtained from the federal granting agency. In our MCPA follow-up review report dated July 13, 2007, we noted that, as of March 2007, MCPA had processed \$746,000 in current MHA claims by bypassing system edits during fiscal year 2007, and we were advised that MCPA's testing of 1.5 percent of the \$746,000 did not disclose any errors.

MHA management believes that periodically bypassing specific edits in order to process certain paid claims for federal reimbursement is necessary and valid for various reasons. Management advised us that they intend to continue to request that certain edits be bypassed. For example, we noted that, in September 2007, MHA requested MCPA to suspend an edit to process claims totaling approximately \$32,000.

In the aforementioned MCPA follow-up review report, we stated that, due to the complexity of the MCPA claims processing system as well as the significance of claims processed for which system edits are overridden and bypassed, the Office of Legislative Audits would conduct a separate performance audit of MCPA's claims and edit processes. This audit, for which the fieldwork began in March 2008, will include an evaluation of the assertion that the various edit overrides are appropriate. Consequently, we did not address this issue further during this audit of MHA.

Status of Findings From Preceding Audit Report

Our audit included a review to determine the status of the 11 findings contained in our preceding audit report dated September 15, 2005. We determined that MHA had satisfactorily resolved 8 of these findings. The remaining 3 findings are repeated in this report.

Findings and Recommendations

Federal Funds

Finding 1

The Mental Hygiene Administration (MHA) did not ensure that federal reimbursement rates for certain services corresponded to the related rates paid to providers and, as a result, federal funds totaling \$1.15 million were not claimed in calendar year 2006.

Analysis

MHA did not ensure that federal reimbursement rates for certain services corresponded to the related rates paid to providers and had not adequately investigated why this occurred. Based on our analysis, approximately \$1.15 million in federal reimbursement was not requested for claims paid in calendar year 2006.

Federal reimbursement to the State for eligible claims is normally based on the service rate paid to the provider who submitted the claim. However, we noted many instances in which the reimbursement processed through the Medical Care Programs Administration's (MCPA) automated system was calculated based on a rate that was less than the rate paid to the provider. When this occurs, federal reimbursement to the State is less than if the higher rate had been used. In this regard, our analysis of claims paid in calendar year 2006 disclosed approximately 270,000 claims for which federal reimbursement was calculated based on amounts that totaled approximately \$2.3 million less than the amounts actually paid to the providers. Since federal reimbursement is normally 50 percent of the amount paid to the provider, the State received approximately \$1.15 million (50 percent of \$2.3 million) less in federal funding than it would have if the entire claim amount had been used to calculate the reimbursement to the State. Neither MHA, nor MCPA was able to explain why this occurred or document that the matter had been investigated.

Recommendation 1

We recommend that MHA, in conjunction with MCPA, investigate instances, including those noted above, in which federal reimbursement for paid claims was calculated based on an amount that was less than the claim paid to the related provider. We also recommend that any unclaimed federal funding noted as a result of these investigations be recovered to the extent possible. Finally, we recommend that the necessary steps be taken to ensure that federal reimbursement is received to the fullest extent possible for future claims paid.

Finding 2

Eligible provider claims were not always submitted for federal reimbursement within the two-year timeframe required by federal regulations.

Analysis

Eligible provider claims were not always submitted for federal reimbursement within the two-year timeframe required by federal regulations. Those regulations require that claims be submitted within a two-year period which begins on the first day of the calendar quarter immediately following the date payment was made to the provider. Failure to comply with this requirement subjects MHA to a loss of federal funding for eligible claims. Our test of 26 potentially late claims disclosed 7 claims for which the two-year period appeared to have had elapsed before the claims were submitted for federal reimbursement, and federal reimbursement had not been obtained as of the time of our review. The amount of unreimbursed federal funding associated with these 7 claims totaled approximately \$43,000.

MHA maintained that federal reimbursement was not necessarily lost for such claims because, after the initial payment to the provider, the claims required certain adjustment and reprocessing on the automated claims system, and that such actions effectively extended the time period for obtaining reimbursement. However, we were advised by applicable federal authorities that there are a limited number of restrictive exceptions to the time requirement, such as a court-ordered retroactive payment, and that generally claims requiring correction and reprocessing would still need to be submitted within the initial two-year time period following payment to the provider. Furthermore, MHA did not have any documentation to support that any of the claims tested related to exceptions to the time requirement identified by the applicable federal authorities.

