Department of Legislative Services
Office of Legislative Audits

Maryland Department of Health (MDH)

Efforts to Identify and Analyze Improper Medicaid Payments

Performance Audit

Report Dated June 23, 2020

Report Overview - Audit Scope and Objectives

We conducted a performance audit to determine if the Maryland Department of Health (MDH) had a comprehensive approach to identify and analyze improper Medicaid-related payments. Our audit had the following objectives

1. To determine if MDH had established a comprehensive documented risk-based approach to focus the efforts of its program integrity operations on areas of highest risk and applied industry best practices in its use of data analytics to effectively identify improper Medicaid-related payments. Additionally, to determine if MDH measured and reported quantifiable benefits of its program integrity operations.
2. To determine if MDH's operations were adequately identifying and addressing potential improper Medicaid-related payments.

To accomplish our objectives, we obtained data extracts from the Medicaid Management Information System (MMIS II) for the period beginning July 1, 2015 and ending June 30, 2018 and analyzed more than 290 million fee-for-service claim payments and Managed Care Organization (MCO) encounter data records (billed claims that providers submit to MCOs).

Report Overview – Background Information

Improper Payments are defined by the federal government as "any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements." Incorrect amounts include both overpayments and underpayments.

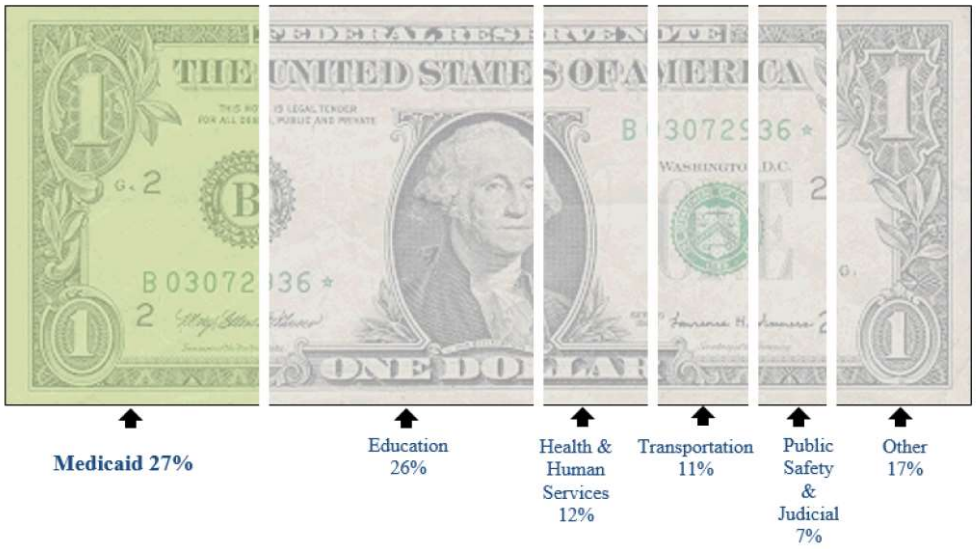
The MDH Office of the Inspector General (OIG) Division of Program Integrity (DPI) is a key component of MDH's efforts to identify and analyze improper Medicaid payments. As of June 30, 2018, the OIG had 64 employees, including 37 employees assigned to DPI. DPI's Surveillance and Utilization Review Subsystem (SURS) unit performs various data analytics on Medicaid claims to identify and analyze improper Medicaid-related payments. The data analytics are performed primarily on an ad hoc basis or to follow up on investigations initiated by others within DPI and MDH.

Report Overview – Medicaid Spending

In FY 2018, $10.9 billion was spent on Maryland Medicaid, including $5.6 billion in payments to the State's nine MCOs. Approximately 27 percent of the State's $41 billion expenditures (from all funding sources) during fiscal year 2018 were for Medicaid.

At the time of our audit, the federal Centers for Medicare & Medicaid Services (CMS) was projecting that total nationwide spending for Medicaid will rise an average of 5.5% per year from 2018 to 2027.

Medicaid Represents 27 Percent of Maryland Expenditures



Source: State of Maryland Comprehensive Annual Financial Report, Fiscal Year 2018

Key Findings

Objective 1 - Effectiveness of Program Integrity Operations

- MDH had not established a comprehensive risk-based approach to focus the efforts of its program integrity operations on areas of highest risk, did not have robust data analytics, and did not fully address MCO encounter data. MDH also did not take advantage of data analysis services available through the federal government and did not implement a formal process to measure and report quantifiable benefits of its program integrity operations.

Objective 2 - Operations to Identify and Address Potential Improper Payments

- MDH paid claims without ensuring the provider was properly enrolled and qualified for Medicaid, as required.
- MDH did not ensure MCOs had not paid claims for excluded services. In addition, MCOs did not include certain critical information in their encounter data and did not perform required investigations of the encounter data.
- MDH's controls were not adequate to identify and prevent improper Medicaid payments (such as payments to incarcerated individuals and duplicate payments).

