Performance Audit Report

Department of Health and Mental Hygiene
Processing of Certain Medicaid Claims

Controls Over Edit Claim Functions Were Deficient and Certain Automated Edits Were Inappropriately Disabled

Post-Payment Claims Review Process Lacked Structure

Sufficient Actions Were Not Taken to Reduce System Rejections of Claims for Federal Reimbursement

November 2009

OFFICE OF LEGISLATIVE AUDITS
DEPARTMENT OF LEGISLATIVE SERVICES
MARYLAND GENERAL ASSEMBLY

- This report and any related follow-up correspondence are available to the public through the Office of Legislative Audits at 301 West Preston Street, Room 1202, Baltimore, Maryland 21201. The Office may be contacted by telephone at 410-946-5900, 301-970-5900, or 1-877-486-9964.
- Electronic copies of our audit reports can be viewed or downloaded from our website at http://www.ola.state.md.us.
- Alternate formats may be requested through the Maryland Relay Service at 1-800-735-2258.
- The Department of Legislative Services – Office of the Executive Director, 90 State Circle, Annapolis, Maryland 21401 can also assist you in obtaining copies of our reports and related correspondence. The Department may be contacted by telephone at 410-946-5400 or 301-970-5400.

DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF LEGISLATIVE AUDITS
MARYLAND GENERAL ASSEMBLY

November 23, 2009

Karl S. Aro
Executive Director

Bruce A. Myers, CPA
Legislative Auditor

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

Ladies and Gentlemen:

We conducted a performance audit of the procedures for processing certain Medicaid claims and conducting post-payment reviews. Such claims, which totaled approximately $2.68 billion during fiscal year 2009, were applicable to certain provider payments made by the Department of Health and Mental Hygiene's (DHMH) Medical Care Programs Administration (MCPA), Developmental Disabilities Administration (DDA), and the Mental Hygiene Administration (MHA).

Our audit disclosed MCPA had not established sufficient internal controls over the automated edit functions within the Maryland Medicaid Information System (MMIS II). System edits help ensure that provider medical claims are valid and are eligible for federal reimbursement. Our tests of edits identified nine automated edits that were inappropriately disabled; consequently, claims valued at $98 million, which otherwise would have been suspended and subject to manual reviews, were allowed to be processed for payment during the nine-month period tested. We also determined that certain employees could change edit settings without independent authorization, and that certain claims were improperly paid due to a programming error involving one system edit.

The post-payment review processes used to validate paid claims (for example, fee-for-service claims) needed more structure and formal procedures to help ensure that the reviews were effective, efficient, fully carried out, and fully documented. For example, the types of claims data analyses to be regularly performed were not established, and the results of such analyses were not documented. Consequently, the full extent to which the post-review process resulted in recoveries from providers was not determinable.

DHMH management needs to determine how to minimize recurring rejections by MMIS II of claims for federal reimbursement submitted by MHA and DDA, and to ensure that rejections are resolved and resubmitted in a timely manner to maximize federal reimbursements.

An executive summary of our findings can be found on page 3, and our audit scope, objectives, and methodology are explained on page 11. DHMH's response to this audit is included as Appendix A to this report. Auditor comments related to certain of DHMH's responses can be found in Appendix B. We wish to acknowledge the cooperation extended to us by DHMH during our audit.

Respectfully submitted,

Bruce A. Myers, CPA
Legislative Auditor

Table of Contents

Executive Summary 3

Background Information 7

Audit Scope, Objectives, and Methodology 11

Findings and Recommendations 15
- Objective 1: Effectiveness of Claims Processing Edits 15
- Conclusion 15
- Background 16
- Finding 1 – MCPA Had Valid Reasons for Most System Edits That Were Disabled, but Some Edits Should Not Have Been Disabled 18
- Finding 2 – Controls Over Changes to Edit Settings Were Inadequate 19
- Finding 3 –Documentation of System Edits and Which Edits to Disable Was Lacking 21
- Finding 4 – A Programming Error Resulted in Improper Claim Payments 21
- Finding 5 – Access to Pay Claims Was Inadvertently Granted to 532 Users 22
- Finding 6 – Staffing Needs of MCPA Had Not Been Analyzed 22
- Finding 7 – Formal Training for Employees Performing Critical and Complex Duties is Lacking 23

- Recommendations 24

- Objective 2: Effectiveness of the Post Payment Review Procedures 27
- Conclusion 27
- Background 28
- Finding 8 – Documentation of the Post-Payment Review Process Was in Need of Significant Improvement 28
- Finding 9 – Certain Utilization Reports Were Not Produced or Fully Used 30
- Finding 10 – Procedures Were Not Always Revised to Correct Deficiencies Identified in Post-Payment Reviews 31
- Finding 11 – Additional Procedures Could Be Used to Publicize Fraud Referral Hotline 32
- Finding 12 – Post-Payment Reviews of In-State Hospital Payments Could Be Improved 33
- Finding 13 – Out-of-State Hospital Payment Rates Were Not Always Verified 34
- Finding 14 – Procedures to Obtain Information About Third-Party Liabilities Could Be Improved 35

Recommendations 36

Objective 3: Effectiveness of Process for Obtaining Federal Funds for Other Administrations 39
Conclusion 39
Background 39
Finding 15 – There Was No Systematic Process to Analyze the Causes of Rejected Federal Fund Reimbursement Claims 40
Finding 16 – Rejected Claims for Federal Funds Were Not Promptly Resolved, and Adequate Records of Rejected Claims Were Not Maintained 41

Recommendations 42

Agency Response Appendix A

Auditor's Comments on Agency Response Appendix B

Executive Summary

We conducted a performance audit of certain aspects of the Department of Health and Mental Hygiene's (DHMH) Medicaid claims processing and federal reimbursement procedures, for which related claims payments totaled $2.68 billion during fiscal year 2009. In our most recent fiscal compliance audit of the Medical Care Programs Administration (MCPA), we stated that MCPA overrode (disabled) automated system edits in the Medicaid Management Information System (MMIS II) that were designed to prevent improper payments. MCPA maintained that many of the edits were appropriately disabled. Due to the complexity of the MCPA claims processing system, as well as the significance of the system edits that were disabled, we conducted this audit. The three objectives of this audit were as follows:

1. To evaluate the effectiveness of the claims edit process, particularly the appropriateness of disabling edits
2. To assess the effectiveness of DHMH's procedures performed to review the propriety of claims after payment
3. To evaluate the effectiveness of the voucher claim processes to obtain federal Medicaid reimbursements for services provided through the Mental Hygiene Administration (MHA) and the Developmental Disabilities Administration (DDA)

Our audit disclosed that it was reasonable to disable many of the automated edits since they were not appropriate for the Maryland Medicaid program requirements. However, we also found many claims with significant payment amounts that should have been processed through other edits that were inappropriately disabled.

Improvements, such as better record keeping and better standardization for routine analyses, are needed in the post-payment review process for Medicaid claims. In addition, training should be provided to employees performing complex significant tasks and MCPA should evaluate the staffing needs of its various units.

The processes used by MHA and DDA to obtain federal Medicaid reimbursements were cumbersome resulting in lost interest, inefficient use of staff resources, and lost federal funding.

Regarding Objective 1, we determined that claims totaling $978 million were processed during the period between July 2007 and March 2008 that bypassed 81 disabled edits. Based on our test of 55 disabled edits, applicable to $976 million in paid claims, we determined that it was reasonable to bypass 40 of the disabled edits for payments totaling $691 million. For example, one edit that was appropriately disabled looked for provider facility numbers that were not in the system. Since other information is used in Maryland to identify providers, the disabling of this edit is appropriate. However, we found that 9 disabled edits, which were applicable to paid claims totaling more than $98 million during this period, should not have been bypassed, and for the remaining 6 edits, neither DHMH nor we could determine whether the edits should have been disabled. We also found that clear descriptions of the purpose of the edits in MMIS II could generally not be provided by DHMH.

In addition to being disabled, edits were often temporarily changed, typically to facilitate processing of certain claim payments. Changing edit settings (which are essentially computer program logic changes) can have a significant impact on whether claims are paid or denied by the Medicaid program. We found that controls over changes to edit settings were extremely lax. Changes to edit settings were made without supervisory review and approval, without documented explanations as to why edit settings were changed, and without maintaining records of the changes actually made.

During our testing of claims, we determined that certain claims were improperly processed in MMIS due to a temporary change in edit settings that was not intended to apply to these claims. After we advised MCPA about these claims, its research disclosed that $1.4 million in claims were paid in error and should be recovered from the providers.

Finally, DHMH had not performed a formal study or review to determine the optimal number of employees required to perform its critical Medicaid functions, and did not have a training program for its employees performing critical claims processing functions. Without determining the optimal staffing levels, MCPA cannot ensure that the appropriate number of its approximately 615 employees has been assigned to claims processing functions.

Objective 2 involved the post-payment review process, which we concluded needed significant improvement. The post-payment review process is vital for helping to ensure that payments to providers were for necessary services that were actually provided. The process was not formally structured or adequately documented. For example, comprehensive records of data analysis reports, specific claims reviewed, and any related recoveries were not

maintained. This information could be used to more effectively direct future analyses of paid claims. In addition, we noted that certain reports designed to identify potentially improper payment patterns were not routinely produced. For example, reports of "spike" payments (large amounts of claim payments to a provider over a short period) were not produced. These reports could identify improper provider billings.

Audits of hospital payments, which were performed by a MCPA contractor, were not timely. As of December 31, 2008, no hospital claims paid since January 1, 2004 had been audited by the contractor.

We noted in objective 3 that numerous Medicaid claims that were previously paid to providers by the Mental Hygiene and Developmental Disabilities Administrations were subsequently rejected by MMIS. As a result, federal funds for these claims were not obtained timely or at all. For example, as of December 2008, claims paid for DDA services provided in calendar year 2006, totaling approximately $8.4 million, were submitted and denied by MMIS II for submission for federal reimbursement, and remained outstanding. Since the claims had previously been determined to be legitimate by the Administrations that paid them, and were processed through MMIS only to obtain federal reimbursement, rejected claims should be minimal. However, resolving rejected claims from these DHMH administrations has been commented upon in our audit reports for at least 10 years.

Background Information

Purpose of Program

Medicaid is a joint federal and state entitlement program for low-income citizens of the United States. The Medicaid program is part of Title XIX of the Social Security Act Amendment that became law in 1965. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving covered individuals. The program is administered by the states, which are required to provide health care coverage to all applicants who meet the program's eligibility requirements. To qualify for benefits, applicants must pass certain income and asset tests.

The Medicaid program in Maryland is primarily administered by the Medical Care Programs Administration (MCPA), a unit within the Department of Health and Mental Hygiene. MCPA is responsible for enrolling providers (such as physicians), establishing program regulations, setting provider payment rates, reviewing and paying provider claims, and obtaining federal reimbursement for eligible costs (generally 50 percent of amounts paid to providers).

Individuals qualifying for cash assistance through the Temporary Cash Assistance program or the federal Supplemental Security Income program automatically qualify for Medicaid benefits. Those eligible for Medicaid through these programs make up most of the Medicaid population and are referred to as "categorically needy." Medicaid eligibility determinations in Maryland are generally made by the local departments of social services of the Department of Human Resources.

Federal law also requires the Medicaid program to assist Medicare recipients with incomes below the federal poverty level in making their co-insurance and deductible payments.

The Maryland Medicaid program funds a broad range of services. The federal government mandates that the states provide nursing facility services; hospital inpatient and outpatient services; x-ray and laboratory services; early and periodic screening, diagnosis, and treatment services for children; family-planning services; transportation services; physician care; federally qualified health center and rural health clinic services; and some nurse practitioner services. The Maryland program also provides optional services, such as vision care and podiatry care.

