Audit Report

Department of Health and Mental Hygiene
Medical Care Programs Administration

December 2010

OFFICE OF LEGISLATIVE AUDITS
DEPARTMENT OF LEGISLATIVE SERVICES
MARYLAND GENERAL ASSEMBLY

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DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF LEGISLATIVE AUDITS
MARYLAND GENERAL ASSEMBLY

December 6, 2010

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Annapolis, Maryland

Ladies and Gentlemen:

We have audited the Medical Care Programs Administration (MCPA) of the Department of Health and Mental Hygiene (DHMH) for the period beginning September 1, 2005 and ending June 30, 2009. MCPA, through the Medical Assistance Program, spent $6.8 billion during fiscal year 2010 to provide low-income Maryland residents access to a broad range of health care benefits.

Our audit disclosed that comprehensive procedures were not in place to monitor and address longstanding deficiencies with recipient eligibility determinations, which have been reported in our preceding audit reports of MCPA and several Department of Human Resources (DHR) units. DHMH and DHR entered into a memorandum of understanding (MOU) under which DHR is primarily responsible for determining recipient eligibility and providing MCPA with accurate and timely eligibility data. However, the MOU had not been updated since its inception in 1985, and it did not contain provisions needed to help ensure that the aforementioned deficiencies, which could allow ineligible persons to receive Medicaid services, are corrected.

MCPA did not sufficiently verify data that were factored into the computation of capitation (per person) rates paid to managed care organizations (MCOs), which enroll about 70 percent of Medicaid recipients. Specifically, MCPA did not always verify provider-enrollee encounter (medical services) data and third-party recoveries and cost avoidance reported by MCOs. Reporting errors, such as over-reporting medical service encounters and under-reporting recoveries, could result in improperly increasing the capitation rates.

MCPA did not establish adequate procedures and controls over certain claims and provider applications, ensure that cost settlements were performed in a timely manner for long-term care facilities, nor verify the reasonableness of drug prices paid to pharmacies under the Maryland Medicaid Pharmacy Program. In addition, MCPA did not fully correct procedures and control deficiencies, which contributed to a $1.8 million fraud in the Kidney Disease Program. Finally, MCPA did not institute certain security controls affecting information systems.

In our preceding audit report, dated July 28, 2006, we reported that MCPA's accountability and compliance level was unsatisfactory in accordance with the rating system we established in conformity with State law. Based on the results of our current audit, we have concluded that MCPA's accountability and compliance level is no longer unsatisfactory.

An executive summary of our findings can be found on page 5. The response to this audit from DHMH, on behalf of MCPA, is included as an appendix to this report. We wish to acknowledge the cooperation extended to us during our audit by MCPA.

Respectfully submitted,

Bruce A. Myers, CPA
Legislative Auditor

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* **Denotes item repeated in full or part from preceding audit report**

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Executive Summary

Legislative Audit Report on the Department of Health and Mental Hygiene
Medical Care Programs Administration (MCPA)
December 2010

- **The memorandum of responsibility (MOU) between the Department of Health and Mental Hygiene (DHMH) and the Department of Human Resources (DHR) pertaining to the responsibilities for determining applicant eligibility for participation in the Medical Assistance Program (Medicaid) lacked provisions needed to ensure that longstanding deficiencies with the eligibility process noted in our audits are corrected. Also, the MOU did not provide for adequate MCPA oversight of DHR eligibility determinations, did not include comprehensive procedures to ensure deficiencies were corrected, and was generally outdated.**

  MCPA should review and update the MOU with DHR and ensure it provides sufficient provisions for adequate monitoring of the eligibility determination process and for the timely correction of any deficiencies. MCPA should also use available data to monitor the eligibility process and take appropriate corrective action.

- **Deficiencies were noted in the processes used to determine capitation (per person) payments to managed care organizations (MCOs) participating in the HealthChoice program. MCPA did not sufficiently verify certain data that were factored into the computation of capitation rates, such as encounter data (that is, medical services provided to enrollees) and third-party recoveries. Also, MCPA did not ensure its contractor properly determined the related capitation rates.**

  MCPA should verify encounter data submitted by the MCOs, at least on a test basis, and follow up when errors in the data are identified. MCPA should establish procedures to ensure that MCOs accurately report third-party recoveries and cost avoidance data and that its contractor properly determined the capitation rates.

- **MCPA lacked adequate procedures over claims paid for Medicaid recipients who also had Medicare coverage (Medicare crossover claims). MCPA also did not ensure that claims adjustments were subject to independent supervisory review and approval.**

  MCPA should establish procedures and controls over the payment of Medicare crossover claims, should review claims previously processed to identify any overpayments, and should pursue related recoveries. MCPA should also establish adequate controls over claims adjustments.

- **MCPA used inmates for data entry of sensitive claims information, including social security numbers, and did not ensure a contractor that also performed data entry had obtained the required criminal background checks for its employees. (Policy Issue)**

  DHMH should reevaluate the practice of using inmates to process sensitive claims data and should ensure that the contractor obtains criminal background checks, as required.

- **Certain healthcare provider applications were not subject to adequate supervisory review and approval.**

  MCPA should ensure supervisory review and approval of manually processed applications, at least on a test basis.

- **MCPA did not have procedures in place to ensure that drug prices paid for pharmacy reimbursements under the Maryland Medicaid Pharmacy Program (MPP) were reasonable. Such payments totaled $271 million during fiscal year 2009.**

  MCPA should establish procedures to ensure that drug prices paid to pharmacies under the MPP were reasonably accurate.

- **MCPA did not adequately account for cost settlements from long-term care facilities to ensure that all cost settlements were conducted as required. As of April 2010, there were 246 cost settlements that were not issued within the one year required period. Settlements completed in fiscal year 2009 resulted in net recoveries of $18.1 million.**

  MCPA should maintain cost settlement records in a manner that allows it to readily monitor the timeliness of cost settlements, and should ensure that cost settlements are completed in a timely manner and amounts owed to the State or the facility are promptly settled.

- **MCPA did not implement sufficient procedures and controls over its Kidney Disease and Transportation Grant programs. For example, MCPA did not adequately correct procedures and control deficiencies in the Kidney Disease program that contributed to an employee fraud totaling $1.8 million.**

  MCPA should implement sufficient procedures, controls, and segregation of duties over the Kidney Disease and Transportation Grant programs.

- **Adequate authentication, access, and monitoring controls did not exist over a critical Internet web-based application that allows health care providers to electronically submit claims. Also, security software settings were not activated to identify certain changes made to critical Medicaid Management Information System (MMIS II) production database tables.**

  MCPA should institute better security controls to protect its computer applications and databases.

