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Maryland Department of Health Medical Care Programs Administration (MCPA)

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Presentation to the Joint Audit Committee

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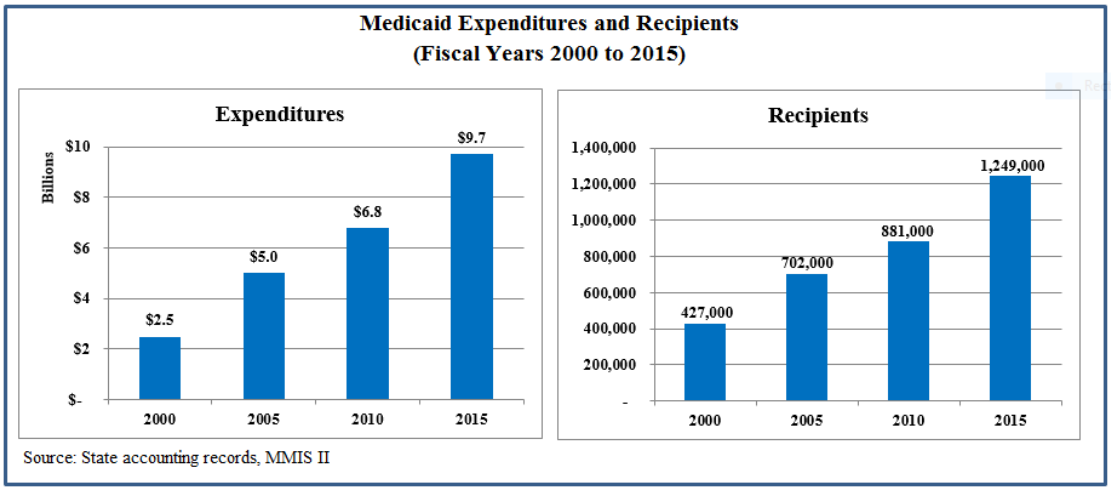
Audit Overview

- MCPA expenditures have mirrored the growth in Medicaid enrollment since FY 2000.



- The report contains 15 findings, including 7 repeats presented in 6 findings.

- OLA determined that MCPA's accountability and compliance level was unsatisfactory, in accordance with the rating system OLA established in conformity with State law. The primary factors contributing to the unsatisfactory rating were the significance of the audit findings and the number of repeat findings (**Findings 2, 4, 5, 6, 7, and 11**).

Key Findings

- Certain new enrollees were not properly processed, resulting in delays in placing these individuals into a managed care organization, which can increase claim costs.
- Agreements with the Department of Human Services and the Maryland Health Benefit Exchange (MHBE) for delegated recipient eligibility services were not sufficiently comprehensive.
- Follow-up of potentially ineligible Medicaid recipients was untimely.
- MCPA did not take certain actions to maximize recoveries from other sources, including Medicare, to reduce Medicaid payments.
- MCPA did not monitor vendors contracted to assist in its administration of the Medicaid program including processing claims and/or verifying billings by hospitals, and behavioral health and dental providers.
- Certain security measures and controls over IT systems and data were lacking.

Recipient Enrollment (Finding 1)

MCPA did not assign a temporary enrollment status to 11,153 new enrollees, resulting in delays in placing individuals in Managed Care Organizations (MCO). Such delays resulted in certain claims being paid on a fee-for-service (FFS) basis, which are generally higher than capitation fees paid to MCOs.

- MCPA became aware of the problem in July 2014 after several new enrollees questioned why they were not enrolled in an MCO.

- Queries run by MCPA in October 2014 and November 2015 identified, in the aggregate, 11,153 new enrollees who remained in a FFS status.

- MCPA advised that all of these cases were investigated and the individuals were placed in MCOs if warranted.

Recipient Enrollment (Finding 1 – cont.)

- The fiscal impact of these delays (that is, the cost differential between FFS claims that should have been covered by an MCO and the related MCO capitation fees) could not be readily determined.

- After excluding readily identifiable claims that were appropriately paid as FFS, we identified FFS claims totaling $13.3 million for 1,571 of the 11,153 new enrollees paid in FY 2015.

- Our test of the 10 highest FFS claims paid during FY 2015 found that 4, totaling $826,000 were improperly paid as FFS due to the delay in enrollment.

- The problem was allegedly due to a computer compatibility issue between MCPA's IT system and the Maryland Health Benefit Exchange's computer system (HBX).

Recipient Enrollment (Finding 2)

MCPA did not have sufficiently comprehensive Memoranda of Understanding (MOUs) with DHS and MHBE, outlining responsibilities for ensuring Medicaid eligibility determinations are performed timely and properly.

In response to a prior audit report, MDH updated its MOU with DHS in July 2011. An MOU was also established with MHBE in September 2013. However, the MOUs did not adequately address

- quality control procedures at DHS and MHBE to ensure the integrity of the eligibility process;
- longstanding deficiencies identified in prior OLA reports, such as recipients with multiple Medical Assistance numbers that could result in duplicate claims paid; and
- resolution of potential fraud or abuse identified, and the correction of any eligibility process problems identified by MCPA.

Recipient Enrollment (Finding 3)

MCPA did not take timely follow-up action on questionable enrollee eligibility information it identified nor ensure that critical eligibility information was recorded in its provider claims payment system (MMIS II).

- As of June 2015, MCPA reports identified three large LDSSs that had 2,721 alerts (such as recipients enrolled in other states), which were outstanding for 79, 125, and 194 days on average.
- Efforts to investigate reported discrepancies in recipient data were not documented, including instances in which reportedly deceased recipients were still active on MMIS II.

Recipient Enrollment (Finding 3 – cont.)