Recommendation 2

We recommend that MHA submit eligible claims for federal reimbursement within the timeframe required by federal regulations.

Administrative Service Organization (ASO)**Background**

MHA established the current system for the delivery of mental health services to eligible individuals in July 1997. Specifically, MHA contracts with an administrative service organization (ASO) to provide benefit management services, such as ensuring consumer eligibility, authorizing consumer services, and paying provider claims for the public mental health system. The ASO pays

providers based on an established fee schedule, and payments are made from a special bank account established by MHA for this purpose. MHA opened this bank account in October 2004 (with the approval of the Comptroller's General Accounting Division) with an initial deposit of \$35 million to be used by the ASO to pay provider claims. As claims are paid from the account, the ASO obtains reimbursement for the account from MHA. During fiscal year 2007, the ASO paid provider claims totaling approximately \$475 million. For its services during that year, MHA paid the ASO approximately \$14.4 million.

Finding 3

MHA did not adequately develop and document its procedures for selecting ASO authorization decisions to ensure sufficient coverage. State regulations require MHA to regularly and systematically review these medical decisions.

Analysis

Although MHA had implemented certain procedures for reviewing service authorization decisions made by the ASO (such as type of services and number of treatments approved), the selection process used for these reviews was not adequately developed and documented to ensure that the ASO was properly performing under the contract. Specifically, there was no documentation of how MHA selected its sample of authorization decisions to review, such as the sample size, the types of services to examine, and the frequency of such reviews. Consequently, there was a lack of assurance that MHA consistently reviewed a sufficient and comprehensive sample of authorization decisions. State regulations require MHA to regularly and systematically review these decisions.

During fiscal year 2007, MHA reviewed 12 inpatient hospital authorizations. According to records provided by the ASO, approximately 20,000 inpatient stays were authorized during the first 6 months of that fiscal year. Furthermore, no other types of services, such as authorizations for outpatient claims, were reviewed. As a result, we question whether the sample selected for review by MHA was sufficiently comprehensive.

Recommendation 3

We recommend that MHA develop and document the procedures to be used for selecting service authorization decisions to ensure sufficient review coverage. For example, the procedures should include the minimum quantity of service authorization decisions to be reviewed, the types of services to be selected, and the selection process should be primarily risk-based.

Finding 4

The ASO did not perform the required number of inpatient facility claim audits.

Analysis

The ASO did not perform the number of inpatient facility claim audits required by its contract. Specifically, the contract required the ASO to examine claims filed by a minimum of six inpatient facilities per year to ensure the accuracy of claims made by such facilities. The examinations were to include a review of billing documentation, as well as of related medical records. However, as of June 30, 2007, the ASO only performed two such audits since the inception of the contract in October 1, 2004. MHA management advised us that the current need for inpatient facility audits may, for certain reasons, be less critical than in the past, and that a change to this contract requirement may be warranted. However, no change had yet been made. According to MHA's records, during the period July 1, 2006 to April 30, 2007, inpatient claims totaled approximately \$75.6 million.

Recommendation 4

We recommend that MHA ensure that the ASO performs the required number of inpatient facility claim audits. If a change in this contract requirement is initiated, a contract modification with all required approvals should be developed.

Finding 5

Interest income totaling approximately \$1.8 million earned on the bank account used by the ASO to pay provider claims had not been transferred to the State's General Fund, and review and approval of the related bank reconciliations was not documented.

Analysis

Interest income earned on funds in the claims bank account used to pay providers was not transferred to the State's General Fund. Also, the employee responsible for reviewing and approving the bank reconciliation for the related bank account did not document the review of the account reconciliation.

Specifically, we noted that interest income earned on the account totaling approximately \$1.8 million as of June 2007 had not been transferred to the State's General Fund since the inception of the account in October 2004. Generally, the State Treasurer's Office requires banks holding State accounts to transfer interest earned to the General Fund. We believe that MHA should ensure the proper disposition of interest income earned on this account.