Background Information

Agency Responsibilities

The Medical Care Programs Administration (MCPA) operates under both Title XIX of the Federal Social Security Act (Medicaid) and State law. MCPA, through the Medical Assistance Program, provides low-income Maryland residents with access to a broad range of health care benefits that are financed by State and federal funds. According to MCPA records, the Medical Assistance Program served approximately 881,000 individuals, as of June 30, 2010, through more than 40,000 health care providers. Individuals qualify for the Medicaid Program as either categorically eligible or medically needy. A categorically eligible person is one who receives public assistance payments, while a medically needy person is one who cannot meet the cost of needed medical care, but is generally self-supporting in other respects.

According to MCPA records, during fiscal year 2010, Medicaid expenditures totaled approximately $6.8 billion (at least 50 percent of which was recovered from the federal government), including approximately $2.6 billion in capitation payments to managed care organizations, approximately $1.1 billion for long-term care expenditures, and approximately $3.1 billion in fee-for-service expenditures.

Performance Audit Status

In November 2009, the Office of Legislative Audits issued a performance audit report on the Department of Health and Mental Hygiene's (DHMH) Medicaid claims processing and federal reimbursement procedures, entitled *Department of Health and Mental Hygiene, Processing of Certain Medicaid Claims*. The basis for that performance audit was our preceding fiscal compliance audit of MCPA, in which we reported that MCPA overrode (disabled) automated system edits in the Medicaid Management Information System (MMIS II) that were designed to prevent improper payments. In response, MCPA maintained that many of the edits were appropriately disabled. Consequently, the performance audit had three objectives:

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 claims processes to obtain federal Medicaid reimbursements for services provided through the Mental Hygiene Administration (MHA) and the Developmental Disabilities Administration (DDA)

Regarding Objective 1, our performance 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. For example, from our test of 55 disabled edits, applicable to $976 million in paid claims, we found 9 disabled edits, which were applicable to paid claims totaling more than $98 million, that should not have been bypassed and 6 other edits that 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.

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

Finally, regarding objective 3, we found that 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. Resolving rejected claims from these DHMH administrations has been commented upon in our fiscal compliance audit reports for at least 10 years.

DHMH's responses to the 16 specific findings in the performance audit report indicated general agreement with the findings. However, the response indicated that several critical issues would not be resolved until DHMH replaces the computer system used for processing Medicaid transactions. Areas covered by the objectives of this performance audit were excluded from the scope of our current fiscal compliance audit.

Status of Findings From Preceding Audit Report

Our audit included a review to determine the status of 18 of the 20 findings contained in our preceding audit report dated July 28, 2006. We determined that MCPA satisfactorily addressed 16 of the findings and 2 other findings were not resolved and are repeated in this report. We did not review the status of 2 of the

findings in the preceding audit report related to claims payments and associated edits; we limited our review of these areas because they were addressed in our November 2009 performance audit entitled *Department of Health and Mental Hygiene, Processing of Certain Medicaid Claims*.

In our preceding audit report, we reported that MCPA's accountability and compliance level was unsatisfactory, in accordance with the rating system we established in conformity with State law. Based on the results of this audit, we have concluded that MCPA has improved its fiscal compliance operations and accordingly, MCPA's accountability and compliance level is no longer unsatisfactory.

Findings and Recommendations

Recipient Eligibility

Background

The State's Department of Health and Mental Hygiene (DHMH) and Department of Human Resources (DHR) maintain a memorandum of understanding (MOU) which assigns responsibility to DHR for determining applicants' eligibility for participation in the Medical Assistance Program.[1] Under the MOU, DHMH is responsible for establishing regulations, guidelines, and procedures to be used by DHR.

Medical Assistance applicant eligibility is primarily determined by the various local departments of social services (LDSS), which are under the supervision of DHR. DHR processes eligibility determinations for recipients who are both categorically eligible and medically needy. A categorically eligible person generally receives benefits from both DHMH (Medical Assistance) and DHR (such as Temporary Cash Assistance) and a medically needy person generally only receives Medicaid benefits. Applicants are recorded on DHR's automated system (CARES), and those deemed eligible for Medicaid are subsequently interfaced into the Medicaid Management Information System (MMIS II). Recipient eligibility for Medicaid benefits is generally redetermined annually. According to DHMH's records during the 11 months ending May 31, 2009, reimbursements paid to recipients who only received Medicaid benefits totaled $2.0 billion.

Finding 1
The Medical Care Programs Administration (MCPA) lacked comprehensive policies and procedures to monitor the eligibility process and to correct certain long-term deficiencies.

Analysis

MCPA lacked comprehensive procedures to monitor and correct long-term deficiencies with the recipient eligibility process. Deficiencies with the eligibility process and related monitoring have been commented upon in MCPA audit reports dating back to 1992 and in our audit reports of several DHR units. (Refer to Exhibit A for a summary of DHR deficiencies—such as improper eligibility determinations and the failure to identify ineligible recipients—that were noted in recent reports.) These conditions occurred, at least in part, because the MOU

[1]Eligibility for certain MCPA programs, such as the Primary Adult Care (PAC) which represents about five percent of the caseload, is determined solely by MCPA.

between DHMH and DHR did not provide for adequate MCPA oversight, did not include comprehensive procedures to ensure problems are corrected, and was generally outdated. Specifically, our review of the MOU and related MCPA procedures disclosed the following conditions:

- The MOU did not provide MCPA with sufficient responsibility for monitoring eligibility determinations. As a result, MCPA monitoring was generally limited to performing reviews of DHR's quality control efforts and did not include any independent monitoring of the eligibility process using available data. For example, MCPA did not attempt to identify clients with multiple recipient numbers. In this regard, we noted 424 individuals with two or more recipient numbers (that is, a total of 978 recipient numbers) on MMIS II. Our test of 11 of these individuals disclosed that, for 9, MCPA paid capitation fees (that is, a per-person payment) totaling $137,000 under both recipient numbers, resulting in overpayments of $63,000. MCPA also did not upload client eligibility periods into MMIS II to help ensure that DHR was performing annual redeterminations in a timely manner. Consequently, most of the 802,271 fiscal year 2009 recipients did not have an eligibility ending date recorded in MMIS II. MCPA management advised us that it intentionally leaves the eligibility periods on MMIS II open to prevent benefits from automatically terminating if DHR does not perform timely eligibility redeterminations. However, without this information, MCPA cannot monitor DHR's efforts and identify cases, for follow-up purposes, which have not undergone a redetermination for an extended period and which may no longer be eligible for services.

- The MOU did not establish specific responsibilities to ensure deficiencies with the eligibility determinations were corrected. For example, deficiencies with DHR's quality review process have been addressed in our six preceding audit reports, dating back to 1992. Although MCPA has notified DHR of these deficiencies, there is no procedure to address DHR's failure to correct the problems. Similarly, MCPA determines the number of active recipients with missing social security numbers and provides this information to DHR. However, MCPA did not ensure that corrective action was implemented when missing social security numbers were identified. In this regard, during our current audit we identified 6,737 active recipients with missing social security numbers as of June 17, 2009. This is significant because DHR is supposed to use the social security number to verify applicant identity for eligibility determination purposes.