Most Maryland Medicaid recipients are required to enroll in HealthChoice, the statewide managed care program that began in 1997. As of June 2009, approximately 555,000 recipients were enrolled in HealthChoice. Under HealthChoice, MCPA makes specified capitation payments to private Managed Care Organizations (MCOs) that provide services to these Medicaid recipients in Maryland. Our audit did not include payments to MCOs which, during fiscal year 2009, totaled approximately $2.21 billion.

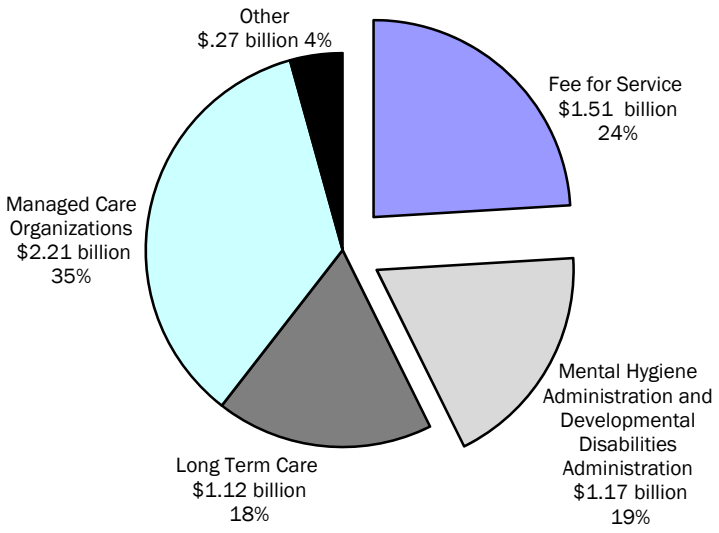
Populations excluded from the HealthChoice program include the institutionalized and individuals who are dually eligible for Medicaid and Medicare. Populations that are not institutionalized and are not covered by an MCO are covered on a fee-for-service basis. Under this system, health providers (such as physicians, hospitals, and medical equipment suppliers) are paid a fee for each service or supply provided. Fees are generally billed at rates established by MCPA or, in the case of hospital stays, at rates established by the Maryland Health Services Cost Review Commission. During fiscal year 2009, payments made on a fee-for-service basis totaled approximately $1.51 billion. These payments were the primary scope of our audit.

Our audit did not include payments to long-term care facilities (for example, nursing homes), which are not paid on a fee-for-service basis. Payments to such facilities totaled approximately $1.12 billion during fiscal year 2009.

In addition to Medicaid expenditures incurred by MCPA, DHMH's Developmental Disabilities (DDA) and Mental Hygiene Administrations (MHA) also make payments to providers that are funded through the Medicaid program. During fiscal year 2009 payments to providers for Medicaid recipients made by DDA and MHA totaled $1.17 billion. These expenditures are processed through MMIS for federal reimbursement purposes only, and were also included in the scope of this audit.

Approximately 615 MCPA employees administered the State's Medicaid program which, as of June 30, 2009, had an enrollment of approximately 802,000 individuals. Chart 1 on the next page depicts the State's Medicaid expenditures for fiscal year 2009.

Chart 1
FY 2009 Medicaid Claims Processed
($6.28 Billion)



Source: Medicaid Management Information System II

Updating the Medicaid Management Information System (MMIS II)

MCPA is in the preliminary stages of updating the Medicaid Management Information System (MMIS II), which is the program's claims processing and information retrieval system. MMIS II is being updated in accordance with the Medicaid Information Technology Architecture (MITA) Initiative, a national framework to support improved systems development and health care management for the Medicaid enterprise. States receive a 90 percent federal matching rate for costs for the design, development, and installation of MMIS II and a 75 percent matching rate for operations-related costs.

The current MMIS II is considered by MCPA to be outdated. It was not designed for the large volume of claims currently processed and it is deemed costly to maintain. MMIS II reporting capabilities are limited, and making program changes to the system is difficult.

The State's fiscal 2009 budget included $1.6 million in funding for DHMH to work with consultants to prepare an advanced planning document for a new MMIS in accordance with MITA. Throughout the year, MCPA worked with the consultant to determine exactly what the administration needed from a new MMIS. The advance planning document was completed and submitted to the Federal Centers for Medicare and Medicaid Services (CMS) in June 2009.

After receiving CMS approval of the advanced planning document, DHMH will develop a draft request for proposal (RFP) to obtain vendor bids and proposals for designing and implementing the new system, which will also be submitted to CMS, as well as to the State's Department of Information Technology, for approval. DHMH anticipates receiving federal approval of the RFP by the end of calendar year 2009.

A definitive timeline and cost estimate for a new MMIS are not yet available. However, DHMH is projecting to need approximately 30 months for design and implementation, from July 2010 through December 2012.

Federal Audit of Maryland's Payment Error Rates

CMS implemented the Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid program. CMS began PERM audits of state Medicaid programs during federal fiscal year 2006. In November 2008, CMS submitted its findings for Maryland.

The data DHMH obtained from CMS to support the findings indicated that CMS tested 1,591 claims (including 513 fee-for-service claims) totaling $3.9 million, and noted errors totaling $14,193. Primarily, these errors were due to providers that did not submit adequate documentation to support the claims. CMS determined the error rate for Medicaid fee-for-service claims to be 1.04 percent. This error rate is well below the published national average error rate of 8.9 percent for fee-for-service claims.

Although the error rate is commendable, even small error rates in Maryland's Medicaid program, which disburses billions of dollars annually, could result in millions of dollars of overpayments. Also, the federal audit only reviewed claims for which federal reimbursements were made to Maryland. The federal audit did not include Maryland-paid Medicaid claims that were not submitted for federal reimbursement, nor did the federal audit determine the amount of Medicaid-eligible claims that were never submitted for federal reimbursement.

Audit Scope, Objectives, and Methodology

Scope

We conducted a performance audit of certain aspects of the Department of Health and Mental Hygiene's Medicaid claims payment procedures. This audit was conducted as a result of the Department's responses to our previous fiscal compliance report, dated July 28, 2006, on the Medical Care Programs Administration (MCPA), the agency primarily responsible for administering the Medicaid program in Maryland. In that report, we stated that MCPA bypassed certain automated system edits designed to prevent improper payments. The Department maintained that there were legitimate reasons for disabling the edits. Due to the complexity of the MCPA payment processes, we conducted this audit to examine certain of the payment processes in more depth.

We conducted the audit under the authority of the State Government Article, Section 2-1221 of the Annotated Code of Maryland, and performed it 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.

Objectives

Our audit had three specific objectives:

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

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

3. To evaluate the effectiveness of the voucher claim processes to obtain federal Medicaid reimbursements for services provided through the

Mental Hygiene Administration (MHA) and the Developmental Disabilities Administration (DDA)

Methodology

To accomplish our objectives, we reviewed and tested numerous paid claims; reviewed available documentation describing system edits including programming logic; examined other records related to paid Medicaid claims, including provider documentation available from DHMH, and reviewed audit reports related to other Medicaid organizations. We interviewed DHMH personnel, specifically MCPA, DDA, and MHA personnel and their contractors, and performed extensive procedural reviews and tests of a number of systems deemed critical to our audit objectives. The audit also included a review of appropriate federal requirements and regulations regarding operations of Medicaid programs.

Our first objective was to evaluate the effectiveness of the automated edit controls for processing Maryland fee-for-service Medicaid claims. To determine the extent of automated system edits that were disabled, we obtained a computer file of all fee-for-service claims paid between July 1, 2007 and March 31, 2008. From this file, we isolated the $978 million of claims that were flagged as having not been processed through one or more of the 81 disabled system edits. We subsequently evaluated the propriety of disabling 55 of the 81 edits; the 55 edits reviewed accounted for $976 million (99 percent) of the transactions that bypassed disabled edits during the period. For these edits, we determined the appropriateness of disabling them by reviewing descriptions of the edits, by reviewing billing procedural manuals, by reviewing programming logic, and by discussing them with MCPA employees. In addition, we tested numerous claims for which these edits had been disabled to confirm our understanding of the edits and to determine if claims were paid that should not have been paid. We also reviewed the procedures used to change edit settings, such as to temporarily disable edits. Additionally, we reviewed the procedures over the payment of claims that were initially suspended by the system due to failing an automated edit control.

Our second objective was to assess the effectiveness and efficiency of the claims post-payment review procedures. The focus of our review was the Surveillance and Utilization Review Subsystem (SURS), which uses computerized reports to monitor providers and recipients to help identify potential abuse of the Medicaid program. We reviewed procedures over SURS, compared the practices used by DHMH's SURS to the practices used by other states, and determined if appropriate action was taken when SURS

identified improper payments. We also evaluated the effectiveness of the contractor used to audit paid hospital claims and evaluated procedures to ensure that the proper rates were used for out-of-state hospital claims.

Our final audit objective was to evaluate the effectiveness of the processes MHA and DDA used to obtain federal Medicaid funds for claims paid on behalf of their recipients. We reviewed procedures used by the two administrations to obtain Medicaid federal funds. Additionally, we reviewed the actions taken by DHMH and the Administrations when claims for federal funds were rejected by the MCPA processing system.

We attempted to compare Maryland's staffing structure with other states. However, unlike most other states, Maryland uses its own employees to perform most tasks associated with the Medicaid program, including the processing of claims. Consequently, we were unable to compare MCPA's staffing structure to other states since the other states generally relied on contractors to administer their programs.

Our audit scope excluded payments made on a capitation basis to Managed Care Organizations (MCOs) and long-term care facilities. Also excluded was an evaluation of the initial payment determinations made by MHA and DDA for payments to their respective service providers; rather, for these two administrations, our focus was the federal reimbursement process through MMIS II.

Fieldwork and Department of Health and Mental Hygiene Response

We conducted our fieldwork during the period from March 2008 through April 2009. The Department's response to our findings and recommendations is included as an appendix to this report.

Findings and Recommendations

Objective 1

Effectiveness of Claims Processing Edits

Conclusion

This audit objective was to evaluate the effectiveness of the Medical Care Programs Administration's (MCPA) management of edits over claims. Our primary focus for this objective was to determine whether it was appropriate for MCPA to disable 81 automated edits that were programmed to prevent improper payments. We also reviewed procedures over changes to edit settings and examined certain other aspects of the claims payment process.

Our performance audit disclosed that MCPA processed fee-for-service claims totaling approximately $978 million between July 1, 2007 and March 31, 2008 that bypassed 81 disabled system edits within MMIS II. We examined 55 of these disabled edits and attempted to determine if it was proper to bypass them. The 55 edits tested were applicable to $976 million of the claims processed through disabled edits.

We found that MCPA's decision to disable automated system edits was proper in most instances. Specifically, out of the 55 disabled edits tested, we determined that the decision to deactivate the edit was appropriate for 40 edits. For example, one deactivated edit was intended to prevent payment if a facility provider number was not in the Maryland Medicaid Information System (MMIS II). Since other information is used in Maryland to identify providers, the disabling of this edit is appropriate. However, we found that 9 disabled edits should not have been deactivated; these 9 edits applied to claims totaling in excess of $98 million of the $978 million disbursed during the nine-month period ended March 31, 2008. For example, one of the deactivated edits was intended to prevent payments for procedures for patients in long-term care facilities when payments for these procedures

would typically be included in the payments made to the facilities. For 6 of the disabled edits, neither the Department nor we could determine if deactivating the edits was proper. We also found that comprehensive descriptions of the purpose of the edits were frequently not available from MCPA.

Controls over changes to edit settings were lacking. Changes to edit settings were made without supervisory review and approval, without documented explanations as to why edit settings were changed, and without maintaining records of the changes actually made.

