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Department of Health and Mental Hygiene – Mental Hygiene Administration

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Presentation to
Joint Audit Committee

Bruce A. Myers, CPA
Paul R. Denz, CPA
Mark S. Hagenbuch, CPA

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Audit Overview

- The Mental Hygiene Administration (MHA) is responsible for developing comprehensive treatment and rehabilitation services for individuals with mental illness. MHA's functions include:
  - overseeing the provision of publicly funded services for the care and treatment of individuals with mental disorders;
  - supervising State mental health facilities; and
  - reviewing and approving local government plans for treatment of the mentally ill
- MHA's expenditures during FY 2007 totaled approximately $575 million, the vast majority of which was incurred for mental health services.
- Our audit included 11 findings, 3 of which were repeated from the preceding audit report.

Key Audit Issues

- MHA did not ensure that provider rates used to obtain federal reimbursement for eligible services were correct and, as a result, $1.15 million in federal funds was not claimed in CY 2006. Eligible provider claims were not always submitted for reimbursement within the required timeframe.

- MHA had inadequate procedures for reviewing authorization decisions made by its administrative service organization (ASO), which was paid $14.4 million during FY 2007, and the ASO did not meet certain contract requirements.

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

- Independent reviews of provider claims paid by the ASO excluded certain verification procedures and problems found were not always investigated.

- Sufficient action was not taken to recover provider advances totaling $737,000.

Federal Funds

- MHA did not ensure that federal reimbursement rates received for certain eligible services corresponded to the related service rates paid to providers. (Finding 1)

  - Our analysis of CY 2006 claims paid disclosed approximately 270,000 claims for which the related federal reimbursement was based on amounts totaling $2.3 million less than the actual service rates paid to the providers.

  - Consequently, the State received $1.15 million (50 percent federal reimbursement of $2.3 million) less in federal funding than it would have if the actual claim amount had been used to calculate the federal reimbursement.

  - Prior to our analysis, MHA had not identified this situation nor initiated any necessary corrective action.

Federal Funds (continued)

- Eligible provider claims were not always submitted for federal reimbursement within the timeframe required by federal regulations. (Finding 2)
  - Federal regulations require that claims be submitted within a specified two-year period after payment to the provider.
  - OLA test of 26 claims paid by the ASO found 7 that appeared to have exceeded the two-year period, and federal reimbursement totaling approximately $43,000 had not been obtained for those claims.
  - Federal authorities advised that there are only a limited number of exceptions to the time requirement, and MHA had no documentation that the tested claims met any of these exceptions.

Administrative Service Organization (ASO)

- MHA lacked adequate procedures for systematically reviewing service authorization decisions made by the ASO. The ASO paid $475 million for provider claims in FY 2007. (Finding 3)

  - Although State regulations require MHA to regularly and systematically review the ASO's authorization decisions, MHA could not document how it selected these decisions for review, including sample size, types of service to examine, and frequency of such reviews.

  - For example, MHA reviewed 12 inpatient hospital authorizations decisions made by the ASO during FY 2007, even though the ASO authorized approximately 20,000 inpatient stays in the first 6 months of that year. We question whether the sample selected for review was sufficiently comprehensive.

Administrative Service Organization (continued)

- The ASO did not perform the number of contractually required inpatient claim audits.
  - The contract requires the ASO to audit, including a review of related billing and medical records, claims filed by a minimum of 6 inpatient facilities per year to ensure claim accuracy.
  - As of June 30, 2007, only 2 such audits had been performed since inception of the contract in October 2004; while inpatient claims paid from July 2006 to April 2007 totaled $75.6 million. (Finding 4)

- Interest income earned in a bank account established by MHA for the ASO's use in processing claims had not been transferred to the State's General Fund since the account's inception in October 2004, as required by the State Treasurer. As of June 2007, interest earned totaled approximately $1.8 million. (Finding 5)

Contractor Claim Reviews

- Independent reviews of provider claims paid by the ASO did not include certain critical verification procedures. (Finding 6)
  - MHA contracted with a private entity to perform periodic reviews of selected claims processed by the ASO for the purpose of ensuring compliance with certain requirements, such as proper authorization.
  - The entity's procedures excluded certain critical attributes, such as verifying that claims paid entirely from State funds were not actually eligible for federal reimbursement, and that the claims were submitted by providers within the timeframe required by State regulations.
  - We noted paid claims totaling $39,000 that had been miscoded as not eligible for federal reimbursement.

Contractor Claim Reviews (continued)

- Deficiencies and discrepancies identified by the contractor's reviews of the ASO were not always investigated and resolved. (Finding 7)
  - Reports issued by the contractor often noted potential problems relating to claims examined, such as instances in which the amount paid to a provider for a particular service was different than the established rate.
  - MHA generally relied on the contractor to resolve such issues, but the contractor's reports frequently noted that no explanation or resolution was obtained, and the issues were not pursued further.

Provider Advances

Sufficient action had not been taken to collect provider advances totaling approximately $737,000. (Finding 9)

- These funds had been advanced several years ago for various reasons, including delays in processing claims by the former ASO (pre-October 2004).
- MHA had no documentation that action had been taken to recover these amounts, such as offsetting future claims from the provider or submission to the Department of Budget and Management's Central Collection Unit.
- During CY 2006, one provider with outstanding advances of $187,000 received claim payments of approximately $4 million that possibly could have been used to offset the amount due.

Conclusion

MHA should:

- ensure the propriety of federal reimbursement for paid claims and recover any amounts due when reimbursement was based on less than the actual claims paid. Furthermore, claims for federal reimbursement should be submitted within the required timeframe.
- establish adequate procedures to select ASO service authorization decisions to ensure sufficient review coverage, and ensure that the ASO conducts the required number of claim audits.
- verify that interest income is regularly transferred to the State's General Fund.
- ensure that procedures used in contractor claim reviews include all critical verification procedures, and that significant deficiencies and discrepancies noted are investigated and resolved.
- initiate recovery procedures for outstanding provider advances.