  In its written response to our prior audit report, MCPA stated that the Secretary of DHMH would request the assistance of the Secretary of DHR in establishing an inter-agency workgroup with the goal of resolving the chronic

outstanding enrollment deficiency issues. According to MCPA management, a workgroup was established; however, the first meeting was not held until October 7, 2009 and no substantive changes have been implemented.

- The MOU has not been updated since its inception in July 1985 resulting in several provisions that are no longer accurate or applicable. For example, the MOU states that DHMH agrees to operate a Medicaid quality control system in accordance with policy and procedures prescribed by the Health Care Financing Administration (HCFA) and makes several references involving the DHR Income Maintenance Administration when both of these entities no longer exist. The MOU also references computer systems such as the Automated Income Maintenance System that have long since been replaced.

Recommendation 1
We recommend that MCPA

a. review and update the MOU with DHR and ensure appropriate provisions are incorporated to allow MCPA to sufficiently monitor the eligibility determination process and to provide a mechanism for addressing and resolving deficiencies timely;
b. obtain recipient redetermination data to monitor and take appropriate follow-up action for cases with longer than usual eligibility periods;
c. investigate recipients with missing social security numbers and multiple recipient numbers on MMIS II, including the ones noted above, and take appropriate corrective action; and
d. work in conjunction with DHR to ensure that corrective actions are implemented to correct the aforementioned deficiencies.

HealthChoice

Background

The HealthChoice program requires qualified Medicaid recipients to enroll in one of seven managed care organizations (MCO). The recipients are categorized by a State university, under agreement with MCPA, into risk adjusted categories (RACs) based on factors such as age and demographics, as well as medical data such as diagnostic records and medical encounters (that is, the medical services provided to the enrollees) incurred. Each participating MCO must submit data to MCPA for all provider-enrollee (medical) encounters within 60 days of receipt of the claims from the providers. These RACS, along with MCO expenditures, are used to annually determine the monthly capitation rates to the MCOs for each recipient. In return for the capitation payments, the MCOs are generally expected to pay the recipients' medical costs regardless of the number or nature of services

provided. In general, the MCOs contract with health care professionals and other entities (such as hospitals) to provide the necessary medical services to enrollees. As of June 30, 2009, approximately 70 percent of all Medicaid recipients were enrolled in HealthChoice (approximately 555,000 recipients). The remaining recipients did not qualify for HealthChoice, such as recipients in long-term care facilities. For fiscal year 2010, payments totaling in excess of $2.6 billion were made by MCPA to seven qualified MCOs.

Finding 2
MCPA did not take steps to verify enrollee encounter data submitted by the MCOs that was used to calculate capitation rates for calendar years 2008 through 2010.

Analysis
MCPA did not always take steps to verify enrollee encounter data submitted by the MCOs and did not take corrective action when errors in the data were identified. Specifically, our review disclosed the following conditions:

- MCPA did not verify encounter data submitted by the MCOs for calendar years 2005 through 2007, which was a factor used in the calculation of the capitation rates for calendar years 2008 through 2010.

- MCPA did not follow up on errors noted during its review of calendar year 2004 encounter data, used for calendar year 2007 rates. For example, MCPA's review of 10,977 calendar year 2004 claims for 201 recipients disclosed 229 claims with no documentation of the encounters, and 2,143 claims with errors in the encounter data. MCPA noted that for 1,892 of the 2,143 claims there were no written medical reports or results by providers in the patients' charts to support the amounts billed and reported in the encounter data. However, MCPA did not ensure that the errors noted were corrected, did not adjust capitation rates, and did not expand testing to determine the extent of the errors.

An August 2009 audit of calendar year 2008 encounter data, that was conducted by a third party for MCPA, concluded that 14.8 percent of the encounters tested did not match the medical records, primarily due to the lack of medical record documentation. The report concluded that, overall, encounters matched the medical records with a rate of 85.2 percent, compared to national performance by Medicaid programs of 51 to 85 percent. We were advised by MCPA management that, as of July 21, 2010, MCPA had not investigated the results of the audit. It is critical that MCPA ensure the accuracy and follow up on any errors in the encounter data since it is used in the determination of capitation rates and in monitoring MCO performance. For example, higher levels of encounters could

increase capitation rates. The failure to adequately verify encounter data was commented upon in our two preceding audit reports.

Recommendation 2
We recommend that MCPA

a. verify enrollee encounter data submitted by the MCOs, at least on a test basis (repeat);

b. take adequate steps when errors in the data are identified, such as expanding testing, adjusting the encounter data and related capitation rates, and pursuing any discrepancies.

Finding 3
MCPA did not adequately monitor MCO third-party recoveries and cost avoidance efforts.

Analysis
MCPA did not adequately monitor MCO third-party recoveries and cost avoidance efforts. MCOs are responsible for identifying enrollees with third-party insurance and for recovering any related costs paid on their behalf from these insurance companies. Rather than recovering these costs, some MCOs established cost-avoidance procedures by identifying any third-party insurance and considering related recoveries prior to making payments. All amounts recovered from third party insurers, as well as all payments avoided, must be reported to MCPA and are used to adjust MCO reported expenditures for calculating capitation rates.

However, MCPA did not ensure that the MCOs were maximizing their efforts to help reduce expenditures through third-party recoveries and did not ensure that the MCOs were properly reporting the related results. Specifically, MCPA did not inquire about the efforts made by the MCOs or establish individual contract goals. Furthermore, during the audit period, MCPA only verified the reported recoveries for one calendar year (that is, calendar year 2005 data used for the 2008 capitation rates) and did not verify the cost avoidance data for any of these years (that is, 2005 through 2007). In addition, MCPA management advised us that it only monitors the MCO recovery and cost avoidance efforts, in the aggregate, and does not investigate disparities in results among the MCOs. MCPA management stated that one or more MCOs could have minimal or no recoveries without any penalty. This is significant because two MCOs reported no cost recoveries in calendar year 2007 (used for the 2010 capitation rates) and the combined cost recoveries and avoidance among the MCOs ranged from 0.5 percent to 4.6 percent of gross medical expenditures (see table on the next page).