During our testing of claims, we determined that certain claims were improperly processed in MMIS II due to a temporary change in edit settings that was not intended to apply to these claims. Consequently, these claims were paid rather than suspended by MMIS II for subsequent manual review. After we advised MCPA about these claims, its research disclosed that claims totaling $5.3 million should have been manually reviewed before payment. It also determined that $1.4 million of these claims were paid in error and should be recovered from the providers.

We also found that authority in MMIS II to process certain claims for payment was inadvertently granted to 532 system users who did not require such capability. After we brought this to MCPA's attention, it removed the capability to process claims from these employees who did not need that capability.

Finally, DHMH had not performed a formal study or review to determine the optimal number of employees required to perform its critical Medicaid functions, and did not have a training program for its employees performing critical claims processing functions. For example, knowledge of system edits, billing procedures, medical procedures, and diagnoses codes, must be used to properly evaluate suspended claims. Without determining the optimal staffing levels, MCPA cannot ensure that the appropriate number of its approximately 615 employees has been assigned to claims processing functions.

Background

The vast majority of Maryland's Medicaid expenditures can be categorized into one of three payment types: fee-for-service, managed care, and long-term care. Under the fee-for-service payment method, healthcare providers, such as physicians and hospitals, submit claims to MCPA for each service provided to a Medicaid recipient. Once MCPA approves the claims, the providers are paid the allowed amount for the services billed. With the managed care

payment method, managed care organizations (MCOs) are paid a specified monthly fee (capitation fee) for each enrollee. The MCOs are then responsible for providing appropriate healthcare to their enrollees through contracted health care providers. Long-term care providers, such as nursing homes, are paid through a cost-reimbursement system. The focus of this audit was on the fee-for-service payments, which totaled approximately $1.51 billion during fiscal year 2009.

An inherent concern with fee-for-service payments is that the entity authorizing payment for services cannot be certain that the services billed by providers were actually provided. As required by the federal government, Maryland uses a computerized system (the Medicaid Management Information System or MMIS II) to pay provider claims and to process paid claims for federal reimbursement. MMIS II contains 658 automated edits that are designed to assist in verifying that claims are complete and legitimate. For example, automated edit controls exist to verify the eligibility of providers and recipients, to prevent payment of duplicate claims, and to allow payment for gender-specific medical procedures for patients of the applicable gender. No single claim would be subject to all of the 658 edits. Rather, each claim would only be subject to certain edits, depending on the nature of the claim. For example, some edits are intended only for inpatient claims; these edits would not be triggered unless the claim met certain criteria defining it as an inpatient claim.

Most claims submitted electronically, pass the automated edits, and are paid with minimal employee effort. However, a large number of paper claims are still submitted that require manual processing. In addition, claims that are suspended by system edits must be reviewed manually by a MCPA employee who then determines if the claim should be paid or denied. Claims paid in this manner are referred to as 'forced' claims because the claims are paid even though they have not passed all MMIS II edits.

In our July 28, 2006 fiscal compliance audit report on MCPA, we stated that significant amounts of claims were paid without going through system edits designed to prevent improper payments. In response to that audit report, MCPA maintained that disabling many of the MMIS II edits was proper because those edits were unique to the State of Florida's Medicaid system (from which the Maryland system is derived) or were federally approved changes to the Maryland Medicaid program.

Findings

1. The disabling of claim edits appeared reasonable for most deactivated edits, but some edits should not have been deactivated. The propriety of deactivating certain other edits could not be determined.

A summary of the results of our review of the propriety of the disabling of edits is shown in Table 1 below. The Department generally agreed with our conclusions.

Table 1
Results of Review of Edits Tested
July 1, 2007 through March 31, 2008

Category	Number of Edits	Value of Paid Claims ❶
Proper to Disable	40	$690,861,748
Should Not Have Been Disabled	9	98,594,958
Propriety Could Not be Determined	6	186,532,323
Total	**55**	**$975,989,029**

❶ Although each claim may pass through more than one edit, each claim is counted only once in this column based on its first bypassed edit. Accordingly, this table conservatively shows the value of paid claims that were not processed through edits.

We determined the appropriateness of deactivating edits by reviewing available descriptions of the edits, billing manuals, and programming logic, and through discussions with MCPA employees. In addition, we tested numerous claims related to these edits to confirm our understanding of the edits and to determine if claims were paid that should not have been paid.

An edit entitled "facility provider number is not on file" is an example of an edit that we determined was properly disabled. This edit denies a claim when a facility provider number on a claim is not entered into MMIS II; however, MCPA does not use facility numbers for payment identification purposes. Instead, Maryland's MMIS II uses alternative provider numbers to ensure payments are only made to eligible providers.

An example of an edit that should not have been disabled is entitled "inpatient claim in conflict with outpatient claim,' which was applicable to claims totaling approximately $33 million between July 1, 2007 and March 31, 2008. This edit was designed to prevent payments to providers for inpatient claims when services may have been previously paid as an outpatient claim. Another example of an edit that should not have been disabled is the edit entitled "procedure invalid for a recipient in a long-term care facility," which was applicable to claims totaling approximately $4 million during the same period. This edit was designed to prevent payments for procedures (including medical equipment and supplies) for patients in a long-term care facility when payment for these procedures would typically be included in the payments made to the facility. We tested 50 claims totaling approximately $120,000 that bypassed this edit and found 5 claims totaling $8,695 that should have been denied. These payments represent claims for procedures on behalf of recipients at a long-term care facility that should not have been separately billed.

An edit entitled "unable to determine waiver eligibility" which was applicable to claims totaling $182.7 million between July 1, 2007 and March 31, 2008, is an example of an edit for which the propriety of disabling the edit could not be readily determined for recipients with Medicaid (only) eligibility as well as for those with Medicare (and Medicaid) eligibility. DHMH management initially advised us that this edit existed in the Florida's Medicaid system and was not applicable to Maryland's program, but subsequently advised us that the edit was not in Florida's system and was added to Maryland's MMIS II system by DHMH. Based on our review and interviews with MCPA personnel, it is believed that this edit relates to eligibility coding in MMIS II; however, neither we nor MCPA could determine the exact reasons why or how this edit applies to these claims. See additional comments in Finding 3 (on page 21) regarding the lack of documentation of system edit descriptions.

2. Adequate internal controls were not established over changes to edit settings.

An informal and generally undocumented process was used to temporarily change edit settings. Four employees could alter (deactivate or reactivate) the MMIS II automated edit settings without further supervisory review. One of these users, who is an MCPA manager, was primarily responsible for altering the edit settings when necessary to process claims through MMIS II. MMIS II allows one user to alter the edit settings without requiring another system user to independently approve the changes. Also, there was no manual approval to document authorizations for changes to edit settings, and

written justifications as to why edit setting changes were made were not prepared. Furthermore, there were no output reports prepared from MMIS II of changes made to edit settings which could be reviewed for propriety.

If an operation as large and complex as Maryland's Medicaid program is to be managed effectively, its edit changes (which are essentially computer program logic changes) must be adequately controlled; otherwise, Medicaid claims may not be processed as intended and inappropriate payments may be made. Because of the very large volume of Medicaid claims, even small error rates in claims processing can lead to millions of dollars in inappropriate payments. It is, therefore, critical that controls be established to minimize the risk of errors.

Written justifications should be prepared and retained for all changes to edit settings. These justifications should clearly explain why an edit setting needed to be modified. Before any changes to edit settings are made, a management employee, other than the employee who initiated the change, should approve the change in edit settings. After the change is made, the results should be monitored to determine that the change is having the desired effect on claims processing, and to ensure that the edit setting is changed back at the appropriate time, if applicable. In addition, records of all changes to edit settings, including the reasons they were changed and the related approvals, should be maintained. Finally, procedures should be implemented to ensure that only properly authorized changes to edit settings are made.

We noted an example of the lack of controls over edits during our test work. Specifically, we identified one edit, which was designed to prevent payments for overlapping inpatient and outpatient periods, which should not have been deactivated. During July 2008, we brought this to the attention of MCPA, and as a result, an MCPA employee altered the edit setting (which was in place since at least July 1999), so that all future inpatient claims for periods when outpatient claims have also been paid would be suspended from payment. This would subsequently allow MCPA employees to review the suspended claims and related documentation to determine if the suspended claims should be paid or denied. Although we agree with the reason for this change in edit setting, the change was not adequately controlled. Specifically, the edit setting was changed solely by one employee without additional review, approval, or documentation of the change or the reason for the change. (This edit is included in Table 1 as an edit that should not have been disabled.)

We were unable to determine the number or frequency of changes made to automated edit settings because MCPA was not producing or retaining a record of these changes.

3. Documentation for the system edit descriptions and the related decisions as to which edits should be disabled was lacking.

Although the MMIS II programming documentation contained descriptions of its edits, these descriptions were often brief and vague. As a result, we frequently had to ask MCPA employees the purpose of edits and under what circumstances they would deny or suspend a claim. On numerous occasions, we received contradictory explanations from MCPA employees regarding the purpose of certain edits. Furthermore, written explanations as to why edits had been deactivated were generally not available and MCPA personnel could not always explain why edits were not being used. We were advised by DHMH management that certain edits were disabled when the system was obtained from the State of Florida, because the edit conditions may have applied to Florida but did not apply to Maryland. However, there was no documentation available to support the decision to disable these edits.

The lack of documentation for the edits contributed to our difficulty in determining if certain edits should be active or disabled. Furthermore, MCPA could not substantiate that it took appropriate actions regarding these edits. While our testing disclosed that there were generally valid reasons to disable most of the edits that were not being used, additional information related to these edits was obtained primarily from one employee. This one employee generally had complete control over the automated MMIS II edit process, including the ability to change edit settings. If this employee were to cease employment at MCPA, because of the lack of documentation of the edit process, it would be extremely difficult for MCPA to be able to effectively manage the edit process.

4. A programming error resulted in the improper payment of claims.

During our testing of claims, we determined that certain claims were improperly processed in MMIS II due to a temporary change in edit settings that was not intended to apply to these claims. Consequently, these claims were paid rather than suspended by MMIS II for subsequent manual review. Our test of 15 of these claims paid in March 2008, totaling $1.05 million, disclosed that all 15 claims should not have been paid without further

research. Specifically, either the preauthorization numbers submitted in the provider claims tested did not match the preauthorization numbers in MMIS II, or there were no MMIS II preauthorization numbers. Preauthorization is required for certain claim types. The intention was that proper preauthorization data must be recorded in MMIS II for the dates of service in order for a claim to be paid. MCPA management agreed that the claims that we tested should not have been paid. After we advised MCPA about these claims, its research disclosed that claims totaling $5.3 million that were paid during March and April 2008 should have been manually reviewed before payment. It also determined that $1.4 million of these claims were paid in error and should be recovered from the providers.

5. MMIS II access to pay forced claims that were suspended was inadvertently granted to 532 users.

During our review of system access, we determined that 532 employees had unintentionally been provided with the capability to direct the MMIS II system to pay claims that had failed edits. According to the system access records, these employees had "inquiry only" access to the system screen that allows the user to direct MMIS II to pay suspended claims. However, we determined that the users actually had update access and these users could force the payment of claims that failed edits. We advised MCPA management personnel who immediately removed all access to this screen for the aforementioned 532 users.

MCPA was not able to determine why the system allowed users full transaction capabilities when the intended setting was to only allow inquiry access. In addition, MCPA was unaware if the system settings for other critical screens allowed users with "inquiry only" access to modify critical data and execute transactions. Our test of selected forced claims found no instances of claims paid by unauthorized users.

6. Although certain functional areas have significant backlogs, DHMH had not performed any formal studies of its staffing requirements to determine if its existing resources should be reallocated.

DHMH management has not performed a formal study or review to determine the optimal number of employees required to perform its critical Medicaid functions. Although there have been several personnel changes, and a realignment of duties during the past several years, there has been no formal

evaluation of the workload and the number and qualifications of the related employees required for each functional unit. Without determining the optimal staffing levels, MCPA cannot ensure that the appropriate number of its 615 employees has been assigned to claims processing functions.