Furthermore, there was no documentation that the bank reconciliations prepared for the account had been reviewed and approved by supervisory personnel, although we were advised that the reconciliations were reviewed.

Recommendation 5

We recommend that MHA ensure that interest earned on the account, including the aforementioned \$1.8 million, is periodically transferred to the State's General Fund. Furthermore, we recommend that the review and approval of the related bank reconciliations be documented.

Contractor Claim Reviews

Background

MHA contracted with a private entity to perform quarterly reviews of claims processed by the ASO, primarily to determine compliance with certain claims processing and record keeping requirements. Each quarter the firm performs certain agreed upon procedures on a random sample of claims, such as tracing claims to proper authorization, ensuring proper recording, and examining the submission of eligible claims for federal reimbursement. The firm issues a report after each review outlining its findings. During fiscal years 2006 and 2007, the firm was paid approximately \$116,000.

Finding 6

Claim reviews performed by the contractor did not include certain critical attributes.

Analysis

MHA's contract for claim reviews did not require certain procedures critical to an adequate examination of provider claims. Specifically, there was no requirement to verify that claims designated by the ASO as to be paid entirely by the General Fund should not have been coded as eligible for federal reimbursement. As previously indicated, claims eligible for federal reimbursement are generally 50 percent financed with federal funds. Furthermore, claims were not tested to ensure that they were submitted by the provider within nine months from the date of service as required by State regulations.

Accurate coding by the ASO is critical to ensure that the State receives federal reimbursement for all appropriate claims. For example, our review of claims paid by the ASO during the period from July 1 to December 31, 2006 disclosed that certain claims for recipients eligible for Medicaid under the Primary Adult Care program had been miscoded as not eligible for federal reimbursement. As a result, claims totaling \$39,000 were not submitted for reimbursement.

Since the claims review contract is one of MHA's primary means for testing the accuracy and propriety of claims processed, MHA should ensure that the contract includes all critical procedures.

Recommendation 6

We recommend that MHA evaluate the claim review contract to ensure that it includes all critical procedures, such as a verification that claims processed as to be paid entirely by the General Fund were not eligible for federal reimbursement, and that claims were paid only if submitted within the required timeframe. We also recommend that MHA submit the miscoded claims noted above for federal reimbursement to the extent possible.

Finding 7

MHA did not ensure that all significant deficiencies and discrepancies reported by the contractor were investigated and corrected.

Analysis

MHA did not ensure that findings reported by the contractor as a result of its claim review were adequately investigated and resolved. Consequently, there was a lack of assurance that the related claims were properly processed. Reports issued by the contractor often noted deficiencies or discrepancies relating to examined claims, such as instances in which federal reimbursement for a particular claim was less than expected, or the amount paid to the provider for a service was different than the established rate. MHA advised us that it generally relies on the contractor to resolve these findings. However, while the reports noted that the contractor normally asked ASO personnel about any claim discrepancies found, the reports often noted that no explanation or resolution was obtained, and the issues were not pursued further. A similar condition was commented upon in our preceding audit report.

Recommendation 7

We again recommend that MHA ensure that appropriate investigative and corrective actions are taken to address significant findings identified by the contractor as a result of its claim reviews.

Documentation of Eligibility

Finding 8

Documentation to support patient eligibility for services paid entirely from the State's General Fund was not always obtained and verified by MHA or the ASO.

Analysis

Documentation to support patient eligibility for mental health services paid entirely by the State's General Fund was not always obtained and verified by MHA or the ASO. Our test of 19 patients whose claims were paid with general funds only disclosed 3 patients for whom documentation of eligibility was not on file at either MHA or the ASO. These 3 patients, for whom provider claims totaling approximately \$25,000 were paid during calendar year 2006, were deemed eligible for mental health services because they were either receiving Social Security disability payments (SSDI) or were recently released from a psychiatric hospital, although these conditions were not documented. The verification of documentation supporting patient eligibility is an attribute that could be tested during the claims reviews discussed in Finding 6.