MCO Third-Party Recovery and Avoidance Efforts - Calendar Year 2007							
	Average Enrollment	Gross Medical Expenditures (GME)	Recoveries and Cost Avoidance			Percent of GME	Average Per Enrollee
			Recoveries	Avoidance	Total		
1	147,208	$446,637,118	$1,922,663	$3,422,928	$5,345,591	1.2%	$36
2	112,742	$395,703,943	$1,801,593	$4,293,975	$6,095,568	1.5%	$54
3	100,520	$296,974,859	$6,043,993	$7,663,471	$13,707,464	4.6%	$136
4	80,380	$286,722,881	$0	$3,687,690	$3,687,690	1.3%	$46
5	21,281	$73,630,100	$149,378	$558,952	$708,330	1.0%	$33
6	7,817	$45,096,461	$42,605	$317,021	$359,626	0.8%	$46
7	5,978	$26,686,236	$0	$127,271	$127,271	0.5%	$21
Total	**475,926**	**1,571,451,598**	**$9,960,232**	**$20,071,308**	**$30,031,540**	**1.9%**	**$63**

Source: MCO Annual Summary Reports to MCPA (unaudited)

The failure to ensure that MCOs maximize their recovery and avoidance efforts, and properly report the related savings, could result in inflated MCO expenditures; this would translate into higher capitation rates paid by the State.

Recommendation 3

We recommend that the MCPA establish procedures to ensure that MCOs

a. accurately report third-party recoveries and cost avoidance, and

b. maximize third-party recoveries and cost avoidance efforts. For example, MCPA could establish recovery and cost-avoidance goals for the individual MCOs.

Finding 4

MCPA did not verify the propriety of enrollee placements into risk-adjusted categories and the related capitation rates that were determined by its contractor.

Analysis

MCPA did not verify the propriety of enrollee placements into risk-adjusted categories (RACs) and the related capitation rates that were determined by its contractor. DHMH entered into a Memorandum of Understanding (MOU) with a State university to provide various services related to the HealthChoice program, including the placement of enrollees into RACs and the development of the

related capitation rates. MCOs are paid, in part, based on the RACs of their enrollees. For example, the monthly rates, effective July 1, 2009, for the Family and Children RAC in Baltimore City ranged from $89 (RAC 1) to $1,783 (RAC 18), depending on demographics and the level of services.

MCPA management advised us that the contractor had quality control procedures in place to ensure the integrity of the process and that any significant errors would be identified annually when individual MCO profits and losses were reviewed. However, the annual review of profits and losses would not necessarily identify improper RAC placements. In addition, our review disclosed that MCPA did not ensure that the placements and/or rates determined by the contractor were proper and/or that the aforementioned quality control procedures were operating effectively.

Recommendation 4
We recommend that the MCPA establish procedures to obtain assurance regarding the propriety of enrollee RAC placements and the related capitation rates that were determined by its contractor.

Claims Processing

Finding 5
MCPA lacked adequate procedures to ensure that the correct amount was paid for Medicaid recipients who also had Medicare coverage, resulting in at least 372 claims totaling $231,000 for which MCPA paid providers more than the amount billed.

Analysis
Procedures were not in place to ensure that the correct amounts were paid on behalf of Medicaid recipients that also had Medicare coverage. These claims are known as Medicare crossover claims. Providers must submit crossover claims for Medicare reimbursement before submitting them to Medicaid, which generally covers the Medicare coinsurance amount and any Medicare deductibles. During the period from July 1, 2008 through May 30, 2009, MCPA processed more than two million Medicare crossover claims, of which claims totaling $120.3 million were received electronically from a Medicare contractor and claims totaling $14.8 million were received by mail directly from the providers.

Our review disclosed that MCPA did not verify the propriety of the data submitted electronically through the Medicare contractor or processed manually by MCPA staff to ensure that the amounts paid for these claims were proper. In this regard, claims were not compared to supporting documentation, such as the

Medicare explanation of benefits. In addition, there were no system edits in place to prevent overpayments based on incorrect claims data entry, such as an edit that would prevent a payment that exceeded the total amount billed. In this regard, we analyzed all manually and electronically received claims data for the period from July 1, 2008 through May 30, 2009 and identified 372 claims totaling $231,000 for which the amounts paid to the providers exceeded the total amounts billed. Our test of 10 of these claim payments, totaling $55,843, disclosed that only a total $1,999 should have been paid, resulting in overpayments of $53,844. For example, for one of the claims, the provider submitted a bill for $110 but was paid $6,673 due to a data entry error. Other overpayments, such as instances in which the amounts paid were less than the total invoice amounts but greater than the amounts owed by MCPA, would not have been detected in our analysis.[2]

MCPA management advised us that providers often notify it of overpayments. In addition, MCPA management advised us that, beginning in January 2009, it initiated a monthly review of crossover claim payments that exceeded amounts billed in order to identify and correct these types of overpayments. However, as evidenced by the results of our aforementioned claims test, we believe that an edit, designed to prevent rather than detect, payments that exceed the amounts billed is warranted.

Recommendation 5

We recommend that MCPA

a. review crossover claims, at least on a test basis, to ensure that the proper data were recorded, including a verification of the amounts paid by Medicare;

b. establish online controls to help ensure the propriety of crossover claims, such as an edit to identify payments where the payment amounts are greater than the amounts that should have been paid; and

c. review claims processed during the audit period, including the 372 claims noted above, and recover any overpayments.

[2]For example, if a provider billed $500 for a service and Medicaid was only supposed to pay $100 but improperly paid $400 due to a data entry error, it would not have been identified in this analysis since the amount paid was less than the amount billed.

Finding 6 (Policy Issue)
DHMH used inmates for data entry of sensitive claims information, including social security numbers, and did not ensure employees of a data entry contractor had criminal background checks as required.

Analysis

DHMH used inmates for data entry of sensitive claims information, including social security numbers, and did not ensure employees of a data entry contractor had criminal background checks as required by the contract. While the majority of claims are processed electronically, during the period from July 1, 2008 through May 30, 2009, approximately 900,000 paper claims totaling $265 million were submitted. MCPA contracted with the Department of Public Safety and Correctional Services – Maryland Correctional Enterprises (MCE) and another vendor to assist MCPA staff in entering data from paper claims into MMIS II. Our review of these two contracts disclosed the following conditions:

- MCE used inmates to enter physician claims into MMIS II. In this regard, claims data submitted to MCE contained social security numbers and other sensitive information such as recipient Medicaid numbers. DHMH did not determine the nature of the crimes committed by the inmates processing these claims to ensure they had not committed fraudulent activity, such as identity theft. Although there is no specific statute or regulation prohibiting the use of inmates for this activity, the use of individuals with criminal backgrounds heightens concerns about protecting sensitive data.

- MCPA did not ensure employees of another vendor used to process claims obtained the required criminal background checks. The vendor was paid $183,000 during fiscal year 2009 to process approximately 1,000 hospital claims per week and was required to provide MCPA with documentation that its personnel passed criminal background investigations. However, MCPA did not maintain a current listing of the contractor's employees, and did not obtain criminal background investigations as required. As a result, there was a lack of assurance that the required criminal background investigations were conducted. The failure to ensure the vendor obtained the criminal background investigations is not consistent with current DHMH policies for State employees. Specifically, in accordance with DHMH policy, criminal background investigations are required for all new DHMH employees.