Most claims are submitted electronically, pass the automated edits, and are paid with minimal employee effort. However, a large number of paper claims are still submitted that require manual processing. In addition, claims that are suspended by system edits must be reviewed manually by an MCPA employee who then determines if the claim should be paid or denied. Claims paid in this manner are referred to as 'forced' claims because the claims are paid even though they have not passed all MMIS II edits. Approximately 60 MCPA employees in three units are responsible for processing paper claims and for determining the resolution of these suspended claims; during the nine-month period ending March 31, 2009, these units processed a total of 721,074, claims totaling $301.5 million. All three of these units had backlogs. For example, as of February 13, 2009, one unit had 52,787 unprocessed claims, including claims that were approximately two months old. We were advised by MCPA management that claim backlogs are typical due to the lack of sufficient number of employees assigned to this unit. In addition, inadequate staffing could also limit the number of manually processed claims that are subsequently reviewed for propriety by supervisory personnel.

7. Formal training for employees performing critical and complex functions is lacking.

MCPA does not have a training program for any employees performing critical claims processing functions. Specifically, employees in the three units (Claims Exam Entry, Adjustments, and Provider Relations) responsible for reviewing claims and determining if these claims should be paid or denied did not receive formal training for their job duties. In order to review and determine the propriety of these claims, extensive knowledge of Medicaid practices must be acquired and utilized. For example, knowledge of system edits, billing procedures, medical procedures, and diagnoses codes, must be used to properly evaluate suspended claims. We were advised by MCPA management that there was no formal training program (such as a training curriculum) for these employees. Rather, these employees received on-the-job instruction, as needed, from supervisors. We noted that one supervisor prepared an ad-hoc (informal) written guide for users to follow when processing forced claims. However, based on responses to our audit inquiries during our fieldwork regarding edit explanations and claims review

procedures, certain individuals responsible for supervising claims processing employees did not appear to be adequately trained themselves. Considering the significant effects from rather complex decisions that these employees make, a formal training program is warranted.

Recommendations

1. We recommend that MCPA
   a. process all claims through all applicable system edits;
   b. further investigate the edits for which it could not be determined if they should have been disabled, and determine whether these edits should be used;
   c. review the questionable payments that we identified, and obtain recovery of any improper payments; and
   d. where systemic issues exist, identify and recover any additional overpayments.

2. We recommend
   a. that DHMH modify its system and procedures to require that all changes to edit settings be independently approved by supervisory personnel who are not involved with initiating the changes;
   b. that written explanations be prepared and retained for each change to edit settings;
   c. that records of all changes to edit settings be maintained that indicate what the changes were, when the changes were made, and by whom; and
   d. that edit setting modifications be documented and that, after the modifications are made, the effects of the changes be monitored to determine if the changes had only the desired effect.

3. We recommend that MCPA develop clear written descriptions for all MMIS II edit settings that indicate the purpose of the edits and categories of claims they impact. These descriptions should include explanation(s) for any edits that are disabled.

4. We recommend that all of the improperly processed claims, due to a programming error that we identified, be reviewed for propriety and that any payments determined to have been made in error be recovered.

5. We recommend that update access to critical data only be provided to employees who require such access to perform their job duties, and that DHMH periodically review employee access.

6. We recommend that DHMH perform a study to determine the staffing needed to ensure adequate claims processing capacity and effective control procedures for Medicaid claims. We also recommend that DHMH allocate the needed staff to these functions.

7. We recommend that MCPA develop a training program that provides. structured and consistent training for new employees, as well as continuing training for existing employees, to ensure that employees with claims processing duties have the requisite knowledge to perform their duties.

Objective 2

Post-Payment Review Procedures

Conclusion

This audit objective was to evaluate the effectiveness of the post-payment review procedures performed by DHMH over fee-for-service Medicaid claims. During fiscal year 2009, fee-for-service claims totaled approximately $1.51 billion. Post-payment review procedures are essential to help determine that medical procedures paid for were actually provided and were medically necessary.

Our audit disclosed that the post-payment review process was not formally structured and adequately documented. For example, written risk assessments were not prepared to identify high-risk types of claims that should be subject to routine additional scrutiny. There were no written requirements as to the type and frequency of claims data analysis (utilization) reports to run and the expected level of research required. Furthermore, comprehensive lists of specific claims data analysis reports actually produced, specific claims reviewed, and records of overpayments recovered as a result of the related investigations were not maintained. Such information can be used to more effectively direct future efforts. Consequently, assurance was lacking that the post-payment review process was as effective as possible.

We also noted that certain reports designed to identify potentially improper provider billings were not routinely produced. For example, reports of "spike" payments (large amounts of claim payments to a provider over a short period) were not produced. In addition, reports to identify unbundling of procedures to increase reimbursements were not routinely produced. (Unbundling occurs when providers bill several related procedure codes rather than bill for one comprehensive code that includes all services provided.) Furthermore, appropriate procedural changes were not always implemented when post-payment reviews identified systemic deficiencies that allowed improper payments to occur. In one instance, a post-payment review detected that MCPA paid claims for female recipients of a drug intended only for males; however, MMIS II was not promptly modified to prevent future similar occurrences.

We noted that the post-payment review practices for hospital billings need improvement. Although MCPA contracted with a vendor to audit in-state paid hospital claims, these audits were not completed timely. As of December 31,

2008, no claims paid since January 1, 2004 had been subject to audit by the vendor. Also, MCPA did not verify that it paid the proper rates for out-of-state hospital bills. Our limited testing of payments to out-of-state hospital billings disclosed an overpayment of $87,054.

Finally, DHMH did not have an effective process for pursuing reimbursement from third parties (such as private health insurers) that may be liable for the costs of treatment provided to Medicaid recipients.

Background

As is the case with all fee-for-service health plans, the entity that pays the claims does not know if the claims submitted were for services that were actually provided and were medically necessary. While a properly functioning automated edit process can prevent some improper payments, such a system cannot ensure that all services paid for were appropriate. To help ensure the propriety of claims paid, state Medicaid programs have post-payment review procedures. One critical component of a Medicaid post-payment review system is the Surveillance and Utilization Review (SURS) process. This process, which as of April 2007 is administered by the DHMH's Office of Inspector General (OIG), attempts to identify potentially improper or fraudulent paid claims by performing computerized analyses of claims data. Such an analysis could, for example, indicate which physicians were paid for substantially more procedures per patient than the average physician in the program. Once such data anomalies are identified, provider case records can be reviewed to determine if the procedures paid for were actually provided and were medically necessary. In addition, MCPA has contracted with a vendor to audit hospital claims.

Findings

8. Documentation of the post-payment review process was in need of significant improvement.

The organization and documentation of the entire post-payment process should be improved. There were no comprehensive written procedures for the post payment review processes, such as the SURS process. As a result, there were no specific requirements as to the type and frequency of computer utilization reports (computerized analyses of claims data) to run to identify potentially improper or fraudulent paid claims, and there was no formal guidance as to which DHMH units were responsible for reviewing the reports. There were also no written directions regarding the level of research required

to review the propriety of the claims identified in the reports, as well as no written guidance regarding the level of extended testing expected when improper claims were noted during a review. Also, utilization reports produced were not based on formal risk assessments to identify the higher risk claim types for analysis. One state that we contacted indicated that it completed a yearly risk assessment based on several factors, including fluctuations in payments, changes in payment rules, and recent industry changes. The results of such a risk assessment could be used by DHMH management to direct resources to be more effective and efficient in identifying potentially improper payments.

On August 1, 2008, DHMH issued draft guidelines and procedures for conducting post-payment reviews or investigations of allegations of fraud, waste, or abuse. This draft provides general guidance rather than specific instructions. For example, the guidelines do not address how investigative efforts are to be documented and the retention requirements for SURS reports or report results. The guidelines also do not provide specific direction or procedures for permanent correction of claim processing weaknesses noted during the post payment reviews as further discussed in Finding 10.

There was no comprehensive list or database of all the utilization reports produced and the results of reviews performed on the related claims. As a result, we were not able to readily determine the total population of utilization reports produced, or effectively evaluate the review processes performed and investigations conducted for the related claims. Moreover, DHMH likewise cannot effectively monitor the effectiveness of the SURS process. A comprehensive list or database of utilization reports produced could be used by DHMH employees and management to ensure that sufficient claims utilization reports were produced and properly investigated, and to help determine which utilization reports should be produced in the future.

Records were typically not maintained in a manner that would allow us, or DHMH management, to easily evaluate the results of the claims reviewed. Documentation was frequently not available to support the number of claims shown on the reports that were reviewed, the type of reviews performed (such as the specific computerized claims analyses), and the conclusion of the claims reviewers. Also, reports produced were not maintained after three months unless the individual user designated a longer retention period.

Furthermore, records of actual recoveries resulting from post-payment reviews, including SURS, were not maintained. The OIG did maintain a record of recommended recoveries, but the actual recoveries were frequently less than what was recommended. For example, one case was investigated and

the OIG recommended recoveries totaling approximately $194,000, but no actual recovery was initiated for this case and no recoveries were made. In this instance, the OIG found that the professional credentials for the provider's employees were expired or not available at the time of the review. The investigation covered services provided during the period from January 5, 2005 through March 31, 2006. We noted payments were made to this provider totaling approximately $500,000 for the period July 1, 2007 through March 31, 2008.

9. Certain utilization reports were not produced or fully used.

While DHMH produced frequent reports based on algorithms deemed to identify high-risk claims, certain 'best practice' reports — as determined by contacting other states and the Federal Centers for Medicare and Medicaid Services (CMS) — were not utilized, and certain other reports were not utilized as fully as possible.

- There was no comprehensive procedure or report to identify all payments made on behalf of deceased recipients for services provided after their dates of death.

- Routine utilization reports were not produced to determine if providers performed services outside of their specialty. However, in October 2006, a one-time utilization report was run for one provider that was enrolled as a podiatrist but who billed for categories of services related to heart procedures. As of September 1, 2008, this case was still under investigation.

- There have been no reports produced to identify 'spike' payments made to providers that submitted large amounts of claims in a short period.

- Reports to determine if procedures were 'unbundled' were not produced on a regular basis. Unbundling occurs when providers bill several related procedure codes rather than bill for one comprehensive code that includes all services provided. By improperly billing separate procedure codes, reimbursement amounts are greater than the amounts that would be paid under the comprehensive procedure codes.

While there are nearly a limitless number of utilization reports that could be produced from claims data, to increase the effectiveness and efficiency of the organization, reports that have been previously used and proven effective, as well as potential reports that have proven beneficial to other State Medicaid

operations, should be regularly evaluated to identify claims with the most potential for recoveries.

10. Procedures were not always revised to correct deficiencies identified in post-payment reviews.

Preventive controls were not always implemented when systematic deficiencies were noted during post payment claim reviews. Specifically, during the course of our audit, we noted the following deficiencies:

- A post payment review detected adopted children that were eligible for federal Medicaid reimbursements, but for which their medical care was paid only from State general funds; however, DHMH did not correct their eligibility for federal reimbursement in MMIS II. Periodically, a utilization report was run for general fund claims paid for adopted children. An employee reviewed the recipient eligibility data to determine if any of the recipients should have been categorized so that their claims were eligible for federal reimbursement. A manual adjustment was performed, when appropriate, so that the proper federal match could be received for the eligible claims. However, the recipient eligibility was not corrected in MMIS II so that future claims would also be automatically processed for federal reimbursement. For the period from October 1, 2007 through June 2008, a manual adjustment totaling $88,000 was made so that the State could obtain a $44,000 (50 percent) federal reimbursement for previously eligible adopted children for whom medical care was being paid for with State general funds.

