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Maryland Department of Health (MDH) - Medical Care Programs Administration (MCPA)

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Presentation to Joint Audit and Evaluation Committee

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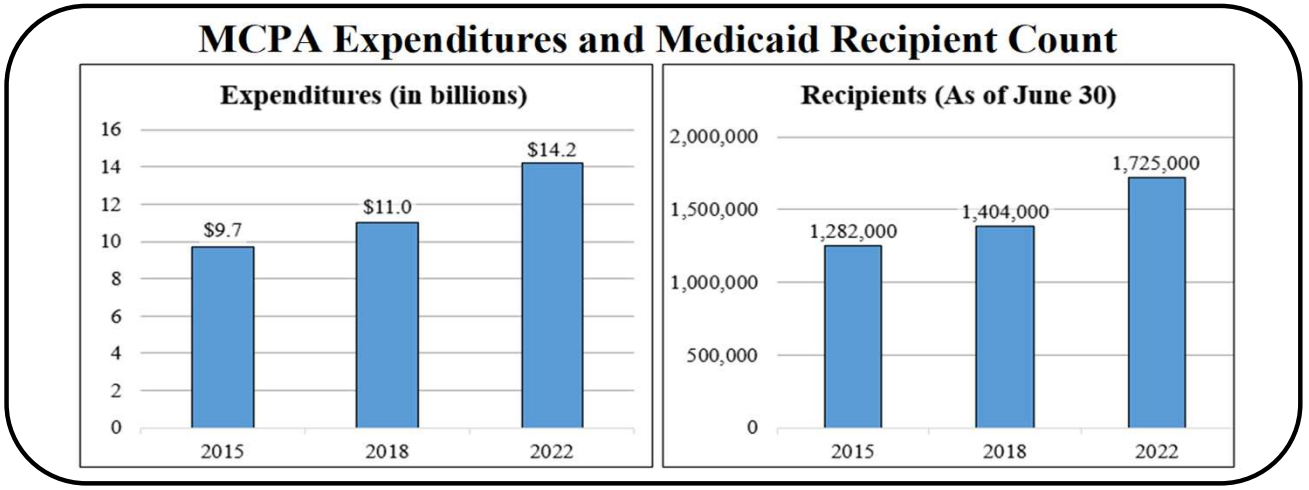
Report Overview

- MCPA administers the Medical Assistance Program (Medicaid), which provides low-income Maryland residents with access to a broad range of health care benefits that are financed by State and federal funds.
- The audit report covers the period from August 1, 2018 to March 31, 2022. The report contains 10 findings, including 6 non-cybersecurity-related repeat findings (Findings 1, 2, 4, 5, 6, and 7) from the prior audit report.
- 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 this rating were the significance of the audit findings and the number of repeat findings.

Report Overview (continued)

- This is the primary MCPA audit, accounting for $4.3 billion in expenditures in FY 2022. Separate audits are conducted of the Managed Care Program, Behavioral Health Administration's Administrative Services Organization, and the Maryland Pharmacy Program.
- MCPA's expenditures have mirrored the growth in Medicaid enrollment since FY 2015.



Key Findings

- Finding 1 – MCPA did not ensure that all referrals of potential third-party health insurance were investigated and recorded in its claims information system, MMIS II, which could result in MCPA improperly paying claims that should have been paid by a third party.
- Finding 2 - MCPA did not have effective processes to identify, prevent, and recover questionable Medicaid payments, including $7.1 million in payments for incarcerated and deceased recipients.
- Finding 4 - MCPA did not ensure that all Community First Choice (CFC) program recipients received personal services in accordance with their plans of service.

Key Findings (continued)

- Finding 5 – MCPA did not monitor the utilization control agent contractor to ensure continued stay reviews of Medicaid recipients in nursing facilities were performed timely.

- Finding 8 – MCPA did not adequately monitor the hospital claims audit contractor and had not collected or recovered improper claims identified by the contractor totaling $6.9 million.

- Findings 9 and 10 - Information Systems Security and Control (see confidential addendum)

Third-Party Liability (Finding 1) Repeat Finding

MCPA did not ensure that all referrals of potential third-party liability health insurance information were investigated and recorded in MMIS II. As a result, certain claims were not reviewed to determine if any portion should have been paid by a third party.