Recommendation 6
We recommend that DHMH

a. reevaluate the practice of using inmates to process sensitive claims data, and

b. obtain documentation that all employees of the aforementioned vendor passed the required criminal background investigations.

Finding 7
MCPA did not ensure that claim adjustments were proper.

Analysis

MCPA did not ensure the propriety of claim adjustments processed on MMIS II.[3] For example, 11 employees were responsible for processing claim adjustments on MMIS II without any independent supervisory reviews to ensure that the claim adjustments were legitimate and were supported by claim request forms. Furthermore, MCPA did not generate output reports of adjustments processed.

Providers submit adjustment requests for various reasons; for example, nursing homes submit claim adjustments to account for changes in recipient resources, such as additional income received by a recipient. At our request, MCPA generated a report that identified 152,485 adjustments recorded during fiscal year 2009. These adjustments increased and decreased the amount of fiscal year 2009 claims by $192 million and $189 million, respectively.

Recommendation 7
We recommend that MCPA establish adequate controls over adjustments. Specifically, MCPA should generate output reports of claims adjustments and, on a test basis, ensure that the adjustments were properly supported and processed correctly.

[3]Our performance audit report entitled "Department of Health and Mental Hygiene – Processing of Certain Medicaid Claims" dated November 23, 2009 identified additional deficiencies with the Adjustment Division. For example, the report noted a significant backlog of adjustment requests that were not processed. A detailed review of the adjustment process was not included in the scope of our current audit.

Provider Eligibility

Finding 8
Healthcare provider applications were not subject to adequate supervisory review and approval.

Analysis
Healthcare provider applications were not subject to adequate supervisory review and approval. Healthcare providers can apply for enrollment as a Medicaid provider by submitting the provider application in hard copy form or electronically through MCPA's online provider system (eMedicaid). The eMedicaid system is also used by providers to verify recipient eligibility and to obtain payment information. Hard copy applications are manually processed by MCPA employees who verify the data using applicable databases and then enter eligible providers into MMIS II. For example, the State licensing database is reviewed to ensure the applicant is licensed, and State and federal sanction lists are reviewed to ensure the applicant has not been excluded from participation in Medicaid or Medicare. The eMedicaid application data is electronically matched against these databases and, if successfully verified, the provider is automatically recorded in MMIS II. If the eMedicaid data cannot be electronically verified, the applications are subject to a manual verification process similar to the hard copy applications.

Our review disclosed that supervisory reviews of the hard copy applications were limited to ensuring that the application data were accurately entered into MMIS II and did not include a verification of the propriety of the data by reviewing the related databases. In addition, no supervisory reviews were performed of eMedicaid applications that were manually verified.

According to MCPA records, during fiscal year 2009, MCPA processed 3,083 hard copy applications and 1,265 eMedicaid applications, of which 853 required a manual verification.

Recommendation 8
We recommend MCPA supervisory personnel review and approve the propriety of manually processed applications, at least on a test basis.

Maryland Medicaid Pharmacy Program

Finding 9
MCPA had no procedures in place to help verify drug prices paid to pharmacies under the Maryland Medicaid Pharmacy Program.

Analysis
MCPA did not ensure that that drug prices paid for pharmacy reimbursements under the Maryland Medicaid Pharmacy Program (MPP) were reasonable; such payments totaled approximately $271 million during fiscal year 2009.[4] MCPA contracted with a vendor to process and authorize pharmacy claims using an electronic point-of-sale system (POS). The POS vendor was also responsible for updating the system with the most current drug prices. However, MCPA did not verify the reasonableness of the pricing information used by the POS vendor.

MCPA management advised us that the drug prices consist of various components, some of which are difficult to verify. However, we were advised that Pennsylvania's Medicaid Program contracted with three vendors to obtain drug pricing and compared its prices to the data from all three vendors for reasonableness. Furthermore, Maryland's Office of Personnel Services and Benefits (OPSB), receives its drug pricing, for verification purposes, from yet another company. MCPA management advised us that MCPA is not authorized to use the OPSB drug prices, but that it had not requested any advice of counsel to help address this issue.

The failure to verify the propriety of the drug pricing is significant because the company used by the POS vendor to obtain pricing data has settled, and is currently involved in litigation, with several government and private entities who allege that it colluded with a drug manufacturer and supplied inflated drug prices.[5] Therefore, MCPA should identify measures to ensure that the pricing data is reasonable and, at a minimum, should be ensuring that the POS system is being updated with current pricing data timely.

MCPA operates the Maryland Medicaid Pharmacy Program (MPP), which is jointly funded by the State and federal governments to help cover the cost of prescriptions for eligible Maryland residents. MPP pays the prescription costs for individuals enrolled in several programs, including Medical Assistance, Primary Adult Care, Family Planning, and Medicare Part D.

[4] This amount excludes rebates, totaling $78.5 million, collected during fiscal year 2009 that relate to pharmacy transactions for years preceding and including fiscal year 2009.

[5] We were advised by MCPA management that it did not participate in this litigation because it determined that the outcome would not result in significant recoveries to the State.

Recommendation 9
We recommend that MCPA establish procedures to verify the reasonableness of drug prices to reimburse pharmacies under the MPP.

Long-Term Care – Cost Settlements

Finding 10
MCPA did not maintain adequate cost settlement records and ensure that all cost settlements were conducted as required.

Analysis
MCPA did not maintain adequate cost settlement records for payments to long-term care facilities, and did not ensure that its vendor conducted all cost settlements, as required. During the year, MCPA paid long-term care facilities based on interim rates, which were estimates of the facilities' annual expenditures. MCPA contracted with a vendor to conduct annual cost settlement reviews of the facilities, which included reconciling each facility's reported actual costs with the reimbursements it received based on the interim rates, and identifying any underpayments or overpayments. However, our review disclosed the following conditions:

- MCPA did not maintain a comprehensive listing of all long-term care facilities to account for the due dates and receipt of the cost settlements for each year. As a result, there was a lack of assurance that all facilities were subject to an annual settlement and the related amounts due to or from the facilities were properly settled.

- MCPA did not ensure that all annual cost settlements were completed by the vendor in accordance with the timeframe established by the contract. The vendor was required to perform an annual cost settlement for each nursing facility within one year of receipt of the cost reports, and was also required to complete any settlements from previous years that were not performed by the preceding vendor whose contract ended in June 2006. However, in its monthly billing statement, the current vendor indicated that, as of April 2010, there were 246 settlements that had not been issued within the one year required period. In addition, as of September 2009, the vendor had not conducted 40 settlements that remained outstanding from the preceding vendor (for claims dating back to 2002). MCPA withheld a portion of the vendor's payments pending the completion of the required settlements. MCPA management advised us that it is monitoring the vendor's ongoing efforts to eliminate the backlog.