- DHMH - OIG concluded an investigation of a case based on SURS utilization reports that showed instances in which payments were made to a provider for a male-specific drug given to female recipients. As a result of the investigation, recoveries were made from the provider. The investigation also discovered that the system edit for this procedure was not set to prevent payment based on the patients' sex and, therefore, did not preclude payment of claims billed on behalf of a female recipient for a procedure that can only be performed on a male patient. In December 2007, the DHMH-OIG notified the MCPA of the need to correct the related system edit; however, the correction was not made until we advised MCPA of the miscoding.

11. Additional procedures could be used to publicize the DHMH fraud hotline and more data should be maintained to monitor its effectiveness.

DHMH operates a hotline and a website to report instances of Medicaid fraud, waste, and abuse. However, procedures could be improved to increase their effectiveness.

A call log has been maintained since January 2008, which shows that 81 calls were received during calendar year 2008. The majority of calls were unrelated to Medicaid fraud, waste, and abuse; rather, many calls were questions and comments about other DHMH operations. The DHMH website also has a method to report instances of fraud via email. A log of the emails that were received from the DHMH website showed that 22 referrals were received from the implementation date of the website (August 2008) through December 31, 2008.

DHMH uses several methods to advertise the hotline, such as posting the telephone number on its website and placing posters in State-owned hospitals and DHMH offices. Based on our previous survey of other state governments, DHMH could use the following methods to increase public awareness of its Medicaid fraud hotline:

- Placing information and the telephone number on State employee check stubs
- Including the hotline number on DHMH business cards
- Placing posters and brochures in non-DHMH State government buildings

Stakeholders that are likely to be knowledgeable about Medicaid fraud, waste, and abuse cases include Medicaid recipients, as well as providers and their staff. In order to reach these individuals, DHMH should consider additional methods to advertise the hotline, such as placing posters at private provider locations, and working in conjunction with DHR to notify recipients during eligibility determinations. Considering the limited number of referrals received on the hotline and website, additional publicity about the fraud referral methods may be beneficial.

We also noted that DHMH did not maintain statistics to monitor the effectiveness of the hotline. Although logs were maintained to record the referrals and, when applicable, to indicate the DHMH unit that was assigned the case, the logs typically did not contain the ultimate disposition of the investigations. Specifically, statistics were not maintained to show the origin

and outcome of all hotline tips, such as the number of hotline tips that led to recoveries or referrals to the Medicaid Fraud Control Unit (MFCU).

Increasing the efforts to make individuals aware of the hotline, and maintaining comprehensive statistics may improve the effectiveness of the hotline.

12. Post-payment reviews of in-state hospital claims could be improved. DHMH should ensure that a sufficient number of claims are audited and that they are audited more timely.

Audits of hospital claims were not timely. DHMH has contracted with a vendor to review medical documentation for in-state hospital claims. The scope of the contract requires the vendor to obtain and review documentation for payments made to hospitals to determine if reimbursement was based on actual services rendered to patients. For a specified period, as directed by DHMH, the vendor reviews hospital medical records for documentation evidencing that the services were provided. The vendor is compensated by the providers on a contingency fee basis. Specifically, the provider must pay the vendor a percentage of the amount of overpayments found during claims reviews and must also return the identified overpayment amounts to MCPA. This post-payment review mechanism was recognized by CMS as a benchmark best practice. During fiscal year 2008, the contractor identified overpayments totaling approximately $3.3 million.

- Our fiscal compliance audit report on MCPA, dated July 28, 2006, noted that MCPA did not ensure that the hospital audit contractor performed the required number of hospital bill audits. At the time that our audit work was conducted, the contract required a specific number of reviews to be performed. For example, the contractor was required to audit at least 50 percent of the inpatient claims over $6,000 and the outpatient claims over $1,000. Effective December 2005, DHMH amended the contract to no longer require a specific number of audits; rather, the contract stated that the contractor would use its own criteria to determine which claims would be subject to medical documentation reviews during the hospital bill audit. However, DHMH management was not able to adequately describe the selection criteria used by the vendor, nor had DHMH evaluated the selection criteria used by the vendor.

- There was a significant time lag between the claim payment dates and the dates the claims were reviewed by the vendor. As of December 31, 2008, the most recent claims subject to review covered services paid for during the period from October 1, 2001 through December 31, 2003, a delay of five years. (According to the contractor reports, there were a total of 33,193 hospital claims paid during this period; however, certain claims that were outside the scope of the audit, such as inpatient claims less than $6,000 and claims that have historically proven to be areas of low risk, were excluded. The contractor determined that 27,312 of these claims were subject to the selection process, of which 6,373 were selected.) We were advised by MCPA management that the delay is intentional because it allows time for the hospitals to perform self-audits. Hospitals have an incentive to perform accurate self-audits and return amounts paid for undocumented services since the hospitals are subject to additional fees when the MCPA contractor audits result in claim retractions. While some delay is necessary, the Medicaid provider agreement only requires that providers maintain adequate records describing the nature and extent of goods and services provided for six years. MCPA advised that certain claims for services provided during calendar year 2003 can no longer be audited since the six-year record period has lapsed.

- The hospital bill audit contract expired on July 31, 2008. MCPA did not procure a new contract for hospital bill audits until July 1, 2009.

13. DHMH did not always verify that payments to out-of-state hospitals were made at the proper rates.

Our limited tests of out-of-state hospital payments resulted in the identification of an overpayment of $87,000 to one hospital. Maryland Medicaid reimburses out-of-state hospitals the lesser of the billed amount or the amount that the host state's Medicaid program would pay. Generally, in order to determine the proper reimbursement rate, DHMH is required to receive and review documentation of the host state's Medicaid rate structure for the specific bills prior to making payments. Our test of 27 payments to out-of-state hospitals for claims paid during fiscal years 2006 through 2008, totaling $813,276, disclosed that 7 claims totaling $548,928 were paid by DHMH to five hospitals without obtaining documentation of the proper rates from the applicable states. After we brought this to the attention of DHMH management, they could not readily obtain the proper rates for six of these claims because the rates were no longer recorded in MMIS II. The rate

documentation obtained from the host state for the remaining claim payment, totaling $128,375, indicated that the proper payment should have been $41,321 — an overpayment of $87,054.

Out-of-state hospital claims must usually be processed manually since DHMH must obtain documentation of the proper rates from the host state(s). (MMIS II will only process claims automatically when rates are recorded in the system.) We were advised by DHMH management that maintaining current rates in MMIS II for all out-of-state hospitals would not be feasible due to the its limited capacity. Nevertheless, for six of the seven aforementioned claims, the payments were made automatically because rates had been recorded in MMIS II; accordingly, no documentation was obtained for the rates used to pay these claims. Subsequently DHMH management advised us that they believed the rates to be incorrect (overstated), and that they would remove the rates for these hospitals from MMIS II so that future claims would have to be paid manually only after receipt of documentation of the host states rates. According to MCPA records, payments to out-of-state hospitals totaled approximately $21.3 million for the period from July 1, 2005 through June 30, 2008.

14. Procedures to obtain information regarding third-party liabilities could be improved.

Payments made for procedures that are performed on patients with certain specific diagnosis codes (such as injuries caused by trauma) are coded in MMIS II so that a letter is produced to attempt to determine if there is a legally responsible third party to pay the claim, such as a private health insurer or a settlement payment from a liability insurer. The letter and related questionnaire is sent to the recipient requesting information about the incident that may have caused the injuries requiring medical services. The recipient is requested to answer the questionnaire, and return it to DHMH. If the questionnaire is not returned within 30 days, a second request is sent. If the second request is not returned, DHMH does not pursue the issue further. According to DHMH records, 10,203 second request tort letters and related questionnaires were sent during fiscal year 2008; however, only 2,342 of these questionnaires were returned. DHMH management advised that they do not send additional requests because they believe there is a low likelihood of receiving a response since the medical assistance population is transient.

The Department of Human Resources (DHR) is responsible for performing an annual reassessment of eligibility for Medicaid clients. The reassessment is typically performed through the mail, as necessary forms are sent to the client, and submitted back to DHR representatives to verify that the individuals are still eligible. In an effort to improve the aforementioned response rate, DMHM could have DHR send the questionnaires with the annual reassessments.

Recommendations

8. We recommend
   a. that DHMH develop comprehensive written procedures for the post-payment review process;
   b. that the procedures developed indicate how topics for SURS reports are to be selected and their related frequencies, how data on reports are to be investigated, how reviews of data on reports are to be documented, and specify policies for retention of SURS reports and the related documentation of investigation on the reports; and
   c. that a listing of all SURS reports, the number of claims reviewed, and the related results (such as recoveries) be maintained and be used when determining which areas to select for future SURS reviews.

9. We recommend that DHMH perform periodic and documented assessments of areas or categories of claims considered to be high risk for fraud and abuse, and document how these assessments were addressed in the post-payment review procedures through the use of utilization reports.

10. We recommend that DHMH modify its procedures (such as edits in MMIS II) to prevent improper payments due to systemic issues discovered during the post-payment review process.

11. We recommend that DHMH
    a. consider additional methods to publicize its Medicaid fraud hotline and website-based fraud referral process, and
    b. maintain statistics that can be used to evaluate the effectiveness of the fraud referral procedures.

12. We recommend that DHMH
    a. establish and maintain a current contract for post-payment audits of hospital claims, and
    b. review and assess the procedures used by the contractor to select claims for audit to ensure a sufficient number of hospital claims is audited in a timely manner.

13. We recommend
    a. that DHMH verify that payments to out-of-state hospitals are based on the appropriate rates, and
    b. that previous payments to out-of-state hospitals are reviewed and any overpayments identified are recovered.

14. We recommend that DHMH develop and implement a more effective process for pursuing reimbursement from third parties that may be liable for treatment provided to Medicaid recipients, such as working with DHR during the reassessment process.

Objective 3

Obtaining Federal Funds for Other Administrations

Conclusion

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

Numerous Medicaid claims that were paid by MHA and DDA were subsequently rejected by MMIS II; as a result, the receipt of federal Medicaid funds for these claims was delayed or not obtained. For example, as of December 2008, claims paid for DDA services provided in calendar year 2006, totaling approximately $8.4 million, were submitted and denied for federal reimbursement by MMIS II and remained outstanding. MHA claims for federal reimbursement totaling $14.5 million that were rejected by MMIS II were outstanding as of January 2009, including $6.3 million in claims that were outstanding for more than one year.

Since these claims were previously determined to be legitimate and were paid by these Administrations, the amount of claims rejected by MMIS II for federal reimbursement purposes should be minimal. However, the large number of claims rejected by MMIS II from these DHMH administrations has been a long-standing problem. Comments regarding this issue have been in our audit reports for the last ten years. Moreover, DHMH lacked a systematic process—involving MHA, DDA, and MCPA—to identify the causes of the rejected claims and to modify procedures to reduce the magnitude of rejected claims in the future. We also noted that follow-up efforts to resolve the rejected claims were frequently untimely, resulting in lost interest to the State, and lost federal recoveries.

Background

MHA and DDA are responsible for paying providers for mental health services and services provided to individuals with developmental disabilities. Both agencies pay providers through separate automated payment systems, and subsequently submit paid claims to MCPA for MMIS II processing to obtain

federal reimbursements. Since the processing of these claims through MMIS II does not generate payments to providers but only reimbursements from the federal government, these are referred to as "voucher only" claims. MHA contracts with an Administrative Service Organization (ASO) to pay its claims and to electronically submit eligible claims to MMIS II for federal reimbursement. DDA uses an in-house computer system (Provider Consumer Information Service or PCIS) to directly process claims and to electronically submit eligible claims to MMIS II. During fiscal year 2009, Medicaid funding received by MHA and DDA totaled $517 million ($280 million was received by DDA and $237 million was received by MHA). These paid claims must pass MMIS II edits in order for reimbursement to be obtained. Since both DDA and MHA claim payments to providers are made outside of MMIS II, and the claims must be processed through MMIS II for federal reimbursement, MMIS II edits that deny these claims may cause delays in receipt of federal reimbursement to the State, or denial of federal reimbursement.