- Only 180,000 (12 percent) of the 1.5 million referrals received from MCPA's third-party liability vendor between January 2021 and June 2022 were recorded in MMIS II. For example, the January 2022 referrals for 84,672 recipients were not recorded and claims paid entirely by MCPA for these recipients between February and December 2022 totaled $103.1 million.
- MCPA did not document its investigation of MCO referrals. Our test of 135 MCO referrals received during two months of fiscal year 2022 disclosed that 86 referrals had not been investigated and recorded in MMIS II as of November 2022.

Questionable Activity (Finding 2) Repeat Finding

MCPA did not have effective processes to identify, prevent, and recover questionable Medicaid payments.

- Recipients with missing social security numbers were not referred to the Department of Human Services (DHS) and Local Health Departments (LHDs) for investigation. In addition, MCPA did not review DHS and LHD investigations of recipients who were also receiving Medicaid benefits in other states.
- We identified claims totaling $3.5 million paid by MCPA between FYs 2019-2022 for 1,954 recipients who were incarcerated at the time of service.
- MCPA could not document its efforts to remove deceased individuals from Medicaid and did not investigate payments after the recipient's death. We identified claims totaling $3.6 million with dates of service that were after the recipient's date of death.

Program Oversight – CFC (Finding 4) Repeat Finding

MCPA did not ensure that all Community First Choice (CFC) program recipients received services in accordance with their plans of service.

- CFC recipients receive assistance with daily living activities from personal assistance providers in accordance with a plan of service. LHDs contract with nurse monitors to evaluate the quality of personal assistance services provided to CFC recipients.
- As of November 2022, 1,873 (19 percent) of the 10,082 recipients receiving personal assistance services were more than 60 days overdue for a nurse monitoring visit, including 901 recipients who were more than one year overdue.
- Baltimore City LHD was responsible for 821 of the 901 one-year overdue recipients.

Program Oversight – Nursing Facilities (Finding 5) Repeat Finding

MCPA did not monitor the utilization control agent (UCA) contractor to ensure continued stay reviews (CSRs) of Medicaid recipients receiving services from nursing facilities were performed timely.

- CSRs ensure that recipients required the level of care provided by the nursing facilities. The UCA was required to perform quarterly CSRs of recipients during their first year in a nursing facility and annually thereafter.
- Our analysis of 13,930 recipients who should have received at least one CSR during CY 2021 disclosed that 2,387 recipients (17 percent) had not received a CSR anytime during that year. During calendar year 2021, MCPA payments to nursing facilities for these 2,387 recipients totaled $165.2 million.

Program Oversight – Hospital Claims Audits (Finding 8)

MCPA did not adequately monitor the hospital claims audit contractor and had not collected or recovered improper claims identified by the contractor.

- MCPA uses a contractor to audit hospital claims to ensure that the services provided to Maryland Medicaid recipients were necessary and not excessive.
- MCPA did not obtain certain deliverables required by the contract, including a plan detailing steps MCPA should take to reduce the occurrence of future improper hospital claims payments.
- As of August 2022, MCPA had not pursued recovery of improper payments totaling $6.9 million that were reported by the contractor between 2 months to 2 years prior.

Other Financial-Related Findings

Finding 3 – Recipient Eligibility

MCPA did not ensure that changes to recipient Medicaid eligibility information were processed timely and accurately.

Finding 6 – Program Oversight (Repeat Finding)

MCPA did not have an established process to ensure costly recipient ventilator care claims submitted by nursing facilities were valid.

Finding 7 – Program Oversight (Repeat Finding)

MCPA did not conduct the required audits of Medical Day Care and Supports Planning providers, and the related audit policy and procedures were not sufficiently comprehensive.

Information Systems Security and Control (Findings 9 and 10)

Redacted cybersecurity-related findings.

See confidential addendum.

Conclusions

MCPA should:

- ensure that third-party insurance information is timely investigated and recorded in MMIS II;
- establish effective processes to identify, prevent, and recover questionable Medicaid payments;
- update recipient eligibility information timely and accurately;
- ensure CFC recipients are monitored;
- ensure that CSRs are performed timely;
- periodically validate ventilator care claims;
- audit Medical Day Care and Supports Planning providers; and
- monitor the hospital claims audit contractor and pursue recovery of identified overpayments in a timely manner.