Individuals with Medicaid coverage are automatically eligible for mental health services through MHA. Individuals who do not qualify for Medicaid may still be eligible for mental health services which will be paid entirely by the State if they meet certain established criteria, such as receipt of SSDI or recent release from a psychiatric hospital. For these two criteria, the applicable providers obtain eligibility information and documentation from their patients. However, MHA and the ASO advised us that they generally do not obtain and verify the documentation to ensure these criteria are met. Consequently, there was a lack of assurance that such individuals qualified for State only payment of mental health services. Claims paid during calendar year 2006 which were designated as general fund only totaled approximately \$46 million.

Recommendation 8

We recommend that MHA establish procedures to ensure that documentation of the eligibility criteria for individuals who are paid for entirely with general funds be obtained in all cases and that the documentation be verified, at least on a test basis, by either MHA or the ASO.

Provider Advances

Finding 9

Sufficient action had not been taken to collect provider advances totaling approximately \$737,000.

Analysis

MHA had not taken sufficient action to recover provider advances totaling approximately \$737,000. In our preceding audit report, we commented that MHA had not taken action to recover advances due from providers totaling approximately \$1.3 million as of September 30, 2004. These funds had been advanced several years ago to certain providers for various reasons, including delays in processing claims by the former ASO. Accordingly, in our preceding report, we recommended that MHA ensure that recovery procedures for these advances be immediately initiated.

Our current audit disclosed that, although a portion of the \$1.3 million had been collected, \$737,000 due from three providers had not been, and there was no documentation that action had been taken to recover these amounts, such as claims offset or submission to the Department of Budget and Management's Central Collection Unit. In this regard, we noted that two of these providers continued to receive claims payments. For example, during calendar year 2006, one provider with outstanding advances of \$187,000 was paid approximately \$4 million. As noted in our preceding audit report, MHA no longer routinely advances funds to providers.

Recommendation 9

We again recommend that MHA initiate recovery procedures for the three providers, including claims payment offset or forwarding the accounts to the Department of Budget and Management's Central Collection Unit.

Cash Receipts

Finding 10

Internal controls over certain cash receipts were not sufficient.

Analysis

Controls over certain collections were not sufficient. Specifically, we noted the following conditions:

- MHA was not adequately verifying that collections received in the mail, which totaled approximately \$1.6 million for fiscal years 2006 and 2007, were

forwarded to and received by the Department of Health and Mental Hygiene's (DHMH) general accounting unit for deposit. These receipts, which related primarily to amounts due from grantees because of cost settlements, were initially recorded on a check log by MHA then forwarded to the accounting unit for processing. Although the accounting unit will provide a receipt to any DHMH unit that forwards collections for deposit, a receipt was not being obtained by MHA. Consequently, there was a lack of assurance that recorded receipts were transferred to and received by the accounting unit.

- Collections received in the mail at the Crownsville Hospital Center, which represented utility payments from tenants currently occupying the Center, were not adequately controlled and verified to deposit. Specifically, these funds, which totaled approximately \$390,000 during fiscal year 2007, were not recorded when received at the Center, but were subsequently picked up by an employee from MHA headquarters for processing. This employee was also responsible for mailing related monthly invoices to tenants, recording the related payments in the accounts receivable records, and depositing the payments. Consequently, this employee had complete control over the collections. Under these conditions, errors or other discrepancies could occur without detection.

Recommendation 10

We recommend that MHA obtain an approved receipt from the DHMH general accounting unit whenever funds are transferred for deposit. We also recommend that collections received at the Crownsville Hospital Center be recorded upon receipt. Furthermore we recommend that, for all collections, an employee independent of the cash collection functions verify recorded collections to either the receipt from DHMH or validated bank documentation, as appropriate. We advised MHA on accomplishing the necessary separation of duties using existing personnel.

Capitation Program

Finding 11 (Policy Issue)

MHA did not formally analyze and document the potential cost benefits and feasibility of expanding the capitation program, in spite of potential cost savings from the program.