Findings

15. There was no systematic process involving MHA, DDA, and MCPA to analyze the cause(s) of rejected federal fund reimbursement claims and to modify procedures to reduce the amount of future rejected claims.

Numerous claims for federal reimbursement from DDA and MHA were rejected by MMIS II. However, there was no systematic process among DDA, MHA, and MCPA to determine the causes for the rejected claims so that procedures and processes could be modified to minimize future rejected claims.

For example, during a five-week period ending in August 2008, 7,657 MHA claims totaling $3.7 million were rejected by MMIS II. Similarly, 116,000 DDA claims submitted during August 2008 totaling $12.2 million were rejected by MMIS II. As of January 6, 2009, outstanding MHA rejected claims for federal reimbursement totaled $14.5 million, including $6.3 million of rejected claims that had been outstanding for more than one year. (A cumulative record of outstanding DDA rejected claims for federal reimbursement was not maintained, as noted on the next page.) Obtaining the federal funds for these rejected claims requires labor-intensive investigative efforts by DDA and MHA. The reason(s) for the rejections must first be determined and corrective action, often for each claim, must then be taken so that the claims can be submitted to the federal government.

Our tests indicated that some DDA claims were being unnecessarily rejected by MMIS II. We tested 25 DDA claims that were rejected for federal funding by MMIS II during July 2007 and determined that 10 of the claims should not have been rejected. For example, 8 of the claims were rejected because each recipient's eligibility was not properly recorded in MMIS II.

The difficulties of MHA and DDA in obtaining federal Medicaid funds for their previously paid claims has been a long-standing issue, for at least 10 years. Our October 20, 1999 audit report on MHA, and several subsequent reports on both DDA and MHA, have included comments about these difficulties. Despite these ongoing deficiencies, there have been no systematic efforts by DDA, MHA, and MCPA to reduce the amount of rejected claims for federal reimbursement. For example, no cumulative records of the amount of DDA rejected claims for federal reimbursements or the causes of rejected claims are maintained. Furthermore, records of DDA rejected claims that were never resolved were not maintained.

16. Rejected claims for federal reimbursement were not promptly investigated and resolved, adequate records of rejected claims were not maintained, and certain rejected claims were not pursued.

We noted many instances in which federal funds were not obtained for extended periods after State funds had been disbursed to providers. For example, payment data we obtained from DDA, which we determined was reliable, showed that, as of December 2008, claims paid for services provided in calendar year 2006, totaling approximately $8.4 million, were submitted and denied for federal reimbursement and remained outstanding. The federal government generally will reimburse claims for up to two years after the calendar quarter in which the expenditures were made. If these claims were not successfully processed through MMIS II, federal fund reimbursements of up to $4.2 million (50 percent of $8.4 million) may have been lost. As previously mentioned, MHA claims for federal reimbursement totaling $14.5 million that were rejected were outstanding as of January 2009, including $6.3 million in claims that were outstanding for more than one year. At a minimum (assuming that federal reimbursement for all of these claims are received immediately), the State will have lost interest income totaling at least $243,000.

Records for rejected DDA claims were not maintained in a manner that facilitated a complete and timely resolution of the claims. DDA received a weekly status report that showed claims that were accepted through MMIS II for reimbursement and claims that were denied. Although DDA received a file of rejected claims, it did not document the efforts used to investigate and correct the claims, and the ultimate status of the claims.

DDA did not typically submit claims to MMIS II for reimbursement beyond nine months past the dates of service. DDA management advised us that they adhere to the requirements in State regulations, which allow providers only nine months to submit Medicaid claims for reimbursement. (Effective March 1, 2008, State regulations allow providers twelve months to submit claims.) However, federal regulations allow States to submit claims for reimbursement up to two years after the calendar quarter in which the expenditures were made. Therefore, regardless of the dates of service, DDA may submit claims within two years from the expenditure dates.

Recommendations

15. We recommend
    a. that MCPA, in conjunction with DDA and MHA, improve the process for obtaining federal Medicaid funds for voucher claims;
    b. that, at a minimum, MCPA continually track the number and amount of claims rejected, determine why the claims were rejected, document what actions were needed to resolve the rejection of claims, and develop processing modifications that will reduce the number of future rejections by MMIS II; and
    c. that, if necessary, DHMH consider alternative methods of processing claims for DDA and MHA.

16. We recommend that MCPA, in conjunction with DDA and MHA, ensure that all rejected claims for federal Medicaid funds are promptly pursued and resolved.

APPENDIX A

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

November 19, 2009

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

Dear Mr. Myers:

This is in response to your November 3, 2009 letter that included the draft performance audit report on the Department of Health and Mental Hygiene- Processing of Certain Medicaid Claims. Attached you will find the Administration's response and plan of correction that addresses each audit recommendation. I will work with the Administration to promptly address all audit exceptions. In addition, our Office of the Inspector General will follow-up on the recommendations to ensure compliance.

If you have any questions or require additional information, please do not hesitate to contact me at (410) 767-4639 or Thomas Russell of my staff at (410) 767-5862.

Sincerely,

John M. Colmers
Secretary

cc: John G. Folkemer, Deputy Secretary, Health Care Financing, DHMH
Thomas V. Russell, Inspector General, DHMH
Ellwood L Hall, Jr., Assistant Inspector General, DHMH
Wendy Kronmiller, Chief of Staff, Office of the Secretary, DHMH

PERFORMANCE AUDIT RESPONSES
MEDICAL CARE PROGRAMS
November 19, 2009

MMIS EDITS

AUDITOR'S FINDING #1

The disabling of claim edits appeared reasonable for most deactivated edits, but some edits should not have been deactivated. The propriety of deactivating certain other edits could not be determined.

AUDITOR'S RECOMMENDATION

We recommend that MCPA:

a. **process all claims through all applicable system edits;**
b. **further investigate the edits for which it could not be determined if they should have been disabled, and determine whether these edits should be used;**
c. **review the questionable payments that we identified, and obtain recovery of any improper payments; and**
d. **where systemic issues exist, identify and recover any additional overpayments.**

ADMINISTRATION'S RESPONSE

1a: The Administration agrees with the recommendation to process all claims through the system edits that are determined appropriate and will be undertaking this task as we develop the requirements for the new MMIS. In the interim, MCPA believes that there are adequate controls to minimize the risk that inappropriate claims are paid. These controls include but are not limited to: prior review of medical necessity and limiting the medically necessary number of inpatient days to be claimed, existing MMIS edits, post payment reviews of forced claims, post payment hospital bill audits and credit balance audits, and utilizing the capabilities of SURs to identify patterns of over utilization and potential fraud and abuse. As the review of MCPA's claims and edit processes revealed, 40 of the 55 edits representing $690 million out of $976 million in claims, reviewed by the Legislative Auditors were determined to be proper to lift the edits. The results of the PERM audit, performed by CMS, indicate that the MMIS does support the correct payment of claims according to Maryland policy.

1b: The Administration agrees with the recommendation to investigate the 6 edits, totaling $186 million, that the Legislative Auditors were not able to determine if they should be bypassed or not. MCPA has investigated these edits and continues to affirm that these edit overrides are appropriate.

1c/d: Additionally, the Administration agrees with the recommendation to review the questionable payments identified and ensure recovery of improper payments. For the 9 edits, totaling $98 million, which were categorized as "should not have been lifted", MCPA has reviewed the rationale for lifting the edits and has taken appropriate steps to change the status for several of the edits from pay to suspend or deny. The fact that an edit should have been set does not indicate that the claim was improper and should not have been paid. Subsequent review of the suspended claims by MCPA staff could result in the edit being overridden, subject to the 3% post-payment review. Coding errors by providers may also cause an edit to be set and require correction and resubmission in order to pass the edit. A significant number of the overridden claims occurred as a result of lifting the edits for special MHA batches to obtain federal funding, which MHA and MCPA are working to reduce or eliminate with the new MHA ASO vendor. Additional controls over inappropriate payments exist as part of the SURS post payment review process in which providers are subject to audits based upon abnormal billing patterns (see audit finding #10 response for additional info). Where MCPA believes that lifting the edit resulted in claims that were improper, we are taking steps to retract the improper payments.

AUDITOR'S FINDING #2

Adequate internal controls were not established over changes to edit settings.

AUDITOR'S RECOMMENDATION

We recommend

a. **that DHMH modify its system and procedures to require that all changes to edit settings be independently approved by supervisory personnel who are not involved with initiating the changes;**
b. **that written explanations be prepared and retained for each change to edit settings;**
c. **that records of all changes to edit settings be maintained that indicate what the changes were, when the changes were made, and by whom; and**
d. **that edit setting modifications be documented and that, after the modifications are made, the effects of the changes be monitored to determine if the changes had only the desired effect.**

ADMINSTRATION'S RESPONSE

2a: The Administration disagrees with the recommendation to modify its system so that on-line changes to edits are approved by supervisory personnel who are not involved with initiating the changes. The Administration is currently in the process of replacing its legacy system and any significant systemic changes to the current system are on hold. In the interim, the Administration agrees with the recommendation to modify its procedures so that all changes to edits are approved by supervisory personnel who are not involved with initiating the changes.

2b: The Administration agrees with the recommendation to prepare and retain written explanations for each change to edit settings.

2c/d: Additionally, the Administration is producing the MMIS report that contains edit settings. This report will be reviewed by executive management. All documentation pertaining to the edit settings will be maintained. The Administration is currently training a staff person that can perform this function independently of claims processing staff. The training is expected to be completed by December 15, 2009.

AUDITOR'S FINDING #3

Documentation for the system edit descriptions and the related decisions as to which edits should be disabled was lacking.

AUDITOR'S RECOMMENDATION

We recommend that MCPA develop clear written descriptions for all MMIS II edit settings that indicate the purpose of the edits and categories of claims they impact. These descriptions should include explanation(s) for any edits that are disabled.

ADMINSTRATION'S RESPONSE

The Administration agrees with the recommendation and as part of the requirements analysis for the design, development and implementation of the new MMIS, the Administration will be identifying all edits and their disposition appropriate for the Maryland Medicaid Program.

AUDITOR'S FINDING #4

A programming error resulted in the improper payment of claims.

AUDITOR'S RECOMMENDATION

We recommend that all of the improperly processed claims, due to a programming error that we identified, be reviewed for propriety and that any payments determined to have been made in error be recovered.

ADMINSTRATION'S RESPONSE

As recommended, the Administration reviewed 766 claims as identified by the auditors. The review revealed the following results:

The 766 claims were released mistakenly during the initial weeks when we required providers to submit claims using their NPI. Claims that did not have a NPI were suspended and were eventually paid after holding them for two weeks.

After reviewing the claims further, it was determined that approximately one-half of the claims would need to be retracted. Therefore, the Administration recouped the money owed from the providers during the November 14, 2009 payment run.

AUDITOR'S FINDING #5

MMIS II access to pay forced claims that were suspended was inadvertently granted to 532 users.

AUDITOR'S RECOMMENDATION

We recommend that update access to critical data only be provided to employees who require such access to perform their job duties, and that DHMH periodically review employee access.

ADMINISTRATION'S RESPONSE

The Administration agrees with the recommendation.

The security access that was granted to unauthorized staff has been revoked. This was resolved almost immediately when it was reported to the Administration. As per the auditor's request, the Administration has modified the MMIS Security Application to restrict individuals from updating critical data.