Program Integrity Operations (Finding 1)

MDH's process to identify and analyze improper Medicaid payments through its DPI was not comprehensive and did not incorporate certain best practices.

- DPI data analytics need improvement. Specifically, DPI efforts:
  - lacked capabilities to cross-match between different datasets (such as between MDH's systems and external datasets) and did not include geo-mapping and data visualization techniques (summary charts and tables) to proactively highlight trends, patterns, and irregularities in Medicaid payment activity that would warrant further investigation;
  - were not tied to a risk-based approach or annual plan, which can enhance the effectiveness of such activities; and
  - did not include performing comprehensive analytics of MCO encounter data.
- Consequently, OLA performed its own advanced data analytics using available commercial software that we determined was more comprehensive than the software available through the DPI unit. As a result, in Findings 2, 3, 5, 8, and 9, our data analytics identified various potential improper payments, and we analyzed data for trends, patterns, or irregularities in Medicaid payment activity by provider.

Program Integrity Operations (Finding 1) - continued

- DPI did not leverage available data matching resources provided through the United States Treasury's Do Not Pay (DNP) Center. The DNP Center is a free robust analytic tool that helps agencies identify and prevent improper payments by matching agency data to various federal databases, some of which are only available through the federal government. Additionally, the DNP Center provides pattern and trend analysis, detection of anomalies to identify high risk areas, and detection of duplicates. Although MDH performed its own in-house matches, we believe MDH could achieve better data matching results through the DNP Center.

- According to a 2015 federal report, Maryland was one of seven states that could not identify any steps taken to quantify improvements in the outcomes or effectiveness of its program integrity efforts attributable to the use of information systems. Such steps should include conducting a formal annual risk assessment and tracking the measurable and quantifiable benefits of its systems.

Payments to Unenrolled Providers (Finding 2)

MDH did not ensure that prescribing physicians and referring providers were enrolled in Medicaid prior to approving claims, as required by federal regulations.

- During the period FY 2016 to FY 2018, of the 17 million pharmacy and laboratory claims totaling approximately $2 billion, MDH approved 1.6 million claims totaling approximately $175 million submitted by prescribing physicians and referring providers whose enrollment in Medicaid was not validated.
- MDH allowed the claims to be processed in MMIS II with a general number (known as a dummy number). The information identifying the provider associated with these claims was not provided to DPI, preventing it from performing data analysis of claim activity and to identify improper payments.
- Our cursory review of the laboratory providers with a dummy number and the highest dollar amount of claims disclosed at least 5 laboratories, of the top 15, were subsequently under investigation or had settlements against them for improper billing or claims (including 2 that were investigated by the federal government, resulting in large settlements).

Payments to Unenrolled Providers (Finding 3)

MDH did not ensure that rendering providers for certain group practices (physical, occupational, and speech therapy) were enrolled in Medicaid, as required by State regulations.

- Of the approximately 846,000 claims paid, totaling $46.2 million, during the period from FY 2016 to FY 2018 for certain therapy group practices services, MDH approved 835,000 claims totaling approximately $45.6 million that did not identify the rendering providers. As a result, there was lack of assurance as to whether the services were performed by properly qualified medical practitioners enrolled in Medicaid.
- Claim amounts related to these therapy group practices increased by 89% from FY 2016 to FY 2018. These claims were submitted by 125 practices, with 10 practices or 8% of the practices representing 67% of the claim activity.
- MDH management advised us that they were aware of this issue and distributed a written notification in August 2017 stating the requirement that, effective January 1, 2018, Medicaid claims were required to include the rendering provider information on each claim.

MCO Encounter Data (Finding 4)

MDH accepted encounter data from MCOs that excluded necessary data elements, which hindered its ability to perform effective oversight and identify and analyze improper claim activity. Specifically, encounter data submitted through December 31, 2017 did not include the following three critical elements:

Excluded Data Element	Impact
Paid or denied status of claim	DPI could not effectively identify paid claims and could not readily focus its investigative and analytic efforts on only paid claims.
Claim payment amount	DPI could not readily determine the materiality of claim activity and focus its analytic efforts on the most significant claims.
Rendering provider information	DPI could not focus its analytic efforts on certain providers or identify unusual patterns in provider claim activity that warranted further investigation.

Since this information was excluded, DPI required assistance from each MCO to manually research and obtain information for each claim it investigated.

MCO Encounter Data (Finding 5)

MDH did not perform a data match or have an alternative method to determine if MCOs were paying claims for certain services that MDH had carved out from the MCO contracts (such as behavioral health, dental, and HIV treatments) and were covered directly by MDH as fee-for-service claims.