Analysis

MHA did not formally analyze and document the potential cost benefits and feasibility of expanding its capitation program, in spite of potential cost savings from doing so. MHA established a capitation program in 1995 which pays

providers a fixed fee for rendering all mental health services for certain high-cost recipients (in lieu of a fee-for-service method). The program is targeted to the adult population of Baltimore City who have serious and persistent mental illnesses, high utilization of inpatient or emergency room services, and have not been able to engage in ongoing treatment within the traditional mental health system. The program has been capped by MHA at 351 recipients, and has an annual cost of approximately \$10 million, a significant portion of which is paid through federal funding.

In our preceding audit report, we recommended that MHA document the potential cost benefits of expanding the capitation program, and determine the feasibility of expanding the program to include additional recipients (for example, children). However, our current audit disclosed that MHA did not prepare formal studies and reports, such as a cost benefits analysis to support the actual cost savings realized by the capitation program and to determine the feasibility of expanding the program. Specifically, MHA did not compare the costs incurred for high-cost recipients that would potentially be eligible for the program to the costs of patients enrolled in the program.

At our request, MHA provided us with financial data for 100 high-cost patients from Baltimore City that were not enrolled in the program. According to MHA's data, fiscal year 2006 costs incurred for these patients, who received intensive residential rehabilitation services, averaged approximately \$36,000, while the cost per patient in the program totaled approximately \$28,000, not including administrative fees. Although there appears to be cost savings generated by the capitation program, MHA management has advised us that they are not considering expanding the program at this time because of various programmatic reasons, such as higher housing costs in certain jurisdictions outside of Baltimore City.

Recommendation 11

We again recommend that MHA document the potential cost benefits of expanding the capitation program by compiling and maintaining formal cost reports, relevant studies, and other data that would help support its decisions to expand or not expand the program. We also recommend that MHA advise the General Assembly's budget committees of the results of the related studies and decisions involving the levels of participation in the program.

Audit Scope, Objectives, and Methodology

We have audited the Mental Hygiene Administration (MHA) of the Department of Health and Mental Hygiene for the period beginning July 1, 2004 and ending June 30, 2007. 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 MHA's 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 findings contained 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. Our audit procedures included inquiries of appropriate personnel, inspections of documents and records, and observations of MHA's 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 MHA by the Department of Health and Mental Hygiene's Office of the Secretary and related units. These support services (such as payroll, purchasing, maintenance of accounting records and related fiscal functions) are included within the scope of our audits of the Department's Office of the Secretary.

Our audit did not include an evaluation of internal controls for federal financial assistance programs and an assessment of MHA's compliance with federal laws and regulations pertaining to those programs because the State of Maryland engages an independent accounting firm to annually audit such programs administered by State agencies, including MHA.

Our audit scope was limited with respect to the MHA's cash transactions because the Office of the State Treasurer was unable to reconcile the State's main bank accounts during a portion of the audit period. Due to this condition, we were unable to determine, with reasonable assurance, that all MHA cash transactions prior to July 1, 2005 were accounted for and properly recorded on the related State accounting records as well as the banks' records.

MHA's 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.

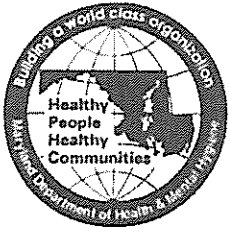
Because of inherent limitations in internal control, errors or fraud may nevertheless occur and not be detected. Also, projections of any evaluation of internal control to future periods are subject to the risk that conditions may change or compliance with policies and procedures may deteriorate.

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 relating to conditions that we consider significant deficiencies in the design or operation of internal control that could adversely affect MHA's 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, and regulations. Other less significant findings were communicated to MHA that did not warrant inclusion in this report.

The Department's response, on behalf of MHA, 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 the Department regarding the results of our review of its response.

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 – John M. Colmers, Secretary

May 20, 2008

Mr. Bruce Myers, CPA
Legislative Auditor
Office of Legislative Audits
Room 1202
301 West Preston Street
Baltimore MD 21201

Dear Mr. Myers:

This is in response to your May 5, 2008 letter that included the draft audit report on the Department's Mental Hygiene Administration, beginning July 1, 2004 and ending June 30, 2007. Attached you will find the Department's response to your audit findings. I will continue to work with the appropriate Directors of Administration, Program Directors, and Deputy Secretary to promptly address all audit exceptions.