AUDITOR'S FINDING #6

Although certain functional areas have significant backlogs, DHMH had not performed any formal studies of its staffing requirements to determine if its existing resources should be reallocated.

AUDITOR'S RECOMMENDATION

We recommend that DHMH perform a study to determine the staffing needed to ensure adequate claims processing capacity and effective control procedures for Medicaid claims. We also recommend that DHMH allocate the needed staff to these functions.

ADMINISTRATION'S RESPONSE

The Administration agrees with this recommendation, but believes that in effect this study has already been completed. In developing our analysis of implementation alternatives for the new MMIS, the Administration made estimates of staffing requirements to maintain industry standard service levels. This analysis contributed to our decision to select the fiscal agent contractor option which will allow for the allocation of appropriate resources to meet contract performance standards. Therefore, due to the impending implementation of the fiscal agent, the Administration will not be performing a separate study of its staff needs.

AUDITOR'S FINDING #7

Formal training for employees performing critical and complex functions is lacking.

AUDITOR'S RECOMMENDATION

We recommend that MCPA develop a training program that provides structured and consistent training for new employees, as well as continuing training for existing employees, to ensure that employees with claims processing duties have the requisite knowledge to perform their duties.

ADMINISTRATION'S RESPONSE

The Administration agrees with the intent of the recommendation to develop a training program, but given the Administration's current lack of resources and our intent to transfer the claims processing operations to a fiscal agent contractor, we are not able to do so. The contractor will be required to process claims in accordance with Department policies and we expect them to be able to train their staff to effectively maintain those procedures.

POST PAYMENT REVIEW PROCEDURES

AUDITOR'S FINDING #8

Documentation of the post-payment review process was in need of significant improvement.

AUDITOR'S RECOMMENDATION

We recommend

a. that DHMH develop comprehensive written procedures for the post-payment review process;

b. that the procedures developed indicate how topics for SURS reports are to be selected and their related frequencies, how data on reports are to be investigated, how reviews of data on reports are to be documented, and specify policies for retention of SURS reports and the related documentation of investigation on the reports; and

c. **that a listing of all SURS reports, the number of claims reviewed, and the related results (such as recoveries) be maintained and be used when determining which areas to select for future SURS reviews**.

* **ADMINISTRATION'S RESPONSE**

8a/b. The Division of Program Integrity ("PI") exists within the Office of the Inspector General. It was transferred from Medicaid's Office of Planning and Finance in July of 2006. Program Integrity's primary objective is to prevent fraud, waste and abuse of Medicaid funds in Medicaid fee-for-service programs. The PI is composed of 5 general sub-units or groups: 1) Data Analysis; 2) Provider Investigations; 3) Provider Audits; 4) Recipient Fraud, and 5) Special Projects-Medicaid. There is no "SURS" unit within PI. "SURS" is a computer program. The Department concurs that Program Integrity should operate under written policies and procedures.

Upon its relocation to the OIG, management began a comprehensive policy and procedure manual to include a substantial appendix of audit-related tools. The procedure manual has not yet been formally approved. The staff person tasked with completing the manual left the Department and was not replaced. More importantly, with the passage of the Deficit Reduction Act of 2005 and the creation of the Medicaid Integrity Group at the federal level, program integrity has been fluid and dynamic. Certain program integrity concepts were developing

* **See Appendix B for related auditor comment.**

and changing at the federal level as the OIG's manual was being drafted. The OIG is currently awaiting the results of a review conducted by CMS' Medicaid Integrity Group of our PIU. Pending those results, OIG management plans to have the manual completed and approved by the close of the fiscal year.

Likewise, the OIG can include in the procedure manual the level of detail recommended by the auditors so long as some flexibility is allowed for the methods selecting "topics for SURS reports." In 2000, CMS (then the Health Care Financing Administration) reacting to Congress' passage of the Balance Budget Act of 1997, repealed the requirement that State PI units conduct rigid System Performance Reviews (SPR). SPRs were requirements placed upon States to run a certain number and type of SURS reports on a yearly basis. Understanding the need for flexibility and creativity, Congress, and in turn CMS removed those rigid requirements. This was done to allow the States to concentrate on developing and working more substantive cases. So, while the OIG can develop some procedures surrounding how topics for SURS reports are to be selected, the OIG would not want to return to a rigid system that dictated quantity of SURS runs over quality case development.

* 8c. The Department does not concur.

First, The J-SURS System is not a unit, but rather, a subsystem of MMIS that allows for certain reports to be created to analyze provider behavior.

When a SURS report is created, it identifies **providers** who do not fit a norm. It does not identify **claims**. Therefore, PI cannot maintain documentation on information that is not produced by a SURS report. Program Integrity determines whether a provider identified warrants an audit. That determination of whether to audit a provider in a SURS run involves a number of considerations. For example, taking into account staff available for review, PI management will scrutinize the Department's total claims exposure attributable to the given provider, whether the provider "excepts" on any other claims criteria, whether the provider has had prior billing issues, etc. Only once these issues are considered does PI decide to audit a given provider. Appearing ("excepting") is merely the first consideration.

Currently, when PI's, Data Analysis Unit creates a report that is to be used by PI to investigate potential improper Medicaid payments, PI maintains the report used to identifying the aberrant provider, and, if the provider is to be audited or reviewed, PI documents pertinent information such as the number of claims initially reviewed, whether the initial review developed into a full audit, the results of the audit, and the amount of any recovery recommended. Program Integrity has not maintained this level of detailed information on SURS reports not leading to full audits, because the information simply does not exists.

* **See Appendix B for related auditor comment.**

Likewise, the J-SURS System is also used by many within the Department to analyze things other than claims payment. Program Integrity's Data Analysis Unit runs reports from the J-SURS System at the request of other DHMH Units so that those units can conduct utilization reviews and quality of care assessments. PI cannot maintain a complete record of those runs and their results because they are not run with the same intent. So while there is a record of the report being run, there will not be any resulting claims reviewed, audits conducted, or recoveries identified simply because the SURS report was requested for a reason other than payment review.

AUDITOR'S FINDING #9

Certain utilization reports were not produced or fully used.

AUDITOR'S RECOMMENDATION

We recommend that DHMH perform periodic and documented assessments of areas or categories of claims considered to be high risk for fraud and abuse, and document how these assessments were addressed in the post-payment review procedures through the use of utilization reports.

* **ADMINISTRATION'S RESPONSE**

The Department does not concur with the recommendation, because the OIG, to the extent possible using the J-SURS System and the limited expertise available, currently conducts assessments of high risk claim areas. The auditors acknowledge that the Department produces reports based on algorithms deemed to identify high-risk claims. However, many of the specialty reports cited as "best practice reports" from CMS and other States are reports run from systems with much more updated and user-friendly software than the J-SURS system. The J-SURS system is an older utilization review technology not perfectly geared towards today's fraud fighting needs. The OIG is actively seeking a more updated technology that can manage and analyze large volumes of detailed health data to provide more timely and accurate investigative data analysis and a decision support system. Before being able to regularly and routinely run most of the reports cited by the auditors, the OIG must have an antifraud system that features improved analytic productivity and requires no database administrator or extensive programming skills

Death Runs

One of the reports listed by the auditors as not being fully utilized involves the "death algorithm." The J-SURS System is capable of creating "death runs" with relative ease. Likewise, the OIG staff employs an individual who is capable of extracting this type of run from the J-SURS System. The Department concurs that until very recently, death algorithm runs were not "routinized" under one unit within DHMH. As a result, there were OIG employees in multiple units reviewing many types of claims after date of death.

Another issue related to the death algorithm involves the reliability of the actual date of death as it appears in MMIS. The date of death in MMIS is a direct data field transfer from the Department of Human Resources' CARES System. When a

* **See Appendix B for related auditor comment.**

DSS case worker enters a Medicaid recipient's date of death in the CARES System, that date of death is automatically fed to MMIS. Unfortunately, if the DSS employee makes an error (by entering a date when the recipient is not actually deceased) and later changes that information in CARES by noting it in the comments field and removing the date of death, the removal of the date (i.e.: the blank field) is not transferred to MMIS.

This problem between the two systems causes potential overpayments identified by using death algorithms to be unreliable. To correct this reliability issue, the Department has previously had to manually check each individual identified[1]. That is potentially a labor-intensive task for which the OIG has no resources.

The OIG has struggled with identifying a method to both "routinize" the running of the death algorithm, and to produce results that are reliable and actionable without individual, manual review. The OIG has determined that, going forward, its staff will run two different death reports, two times each year. A comprehensive fee-for-service run will be conducted twice a year and a capitation payment run will be conducted twice per year. We will place this requirement in the OIG policy and procedure manual.

Prior to seeking recovery of payments that appear on these four runs, the OIG will provide the results file to the Vital Statistics Administration (VSA) and ask that VSA compare the dates of death from the runs to dates of death in VSA. Should VSA's data show the recipient not to be deceased, the OIG will remove the individual from the recovery list. The OIG will then send only those claims to Medicaid to recover that have been verified through the VSA check as having been paid for deceased recipients. The OIG will also send to Medicaid a list of the living individuals to Medicaid to correct the date of death in MMIS.

Billing Outside Specialty Runs

Another issue cited by the auditors involves reports run to determine whether providers are billing outside of their practice areas. The J-SURS System is capable of creating such a run, however, a very experienced user, or "super-user" is required to create such a run. The auditors cite a case of a podiatrist opened by the OIG in 2006. This particular podiatrist's billings were discovered through a routine provider profile comparison. The provider "excepted" because the providers billings per patient were extremely high. The provider was not found through an "billing outside a specialty" run. When this particular podiatrist's were audited by the OIG, the OIG determined that services had in fact been provided, and provided by the appropriate type of service provider. The provider in question was a part of a large practice group with multiple

[1] In a recent project between the OIG and CMS, a manual review demonstrated an approximately 50% error rate in the date of death contained in the MMIS system.

specialty providers. A billing clerk employed by the provider entity had inadvertently used the podiatrist's Medicaid number to bill services performed by others in the practice.

The auditors go on to suggest that the Department should regularly conduct such runs to uncover these anomalies. However, to create most of these runs, a super-user is needed. Additionally, an individual with both significant clinical expertise and significant expertise in coding is needed to both create the run and review the documentation associated with each claim. For some years, the SURS unit employed a physician and two nurses. Unfortunately, the physician PIN has been cut and one of the RN PINs is currently empty. The OIG has, thus far, been unsuccessful in attracting an RN to fill the vacant position. The one remaining nurse has been training steadily in CPT coding to increase her expertise in this arena. Therefore, while the Department concurs that such runs should be conducted, and will conduct them to the extent the expertise in the OIG allows for it.

Spike Reports

Another issue cited by the auditors is the OIG's failure to create runs to determine whether claims have spiked over time. Though the J-SURS system has data mining capabilities, it is primarily a peer-to-peer comparisons tool designed to identify providers billing in patterns that are excessive and unlike their peers. A spike detection model looks for suspicious surges in billings by a single provider. It is used primarily to uncover fictitious providers enrolling in the system.

Therefore, "spike reports" discussed by the auditors, and the drill down reports required to further analyze the resulting data, are quite difficult to craft and require significant expertise using J-SURS. Despite that, the OIG began attempting to utilize J-SURS' "spike" capabilities in March of 2009 and plans to continue creating and reviewing surges to the extent that it is a productive use of scarce resources and can be done with the expertise available to the OIG.

Unbundling

Another issue cited by the auditors is runs to determine whether claims have been "unbundled." As with runs related to billing outside of specialty areas, in order to conduct comprehensive code unbundling runs and the related investigations of potential overpayments, the OIG must have clinical staff and individuals with significant clinical and coding experience.

AUDITOR'S FINDING #10

Procedures were not always revised to correct deficiencies identified in post-payment reviews.