- Based on an OLA developed risk analysis, we performed a data match of fee-for-service behavioral health claims to the encounter data reported by the MCOs during the period from July 2015 through June 2018 which disclosed approximately 1.1 million potential duplicate claims totaling $65.4 million. According to MDH's records, fee-for-service behavioral health claims totaled $3.5 billion during this period.

- Due to the previously mentioned limitations in the MCO encounter data we were unable to determine whether the encounters were paid and represented improper payments.

Oversight of MCOs (Finding 6)

MDH did not ensure MCO providers were enrolled as Medicaid providers, as required by federal regulations.

- In November 2017, MDH estimated that there were approximately 10,000 MCO providers rendering services to Maryland Medicaid recipients whose Medicaid enrollment needed to be verified. Based on our review of MDH records, as of February 2019, MDH was maintaining a list that only tracked the enrollment status of 2,928 of the estimated 10,000 MCO providers. Additionally, the tracking records indicated that only 13% of these 2,928 MCO providers had applied to become Medicaid providers, but did not identify how many had been verified.

- As of February 2019, the MCOs self-reported that 75% to 85% of their providers had been enrolled in Medicaid. However, no detailed support (such as listings of the specific MCO providers who had been enrolled) was provided to MDH by the MCOs to support these reported figures.

Oversight of MCOs (Finding 7)

MDH did not ensure each MCO conducted required investigations of encounter claims activity to ensure payments to providers are proper.

According to a 2017 CMS report, the number of investigations conducted by the MCOs was "extremely low" relative to the size of Maryland's Medicaid managed care program.

The nine MCO's reported that investigations were conducted on at least 409 providers during FY 2018 (see table).

Summary of MCO Investigations for Fiscal Year 2018

(payment amount in millions)

MCO	Count of Enrollees	Fiscal Year 2018 Payments	Number of Providers Investigated
MCO 1	299,689	$1,455	84
MCO 2	280,401	1,139	62
MCO 3	218,722	1,120	10
MCO 4	155,862	706	168
MCO 5	90,561	453	32
MCO 6	64,050	280	*
MCO 7	26,379	197	5
MCO 8	44,598	232	48
MCO 9	4,393	14	*
Totals	**1,184,655**	**$5,596**	**409**

*Could not be determined due to lack of reported investigations

Source: MDH records and MDH Enrollment Data published by the Hilltop Institute

Oversight of MCOs (Finding 8)

MDH used incomplete data to identify incarcerated individuals in State correctional facilities who were improperly enrolled in MCOs. Furthermore, MDH's data analytics did not include certain data needed to identify and prevent improper fee-for-service payments for incarcerated individuals.

- MDH management advised us that it routinely received incomplete data from the Department of Public Safety and Correctional Services (DPSCS) and that although it had previously made attempts to improve the reliability of the data with DPSCS, it had been unable to fully resolve the issues.
- OLA performed its own match using records directly obtained from DPSCS which identified $9.6 million (consisting of $7.9 million in capitation payments and $1.7 million in fee-for-service charges) in potential improper Medicaid payments related to more than 3,200 individuals who were incarcerated on the dates the medical services were provided.
- Our test of the 20 incarcerated individuals in our match with the highest dollar value claims, totaling $912,000, confirmed improper claim payments totaling $867,000 for 19 of these individuals.

MMIS Edits (Finding 9)

MMIS II claims processing edits were not properly implemented to prevent the following:

- Payments to providers who were suspended due to credible allegation of fraud against the providers. Our review of claims paid to suspended providers between January 1, 2016 and June 30, 2018 identified 12,904 claims totaling $1.2 million that were improperly paid, based on federal regulations, to 16 different providers after MDH's OIG determined there were credible allegations of fraud against these providers.

- Duplicate payments and overpayments for claims submitted by two different providers for the same service and for claims involving both Medicaid and Medicare reimbursements (known as Medicare crossover claims). Our analysis of claims data for FY 2016 through FY 2018 disclosed 62,000 claims totaling $3.0 million that related to these scenarios. These claims were submitted by 1,867 providers, including 15 providers that accounted for $1.1 million of the $3.0 million claims.

Conclusions

MDH should

- take steps to effectively identify and analyze improper Medicaid payments through its program integrity operations;
- ensure that prescribing physicians, referring providers, and rendering providers are enrolled in Medicaid;
- ensure MCO reported encounter data includes all federally required elements;
- ensure MCOs are not paying claims related to services that MDH pays as fee-for-service;
- ensure MCO providers rendering services to Maryland recipients are identified and enrolled as Medicaid providers;
- ensure MCOs conduct investigations of encounter claims activity and provide details to MDH;
- ensure its incarceration data match is complete and accurate; and
- take corrective actions to fix system edits.