If you have any questions or require additional information, please do not hesitate to contact me at 410-767-6505 or Thomas Russell of my staff at 410-767-5862.

Sincerely,


John M. Colmers
Secretary

Attachment

cc: Brian Hepburn, M.D., Executive Director, MHA
Arlene H. Stephenson, Acting Deputy Secretary, PHS
Valerie A. Roddy, Assistant Director to the Deputy Secretary, PHS
Thomas Russell, Inspector General, OIG
Ellwood L. Hall, Chief, Division of Internal Audits, OIG

Findings and Recommendations

Federal Funds

Finding 1

The Mental Hygiene Administration (MHA) did not ensure that federal reimbursement rates for certain services corresponded to the related rates paid to providers and, as a result, federal funds totaling \$1.15 million were not claimed in calendar year 2006.

Recommendation 1

We recommend that MHA, in conjunction with MCPA, investigate instances, including those noted above, in which federal reimbursement for paid claims was calculated based on an amount that was less than the claim paid to the related provider. We also recommend that any unclaimed federal funding noted as a result of these investigations be recovered to the extent possible. Finally, we recommend that the necessary steps be taken to ensure that federal reimbursement is received to the fullest extent possible for future claims paid.

Administration's Response

The Administration concurs with the audit recommendations and will work with MCPA to investigate any claims eligible for recovery and to the extent possible, recover funds. The Administration will continue to collaborate with its ASO and Medicaid in order to ensure future claims contain the appropriate federal match.

Finding 2

Eligible provider claims were not always submitted for federal reimbursement within the two-year timeframe required by federal regulations.

Recommendation 2

We recommend that MHA submit eligible claims for federal reimbursement within the timeframe required by federal regulations.

Administration's Response

The Administration concurs with the audit recommendation and eligible provider claims will be submitted for federal reimbursement within the timeframe required by federal regulations. The Administration will continue to work with Medicaid and the Attorney General's Office to ensure that Medicaid rules are followed.

Finding 3

MHA did not adequately develop and document its procedures for selecting ASO authorization decisions to ensure sufficient coverage. State regulations require MHA to regularly and systematically review these medical decisions.

Recommendation 3

We recommend that MHA develop and document the procedures to be used for selecting service authorization decisions to ensure sufficient review coverage. For example, the procedures should include the minimum quantity of service authorization decisions to be reviewed, the types of services to be selected, and the selection process should be primarily risk-based.

Administration's Response

The Administration concurs with the audit recommendation. The Administration will consult with the Systems' Evaluation Center of the University of Maryland Systems Improvement Collaborative for selecting sample size. Using the sample size selected, MHA will review the service authorizations, including types of services and/or procedures, and cost/risks to be selected.

Finding 4

The ASO did not perform the required number of inpatient facility claim audits.

Recommendation 4

We recommend that MHA ensure that the ASO performs the required number of inpatient facility claim audits. If a change in this contract requirement is initiated, a contract modification with all required approvals should be developed.

Administration's Response

The Administration concurs and will ensure that the required number of claim audits are performed by the ASO. In addition, when necessary, a contract modification with all required approvals will be developed if a change in this contract requirement is initiated.

Finding 5

Interest income totaling approximately \$1.8 million earned on the bank account used by the ASO to pay provider claims had not been transferred to the State's General Fund, and review and approval of the related bank reconciliations was not documented.

Recommendation 5

We recommend that MHA ensure that interest earned on the account, including the aforementioned \$1.8 million, is periodically transferred to the State's General Fund. Furthermore, we recommend that the review and approval of the related bank reconciliations be documented.

Administration's Response

The Administration concurs with the audit recommendations. The Administration has received clarification/guidance on this matter from the State Treasury's Office and as previously discussed and agreed upon, transfer of interest earned will be part of the fiscal year-end close-out process.

Contractor Claim Reviews**Finding 6**

Claim reviews performed by the contractor did not include certain critical attributes.