AUDITOR'S RECOMMENDATION

We recommend that DHMH modify its procedures (such as edits in MMIS II) to prevent improper payments due to systemic issues discovered during the post-payment review process.

ADMINISTRATION'S RESPONSE

DHMH agrees with this recommendation and will implement all appropriate payment edits. When notified of systemic errors as a result of the post-payment review process, MCPA will determine if edits can be implemented in MMIS to address the error and if so, make the adjustments. If edits can not be implemented, the program will continue to review through post-payment.

AUDITOR'S FINDING #11

Additional procedures could be used to publicize the DHMH fraud hotline and more data should be maintained to monitor its effectiveness.

AUDITOR'S RECOMMENDATION

We recommend that DHMH

a. consider additional methods to publicize its Medicaid fraud hotline and website-based fraud referral process, and

b. **maintain statistics that can be used to evaluate the effectiveness of the fraud referral procedures**.

* ADMINISTRATION'S RESPONSE

11a. The OIG concurs and will consider additional methods to publicize the Medicaid fraud hotline. Although, certain methods suggested by the auditors are not likely to be effective. For example, the majority of State employees do not receive check stubs. Also, without a legislative mandate, a provider cannot be required to post a fraud hotline notice. However, management from the Office of the Inspector General meets regularly with provider groups and associations in Maryland to educate those groups about how to report fraud. Those providers groups and non-governmental entities generally invite the OIG to speak at association meetings but as stated before, are not legally required to post information about the Department's fraud hotline in their places of business.

11b. The OIG does not concur that it fails to maintain statistics relating to the effectiveness of its fraud hotline. For example, in our FY 2008 Annual Report, we reported the following statistics on our hotline's activity: the number of calls received, the number of calls responded to, the number of calls referred to other Administrations within DHMH, the number of calls referred to Departments outside of DHMH, the number of OIG investigations initiated as a result of the calls, the number of calls abandoned by the complainant, and the number of other issues addressed not related to fraud, waste and abuse. Additionally, the OIG works closely with the Medicaid Fraud Control Unit of the Office of the Inspector General and tracks all cases referred to that office. Furthermore, the fraud hotline is not the sole source of referrals received by the OIG. Many cases are opened as a result of written referrals, calls made directly to OIG management, and data mining activities.

* **See Appendix B for related auditor comment.**

The OIG, however, does concur and will consider the possibility of capturing more data to measure the effectiveness of its hotline.

AUDITOR'S FINDING #12

Post-payment reviews of in-state hospital claims could be improved. DHMH should ensure that a sufficient number of claims are audited and that they are audited more timely.

AUDITOR'S RECOMMENDATION

We recommend that DHMH

a. **establish and maintain a current contract for post-payment audits of hospital claims, and**
b. **review and assess the procedures used by the contractor to select claims for audit to ensure a sufficient number of hospital claims is audited in a timely manner.**

ADMINISTRATION'S RESPONSE

DHMH concurs with the recommendation.

12a: The Program was able to comply with the recommendations by awarding the contract on July 1, 2009.

12b: As a result of the delay in the procurement process, the Program will be unable to review payments for part of the calendar year 2003. The audit contractor is currently reviewing claims from 2003 to 2009. The Program is currently working with the new contractor to ensure that a sufficient number of hospital claims are reviewed in a timely manner.

AUDITOR'S FINDING #13

DHMH did not always verify that payments to out-of-state hospitals were made at the proper rates.

AUDITOR'S RECOMMENDATION

We recommend

a. **that DHMH verify that payments to out-of-state hospitals are based on the appropriate rates, and**
b. **that previous payments to out-of-state hospitals are reviewed and any overpayments identified are recovered.**

ADMINISTRATION'S RESPONSE

DHMH concurs with the recommendation.

13a: As noted in the report, processing of out-of-state hospital claims is a very labor intensive, manual process. The process is unique to Maryland because no other state shares our payment structure for hospitals. Because our in-state reimbursement methodology is different from that of other states, MMIS has never been programmed for other state hospital methodologies. At this time the state is unable to incorporate an IT based solution. Until the Program is able to incorporate an IT based solution in the new MMIS, the Program will use the hospital bill auditor to validate the accuracy of the rate on claims submitted by out of state hospitals from July 1, 2009 forward.

13b: The audit contractor is currently reviewing claims from 2003 to 2009. The Program is currently working with the new contractor to ensure that a sufficient number of hospital claims are reviewed in a timely manner.

AUDITOR'S FINDING #14

Procedures to obtain information regarding third-party liabilities could be improved.

AUDITOR'S RECOMMENDATION

We recommend that DHMH develop and implement a more effective process for pursuing reimbursement from third parties that may be liable for treatment provided to Medicaid recipients, such as working with DHR during the reassessment process.

ADMINISTRATION'S RESPONSE

The Administration agrees with the recommendation to change an existing policy to pursue reimbursement from third parties that may be liable for treatment provided to Medicaid recipients.

The Administration disagrees with the recommendation that DHMH work with DHR to improve the process for identifying third parties that may be liable for health care cost incurred for Medicaid recipients. The Administration does not believe that sending a third tort letter from DHR will be any more effective in increasing the response rate or improving the process for identifying third parties. Therefore, the Administration will employ its TPL Recovery vendor to pursue recovery of Medicaid payments where third parties are liable for health care costs incurred for Medicaid recipients when the second tort letter is returned to the Administration. This initiative will require modification to the new TPL vendor contract which will be implemented on January 10, 2011.

VOUCHER ONLY CLAIMS

AUDITOR'S FINDING #15

There was no systematic process involving MHA, DDA, and MCPA to analyze the cause(s) of rejected federal fund reimbursement claims and to modify procedures to reduce the amount of future rejected claims.

AUDITOR'S RECOMMENDATION

We recommend:

a. **that MCPA, in conjunction with DDA and MHA, improve the process for obtaining federal Medicaid funds for voucher claims;**
b. **that, at a minimum, MCPA continually track the number and amount of claims rejected, determine why the claims were rejected, document what actions were needed to resolve the rejection of claims, and develop processing modifications that will reduce the number of future rejections by MMIS II; and**
c. **that, if necessary, DHMH consider alternative methods of processing claims for DDA and MHA.**

ADMINISTRATION'S RESPONSE

15a/c: DHMH agrees with the recommendation to improve the process for obtaining federal Medicaid Funds for voucher claims. We are considering alternatives to be implemented with the new MMIS system, including modification of the current claims processing flow, where DDA and MHA process claims and then submit them again through the MMIS, should be considered as a way to reduce the risk that appropriate federal funds are delayed or not recovered. We believe that the MHA Administrative Services Organization (ASO) should be utilized to authorize services and that Mental Health providers could submit claims directly into the new MMIS. The current DDA provider payment process will be assessed to determine the best way to integrate them into the new MMIS during the design phase of the MMIS development effort, expected to begin in FY 2011.

15b: The new MMIS is not expected to be available until 2013. In the meantime, the Department is considering revising the edits for MHA claims to minimize the number of claim denials by the MMIS. We are investigating the possibility that edits for MHA ASO claims be limited to: Recipient Eligibility, Provider Eligibility, Timely filing and Duplicate Claims. MHA claims are already subject to additional reviews, primarily by the ASO. These extensive procedures, noted by the

Legislative Auditors, should be sufficient to minimize the risk of submitting claims for Federal Funding that is not appropriate. A final determination of the specific edits to be revised will be completed by MHA and MCPA staff by December 31, 2009 and implemented within 90 days of the decision. Since there is no ASO contractor to rely upon for the accuracy of DDA claims, we would retain the existing edits in place until the new MMIS and revised DDA processes could be established.

Recommendations regarding tracking of claims errors within MMIS II are addressed in our response to audit finding #16**.**

AUDITOR'S FINDING #16

Rejected claims for federal reimbursement were not promptly investigated and resolved, adequate records of rejected claims were not maintained, and certain rejected claims were not pursued.

AUDITOR'S RECOMMENDATION

We recommend that MCPA, in conjunction with DDA and MHA, ensure that all rejected claims for federal Medicaid funds are promptly pursued and resolved.

ADMINISTRATION'S RESPONSE

DHMH agrees with the recommendation that all rejected claims for federal Medicaid funds be promptly pursued and resolved. Although there are adequate electronic records of claim denials available for use in error resolution, there are insufficient dedicated resources at both MHA and DDA to assess and resolve the errors in a timely manner.

DHMH does not agree that the current MMIS should be modified to track the status of each denied DDA claim. Last year, the MMIS set a denial reason for nearly 1.3 million claim lines submitted by DDA. If each claim required only five minutes of staff time to follow-up on, it would take six full time staff working for one year to go through all of the errors. Recipient eligibility errors, the most frequent, almost always require individual research and a change to either an eligibility file or a claim submission to address. The Department intends to work with DDA to identify some of the processes that might reduce the numbers of errors that occur in anticipation of developing revised processes to be utilized in the new MMIS.

We recommend changing the edit for timely filing for claims from DDA and MHA to at least 18 months, instead of the current 12 months, to reduce the number of unnecessary claim denials for timely filing. The Department intends to request at least 4 additional dedicated staff for both DDA and MHA in order to improve the claims and Federal reimbursement process for both agencies and address the requirements for the new MMIS.

APPENDIX B

Auditor's Comments on the Department's Response

In its response (Appendix A) to the audit report, the Department disagreed with certain information in the report. We continue to believe that the information in the report is valid. Auditor's comments are presented below about the Department's responses to certain information in this report.

Finding 8: Minor wording changes were made to address the Department's comments concerning the nature of the Surveillance and Utilization Review Subsystem (SURS).

The Department stated that SURS reports identify providers who do not fit a norm but do not identify claims, and accordingly, it cannot maintain documentation on claims reviewed. Although certain reports produced by the Department may focus on providers and do not include detailed claims data, we would like to point out that SURS analyzes detailed claims information on both providers and recipients to identify activity and trends for further review or investigation. According to Departmental documentation, SURS is designed to reveal, in substantial detail, actual activity in the medical assistance program that can be used to identify claims that should be investigated.

The response also stated that, with respect to specific investigations performed, the Division of Program Integrity maintains the reports, the number of claims reviewed, the results, and the recommended recoveries for investigations performed. The Department's response indicates a misunderstanding of the issue. Specifically, while we recognize that documentation is maintained when SURS reports result in formal investigations, the response does not address the recommendation that a listing of SURS reports produced and the related results (such as actual recoveries) be maintained with respect to *all SURS reports* so that these reports can be evaluated as to their effectiveness. Specifically, a formal process should be in place to evaluate the effectiveness of the SURS reports generated and should be used to determine which areas to select for future SURS reviews.

Finding 9: The audit report recommended that the Department perform periodic and documented assessments of areas or categories of claims considered to be high risk for fraud and abuse, and document how these assessments were addressed in the post-payment review procedures through the use of utilization reports. The Department disagreed with the recommendation because of cited technology limitations of its current SURS system, while acknowledging the need for an antifraud system that features improved analytical productivity. However, the Department does not address

other commercially available analytical tools that could be used to identify high-risk activity.

Finding 11: In its response, the Department disagreed that it did not maintain statistics relating to the effectiveness of the fraud hotline, and pointed out the data that were included in its annual report, including the number of calls received, the calls referred to others, and the OIG investigations initiated. Nevertheless, the Department stated that it does concur and will consider the possibility of capturing more data to measure the effectiveness of its hotline.

Audit Team

Stephen C. Pease, CPA
Audit Manager

Mark S. Hagenbuch, CPA
Alexandra E. Zouras, CPA
Senior Auditors

Nadine L. Forgenie
Michael J. Murdzak
Rick E. Pyles
Amber M. Schon, CPA, CFE
Staff Auditors

Brett M. Sheppard
Staff Auditor Intern

Other Staff Who Contributed to This Report
Richard L. Carter, CISA