A similar comment was made in our preceding audit report, which disclosed that, as of the end of the previous contract term (June 30, 2006), there were a significant number of outstanding cost settlements. Effective July 1, 2006, MCPA awarded the contract to the current vendor. According to MCPA records as of May 2010, there were 225 nursing facilities with a total of 28,703 beds. MCPA records also indicated that 403 settlements were completed in fiscal year 2009, resulting in net recoveries of $18.1 million ($14.3 million due to facilities, $32.4 million due to the State). Long-term care expenditures totaled approximately $1.1 billion during fiscal year 2010.

Recommendation 10
We recommend that MCPA

a. maintain cost settlement records in a manner that allows it to readily determine the number of outstanding settlements for each year; and

b. ensure that all cost settlements are completed in a timely manner as required, and amounts owed to the State or to the long-term care facilities are promptly settled (repeat).

Kidney Disease Program

Background

The Kidney Disease Program (KDP) was established by State law in 1971 to provide financial assistance to eligible end-stage renal disease patients. The KDP is State funded and covers costs such as physician services and prescriptions that are not covered by federal, State, or private medical insurance. During fiscal year 2009, the KDP expended approximately $12.5 million in financial assistance to 2,600 recipients.

In February 2009, a KDP employee was convicted of misappropriating $1.8 million by processing fictitious KDP claims over a ten-year period dating back to 1997. Specifically, the employee processed numerous claims to fictitious providers for deceased individuals and diverted and/or inflated other legitimate claims. The fraud went undetected due to a lack of internal controls over the KDP claims process until the bank used by the employee to process the fraudulent claims became suspicious of the activity and notified DHMH. This individual was convicted and, in February 2009, was sentenced to a period of incarceration and was required to pay restitution of $1.5 million.

Finding 11
MCPA did not implement sufficient control procedures to address deficiencies in the KDP, as recommended by DHMH's Office of Inspector General. In addition, deficient procedures over pharmaceutical claims resulted in overpayments of at least $161,744.

Analysis
MCPA did not implement adequate procedures and controls to address deficiencies in the KDP claims payment process as recommended by DHMH's Office of Inspector General (OIG). In addition, procedures over pharmaceutical claims were insufficient, resulting in overpayments. Specifically, our review disclosed the following conditions:

- In response to the aforementioned KDP fraud, the OIG recommended that MCPA review KDP procedures, controls, and segregation of duties to prevent similar frauds. Our review disclosed that, while MCPA modified certain KDP procedures, the changes were not sufficient. For example, MCPA appropriately segregated the duties surrounding the provider enrollment process, but did not adequately control recipient data. Specifically, three employees still routinely entered new recipients in the KDP automated system or updated existing recipient data without any independent reviews. In addition, we were advised that the automated system did not provide an output report of all changes made to the recipient data. Consequently, these employees could add or change recipients on the system to process improper claim payments without detection.

- MCPA did not ensure pharmaceutical claims were adjusted for payments from other parties. Pharmacies were responsible for submitting claims electronically through MCPA's point-of-sale (POS) system. Our review disclosed that MCPA did not ensure that the pharmacies reduced the claim amounts for the actual third-party payments, such as from Medicare Part D. In this regard, in June 2007, MCPA's vendor responsible for maintaining the POS system noted that one pharmacy was only entering nominal amounts ($1-$2) as third-party insurance payments, which was not typical. A subsequent OIG review of a limited number of claims submitted by this provider disclosed that KDP overpaid the provider $161,744 for 448 claims because the pharmacy failed to record the actual amounts paid by the other insurers. OIG subsequently referred this matter to the Office of Attorney General – Criminal Division.

  As a result of the aforementioned situation, MCPA management advised us that it implemented certain procedures and system edits to help prevent similar overpayments. However, the actions taken were not sufficient.

Specifically, the procedures implemented did not require periodic verifications of third-party insurance payments recorded by the pharmacies with supporting documentation, and the new edits would only identify extreme abnormalities in the amounts entered, and therefore, would not identify all significant errors.

Recommendation 11
We recommend that MCPA

a. implement sufficient procedures, controls, and segregation of duties over the KDP to help prevent frauds; and

b. establish additional controls over pharmaceutical claims to help prevent payments on behalf of KDP recipients that were paid by third parties.

Transportation Grant Program

Finding 12
Procedures for the Transportation Grant Program were not sufficient to ensure that grant funds were used properly by the local jurisdictions.

Analysis
Procedures were not sufficient to ensure the proper use of Transportation Grant Program funds. Payments under this Program totaled $32.5 million during fiscal year 2009. MCPA entered into agreements with the 24 local jurisdictions (primarily local health departments) to provide Medicaid recipients with non-emergency transportation to and from providers rendering Medicaid-covered services. The jurisdictions were responsible for screening applicants and for providing the related transportation services. The screening process included ensuring the applicant was a Medicaid recipient and was potentially eligible for transport services, that the requested transportation was necessary for the needed services, that the transport was for Medicaid-covered services, and that the most efficient method of transportation was used. Under the agreements, jurisdictions could provide these services themselves or could subcontract with vendors for some or all of these functions. Our review disclosed numerous deficiencies with MCPA's oversight over the Program, including the following conditions:

- MCPA did not prohibit the local jurisdictions from subcontracting both the screening and transportation functions to the same vendor. In this regard, 11 jurisdictions, which received payments totaling $6.3 million during fiscal year 2009, used one vendor to perform both the screening and transport functions. In addition, MCPA did not require the local jurisdictions and the vendors to document whether recipients had alternative transportation options, such as

relatives or others living in the household, which would preclude eligibility for transportation through this Program. Furthermore, MCPA did not ensure that the transportation was provided using the least expensive method of transportation. As a result, the vendors could authorize transports for ineligible individuals or services and/or could approve a more expensive mode of transportation (ambulance rather than car service) without detection.

- Site visits conducted by MCPA to monitor the local jurisdictions were not comprehensive or timely. For example, when services were contracted out to vendors, the site visits did not include procedures to ensure the local jurisdictions were monitoring the vendors' compliance with Program requirements. In addition, during the site visits, MCPA relied on verbal representations by the local jurisdictions that the patients received transportation in connection with Medicaid-covered services, rather than verifying these assertions by reviewing the related claims data on MMIS II. Furthermore, the site visits were not always performed timely. For example, one jurisdiction, which received $9.7 million in transportation grants during fiscal year 2009 (representing 30 percent of all grants), had not had a site visit conducted since January 2005. While a site visit was conducted of this jurisdiction in September 2009, only fiscal year 2008 transactions were reviewed.