Recommendation 6

We recommend that MHA evaluate the claim review contract to ensure that it includes all critical procedures, such as a verification that claims processed as to be paid entirely by the General Fund were not eligible for federal reimbursement, and that claims were paid only if submitted within the required timeframe. We also recommend that MHA submit the miscoded claims noted above for federal reimbursement to the extent possible.

Administration's Response

The Administration concurs with the audit recommendations and will ensure that the claims review contract includes all critical procedures and that claims were paid only if submitted within the required timeframe. MHA will submit the miscoded claims noted above for federal reimbursement to the extent possible.

Finding 7

MHA did not ensure that all significant deficiencies and discrepancies reported by the contractor were investigated and corrected.

Recommendation 7

We again recommend that MHA ensure that appropriate investigative and corrective actions are taken to address significant findings identified by the contractor as a result of its claim reviews.

Administration's Response

The Administration concurs with the audit recommendation and will ensure that appropriate investigative and corrective actions are taken to address significant findings identified by the contractor as a result of its claim reviews.

Documentation of Eligibility**Finding 8**

Documentation to support patient eligibility for services paid entirely from the State's General Fund was not always obtained and verified by MHA or the ASO.

Recommendation 8

We recommend that MHA establish procedures to ensure that documentation of the eligibility criteria for individuals who are paid for entirely with general funds be obtained in all cases and that the documentation be verified, at least on a test basis, by either MHA or the ASO.

Administration's Response

The Administration concurs with this recommendation and will establish procedures to ensure that documentation of the eligibility criteria for individuals who are paid for entirely with general funds be obtained in all cases and that the documentation is verified, at least on a test basis, by either MHA or the ASO.

Provider Advances

Finding 9

Sufficient action had not been taken to collect provider advances totaling approximately \$737,000.

Recommendation 9

We again recommend that MHA initiate recovery procedures for the three providers, including claims payment offset or forwarding the accounts to the Department of Budget and Management's Central Collection Unit.

Administration's Response

The Administration concurs with the recommendation and is in the process of recovery procedures for the three providers involved.

Cash Receipts

Finding 10

Internal controls over certain cash receipts were not sufficient.

Recommendation 10

We recommend that MHA obtain an approved receipt from the DHMH general accounting unit whenever funds are transferred for deposit. We also recommend that collections received at the Crownsville Hospital Center be recorded upon receipt. Furthermore we recommend that, for all collections, an employee independent of the cash collection functions verify recorded collections to either the receipt from DHMH or validated bank documentation, as appropriate. We advised MHA on accomplishing the necessary separation of duties using existing personnel.

Administration's Response

The Administration concurs with the audit recommendations and will ensure that receipts are obtained for all deposits and are reconciled to the recorded collections by an independent employee. It should be noted that even though receipts were not obtained from our General Accounting Office, the Administration always verified that the deposited amounts were properly credited to its FMIS accounts.

The Administration concurs with the recommendation that collections received at the Crownsville Hospital Center be recorded upon receipt. Once CHC staff member has recorded receipt of the payments, the checks will be given to MHA's Management Operations Officer for deposit.

Capitation Program

Finding 11 (Policy Issue)

MHA did not formally analyze and document the potential cost benefits and feasibility of expanding the capitation program, in spite of potential cost savings from the program.

Recommendation 11

We again recommend that MHA document the potential cost benefits of expanding the capitation program by compiling and maintaining formal cost reports, relevant studies, and other data that would help support its decisions to expand or not expand the program. We also recommend that MHA advise the General Assembly's budget committees of the results of the related studies and decisions involving the levels of participation in the program.

Administration's Response

The Administration concurs that a formal analysis was not completed, but an analysis was made. Last year there were discussions between Maryland Medicaid, Center for Medicare and Medicaid Services and MHA regarding expanding the Capitation program. After those discussions it was noted that there would be added requirements and costs in moving from a demonstration project to a state-wide program. Based on all discussions to date, it was concluded not to expand the capitation project but rather continue to expand the Assertive Community Treatment. The Administration therefore does not concur with this recommendation to expand the capitation program, but will continue to monitor and evaluate for best practices to ensure efficiencies and efficacies in its provision of services.

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