- Changes to critical recipient eligibility information (such as eligibility information) in MMIS II were not subject to supervisory review and approval. Nor was a mechanism in place to ensure DHS timely processed changes to eligibility information.

  Consequently, errors and delays in data entry resulted in overpayments. Our tests of 22 FFS claims totaling $6 million identified 7 claims totaling $2.4 million were improperly paid as FFS claims rather than by MCOs with capitation fees.

- MCPA did not monitor individuals enrolled in age-specific coverage groups to ensure that they were removed in a timely manner when they no longer met the age requirements. Approximately 1/3 of the 260,000 recipients in age-based coverage groups were older than the age range for their assigned group.

Recipient Enrollment (Finding 4)

MCPA did not take timely action to ensure recipients age 65 or older had applied for Medicare, as required by State regulations, to reduce Medicaid costs.

- According to MCPA records, during FY 2015 MCPA paid $85.4 million for 4,133 recipients who were at least 65 years old and were not enrolled in Medicare.

- In response to our prior audit report, MCPA initiated an outreach program in 2012 to advise potentially eligible individuals to apply for Medicare. But notices sent to individuals were not timely.

- The eligibility of nonresponsive individuals (approximately 20 percent of total outreach participants as of August 2016) was not terminated.

Recipient Enrollment (Finding 5)

MCPA did not ensure that all potential third-party health insurance information for Medicaid recipients was received and properly investigated in a timely manner.

- MHBE was not required by the MCPA/MHBE MOU to submit any reports of potential third party insurance for Medicaid recipients. One report received from MHBE in March 2015 included 24,300 recipients with potential insurance.

- MCPA did not retain documentation of reviews performed of third-party insurance referrals. MCPA received 134,000 referrals from DHS and 10,000 referrals from its contractor during CY 2015. Documentation of investigations for 6 of 15 referrals tested was not maintained.

Program Oversight (Finding 7)

MCPA has not conducted audits of hospital claims processed since CY 2007. Hospital claims totaled approximately $900 million in FY 2015.

- MCPA had previously contracted with a vendor for these audits, with the most recent claims audit period from CYs 2004 to 2007. The vendor had identified overpayments of $10.7 million for claims paid during 2005 and 2006.
- After several unsuccessful attempts to procure audit services, MCPA received a temporary exemption from the federal government in February 2014 from conducting recovery audits until November 2014.
- A new auditor was hired in August 2015, but was terminated one year later due to performance issues.
- During the interim, a few audits were conducted by MDH which identified overpayments of $234,000.

Program Oversight (Findings 9 and 10)

Background

MCPA became responsible for the Administrative Service Organization (ASO) providing benefit management services for the Public Behavioral Health System effective January 2015. During FY 2015, behavioral health claims totaled $900 million, $491 million of which occurred after MCPA assumed responsibility for monitoring the ASO.

- MCPA did not ensure that deficiencies noted during the ASO's provider audits were corrected and related overpayments were recovered. The ASO is required to audit 300 providers per year to validate the behavioral health claims and identify claim deficiencies and provider overpayments.

  For 2 of 10 audits we reviewed, improper claims identified by the audits totaling $21,000 had not been recovered until we notified MCPA (**Finding 9**).

Program Oversight (Findings 9 and 10 – cont.)

- MCPA did not ensure that the ASO resolved rejected behavioral health claims timely, resulting in the payment of potentially improper claims and the loss of federal fund reimbursements (**Finding 10**).

  - In March 2016, the ASO reported claims totaling $1.5 million paid over a 4½ year period ended March 2014 that were rejected for processing by MMIS II, which had not been resolved. These claims exceeded the two-year period available to recover federal participation.

  - As a result, the State lost federal fund reimbursements totaling $768,000, with at least $237,000 applying to the period after MCPA assumed responsibility for the ASO.

Program Oversight (Finding 12)

MCPA did not ensure that the former dental benefits administrator (DBA) was properly administering the dental benefits program. Dental providers were paid $162.5 million during FY 2015.

- Over the 6½ year contract period, MCPA did not conduct audits of the DBA, even though the contract required the DBA to submit to a yearly audit by a firm contracted by MCPA.

- MCPA did not monitor the quantity or quality of provider audits performed by the DBA. At our request, MCPA determined that during FY 2015, the DBA conducted audits of only 32 of the 1,354 participating providers as of August 2014.

- MCPA did not ensure the DBA investigated claims rejected by MMIS II, which as of June 2015 totaled $800,000.

- MCPA did not ensure that the DBA safeguarded sensitive data.

Information Systems Security

- Sensitive enrollee information on an MCPA database was stored and transmitted without adequate safeguards. The database contained 1.7 million unique SSNs in clear text.

  MCPA did not correct 20 of the 21 security vulnerabilities identified in a consultant's report on this database (**Finding 13**).

- Access controls over certain critical servers maintained by the behavioral health ASO were inadequate and the ASO stored personally identifiable information relating to over 2.3 million members in clear text (**Finding 11**).

- Sensitive Medicaid enrollee information provided to a contractor was transmitted to an information management vendor without MCPA approval (**Finding 15**).

Conclusions

MCPA should:

- ensure recipients are enrolled timely in MCOs and ensure the compatibility of MMIS to HBX;
- modify MOUs with DHS and MHBE to address longstanding issues;
- take timely actions on potentially ineligible recipients and establish adequate procedures to maximize recoveries from other sources to reduce Medicaid payments to providers;
- conduct timely audits of hospital billings;
- ensure vendors contracted to assist in its administration of the Medicaid program are adequately monitored; and
- ensure its IT systems, and those used by contractors, are properly secured and that sensitive data is safeguarded.