Recommendation 12
We recommend that MCPA enhance the policies and procedures for the Transportation Grant Program to help ensure that grant funds are used properly. These policies and procedures should include adequate guidance to the local jurisdictions, including requiring a separation of responsibilities for the screening and transportation functions, and should require comprehensive, timely monitoring to ensure funds are used properly.

Information Systems Security and Control

Background
MCPA operates the Electronic Data Interchange Translator Processing System (EDITPS), an Internet web-based application that allows health care providers to electronically submit Medicaid claims. A contractor maintains the EDITPS operating system software on MCPA's behalf. After claims data have been received and subjected to limited edits, the EDITPS application delivers the claims data to the MMIS II application, which operates on the Annapolis Data Center (ADC), to complete claims processing and payment. MCPA manages MMIS II's application program development and maintenance, and uses the ADC's security software to help secure MMIS II.

Finding 13
Adequate EDITPS authentication, access, and monitoring controls did not exist.

Analysis
Adequate EDITPS authentication, access, and monitoring controls did not exist. Specifically, we noted the following conditions:

- Adequate authentication controls did not exist for the EDITPS web servers' operating system software users (MCPA contractual staff) and the EDITPS application users (health care providers who submit claims). Specifically, controls did not comply with the Department of Information Technology *Information Security Policy's* minimum requirements concerning password complexity and account lockout.

- Two programmers' accounts had unnecessary but complete control over the servers hosting the EDITPS web servers. As a result, users who have access to these two accounts could make unauthorized changes to the EDITPS application and operating system files and could obtain access to sensitive information.

- Several separate web sites, including the EDITPS production web site on the EDITPS web server computer, used the same operating system account (which performs system functions) which had extensive system privileges on the EDITPS web server computer. This allowed these web sites to have unnecessary elevated privileges to their host server, including modification access to a majority of the host server's operating system files. As a result, if the web server software were to be compromised by a web site user, it could be used to inappropriately access operating system files.

- Web server software security-related events were not regularly reviewed; rather they were only reviewed in the event of problems with the web servers. In addition, there was no documentation of the reviews that were performed.

According to MCPA management, as of December 2009, approximately 60 percent of all Medicaid claims pass through the EDITPS application. According to its records, for fiscal year 2010, MCPA processed Medicaid claims payments totaling approximately $6.8 billion.

The EDITPS application's claims information includes sensitive "personal" information. This Medicaid identity information could be attractive to individuals who are intent on using it for fraudulent activities.

Recommendation 13

We recommend that MCPA establish adequate authentication, access, and monitoring controls over the EDITPS web servers and application. We made detailed recommendations to MCPA, which, if implemented, should provide for adequate controls over the EDITPS web servers and application.

Finding 14

Security software settings were not activated to identify certain changes made to critical MMIS II production database tables.

Analysis

Security software settings were not activated to identify changes made by using administration accounts that were authorized to directly modify critical production database tables on MMIS II. Specifically, security software flags were not set for 11 accounts that had direct modification access to critical database tables. These tables include important system information such as eligible Medicaid recipients and Medicaid healthcare service providers. Consequently, improper or unauthorized modifications made to these tables using these 11 accounts would not be flagged for review by management.

Recommendation 14

We recommend that security software flags be activated for all accounts capable of making direct modifications to the MMIS II production database tables.

Audit Scope, Objectives, and Methodology

We have audited the Department of Health and Mental Hygiene (DHMH) – Medical Care Programs Administration (MCPA) for the period beginning September 1, 2005 to June 30, 2009. The audit was conducted 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.

As prescribed by State Government Article, Section 2-1221 of the Annotated Code of Maryland, the objectives of this audit were to examine MCPA's financial transactions, records and internal controls, and to evaluate its compliance with applicable State laws, rules, and regulations. We also determined the status of 18 of the 20 findings contained in our preceding audit report, dated July 28, 2006. We did not review the status of the 2 findings in the preceding audit report related to claims payments and related edits; we limited our review of these areas because they were addressed in our November 2009 performance audit, entitled *Department of Health and Mental Hygiene, Processing of Certain Medicaid Claims*. Areas covered by the objectives of this performance audit were excluded from the scope of our current audit.

In planning and conducting our audit, we focused on the major financial-related areas of operations based on assessments of materiality and risk. The areas addressed by the audit included provider eligibility, managed care organizations, enrollee eligibility, long-term care, hospital services, post payment verification, kidney disease program, pharmacy, cash receipts, and collections. Our audit procedures included inquiries of appropriate personnel, inspection of documents and records, and observations of MCPA's operations. We also tested transactions and performed other auditing procedures that we considered necessary to achieve our objectives. Data provided in this report for background or informational purposes were deemed reasonable, but were not independently verified.

Our audit did not include certain support services provided to MCPA by DHMH's Office of the Secretary. These support services (for example, payroll processing) are included within the scope of our audit of DHMH's Office of the Secretary. In addition, our audit did not include an evaluation of internal controls for federal financial assistance programs and an assessment of MCPA's compliance with federal laws and regulations pertaining to those programs because the State of Maryland engages an independent accounting firm to annually audit such programs administered by State agencies.

MCPA's management is responsible for establishing and maintaining effective internal control. Internal control is a process designed to provide reasonable assurance that objectives pertaining to the reliability of financial records, effectiveness and efficiency of operations including safeguarding of assets, and compliance with applicable laws, rules, and regulations are achieved.

Because of inherent limitations in internal control, errors or fraud may nevertheless occur and not be detected. Also, projections of any evaluation of internal control to future periods are subject to the risk that conditions may change or compliance with policies and procedures may deteriorate.

Our reports are designed to assist the Maryland General Assembly in exercising its legislative oversight function and to provide constructive recommendations for improving State operations. As a result, our reports generally do not address activities we reviewed that are functioning properly.

This report includes findings relating to conditions that we consider to be significant deficiencies in the design or operation of internal control that could adversely affect MCPA's ability to maintain reliable financial records, operate effectively and efficiently, and/or comply with applicable laws, rules, and regulations. Our report also includes findings regarding significant instances of noncompliance with applicable laws, rules, or regulations. Other less significant findings were communicated to MCPA that did not warrant inclusion in this report.

In our preceding audit report, we reported that MCPA's accountability and compliance level was unsatisfactory, in accordance with the rating system we established in conformity with State law. Our current audit disclosed that MCPA has improved its fiscal and compliance operations, and accordingly, MCPA's accountability and compliance level is no longer unsatisfactory. Our rating conclusion has been made solely pursuant to the aforementioned law and rating guidelines approved by the Joint Audit Committee. The rating process is not a practice prescribed by professional auditing standards.

DHMH's response, on behalf of MCPA, to our findings and recommendations is included as an appendix to this report. As prescribed in the State Government Article, Section 2-1224 of the Annotated Code of Maryland, we will advise DHMH regarding the results of our review of its response.

Exhibit A

Examples of Eligibility Audit Deficiencies at the Department of Human Resources

Department of Human Resources
Local Department Operations
August 2009

- **Medicaid eligibility determinations for long-term care recipients were not always proper and documented at one Local Department of Social Services (LDSS). In addition, an available online resource was not used to identify certain undisclosed assets, which can affect eligibility.**

  Our review and testing disclosed errors in the eligibility process that allowed improper eligibility determinations to occur, (individuals improperly deemed eligible for Medicaid). In addition, this audit report disclosed a weakness in procedures used to determine eligibility for long-term care. LDSS intake workers at the two LDSSs did not use online real property records to determine the existence of real property owned and/or recently transferred by the applicant when determining resource eligibility. (State Regulations prohibit a recipient in a long-term care facility from receiving benefits in any month in which their financial resources exceed a designated amount.)

- **The DHR - Office of Inspector General (OIG)'s audits of the LDSSs did not fully address significant risks.**

  The OIG's audits of the LDSSs did not provide sufficient audit coverage of certain critical areas with significant risk. Specifically, the OIG did not identify all significant risks to ensure they were included within the scope of its audits. For example, Medical Assistance (Medicaid) eligibility decisions for applicants who applied only for Medicaid (and not for other public assistance programs) were not reviewed during the OIG audits, even though these determinations were made by LDSS employees.

Exhibit A

Examples of Eligibility Audit Deficiencies at the Department of Human Resources

Department of Human Resources
Family Investment Administration
November 2007

- **Computer matches identifying ineligible recipients were not consistently performed.**

  This audit report finding noted that DHR did not conduct adequate computer matches to detect ineligible recipients in programs administered by FIA. The two major programs FIA administers are the Temporary Cash Assistance (TCA) Program, which is funded by both general and federal funds, and the federal Food Stamp Program, which is entirely federally funded. FIA is also responsible for recording certain data in DHR's automated benefits system, the Clients' Automated Resources and Eligibility System (CARES), which interfaces with MMIS II to record Medicaid eligibility.

- **FIA did not detect that computer matches performed by the DHR - OIG improperly excluded about 92 percent of the active recipients.**

  Computer matches performed by the DHR – OIG to identify improper eligibility files information did not include the majority of the recipients. Consequently, the effectiveness of procedures used to detect ineligible recipients was severely limited. DHR utilized these matches to identify inmates and deceased individuals that were recorded on CARES as receiving assistance.

- **Approximately 52,000 recipients with missing or invalid social security numbers received public assistance during calendar year 2006, potentially resulting in improper benefit payments.**

  Our review disclosed that approximately 52,000 of the 887,000 recipients that received public assistance benefits at any time during calendar year 2006 had missing or invalid social security numbers (SSNs) in CARES. For 47,000 of these recipients, no SSNs were recorded in CARES. Inaccuracies of lack of recordation of SSNs may indicate further errors in eligibility determinations.

APPENDIX

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

December 3, 2010

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

Dear Mr. Myers:

Thank you for your letter regarding the draft audit report of the Medical Care Programs Administration (MCPA) for the period beginning September 1, 2005 and ending June 30, 2009. Enclosed is the Department's response and plan of correction that addresses each audit recommendation. I will work with the appropriate Administration Directors, Program Directors, and Deputy Secretary to promptly address all audit exceptions. In addition, the Division of Internal Audits 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 V. Russell of my staff at 410-767-5862.

Sincerely,

John M. Colmers
Secretary

Enclosure

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, DHMH

Medical Care Programs Administration (MCPA) Audit Responses To Legislative Audit Report for the Period September 1, 2005 – June 30, 2009

Finding 1
The Medical Care Programs Administration (MCPA) lacked comprehensive policies and procedures to monitor the eligibility process and to correct certain long-term deficiencies.

Recommendation 1:
We recommend that MCPA

a. review and update the MOU with DHR and ensure appropriate provisions are incorporated to allow MCPA to sufficiently monitor the eligibility determination process and to provide a mechanism for addressing and resolving deficiencies timely;
b. obtain recipient redetermination data to monitor and take appropriate follow-up action for cases with longer than usual eligibility periods;
c. investigate recipients with missing social security numbers and multiple recipient numbers on MMIS II, including the ones noted above, and take appropriate corrective action; and
d. work in conjunction with DHR to ensure that corrective actions are implemented to correct the aforementioned deficiencies.

Administration Response:

a. The Administration concurs with this recommendation. The MCPA/DHR interagency workgroup referenced on pp. 14-15 has discussed this recommendation and added it to our agenda for monthly meetings on "Mutual Operational Concerns." The workgroup will convene a subcommittee, including counsel for both agencies, to determine the design and scope of the monitoring and resolution processes.

   Additional monitoring and data-gathering activities adequate for carrying out the terms of the amended MOU will require technology and staff resources for which MCPA would seek budget approval.

b. The Administration concurs with this recommendation. MCPA is working to add functionality to DataWatch, an executive data system DHR has (in part) shared with DHMH, so as to obtain monthly reports with additional parameters related to redeterminations initiated and not completed, redeterminations initiated and completed, and overdue redeterminations (*i.e.*, lengthy certification periods).

   The MCPA and DHR have had positive experience with the use of overtime and temporary retired workers in "SWAT teams" to assist local departments with clearing redetermination backlogs identified in existing CARES reports. DHR funded these projects for the purpose of complying with the timelines order in the case of *Thompson vs. Donald*. In order to meet the goals of increased monitoring and sustain follow-up efforts as well as to implement a global monitoring and resolution unit

pursuant to the amended MOU, MCPA will require a new staff division and DHR will require additional case processing staff, for which we would seek budget approval.

c. The Administration does not concur with this finding. This item was resolved February 24, 2009 with the CARES Bulletin 09-02. There will always be missing SSNs, but the Program has put a control in place during the audit period to properly address any numbers not recorded in the system. This document was distributed to all local departments and has been included in all subsequent training for Medicaid workers. Errors detected by our current monitoring reports are corrected by MCPA directly on the CARES system and followed up with MCPA for any necessary case worker action. DHMH is reviewing our report parameters to ensure that we are capturing all key data. We also correct errors called in by local departments or others.

   Due to federal and state policy, certain new recipients are appropriately on the system without SSNs for a period of time. Due to lack of SSN for newborns, children newly placed in foster care, children receiving Accelerated Certification of Eligibility (ACE), and unqualified aliens entitled to emergency services, any audit sample will detect recipients without SSNs even when Medicaid eligibility works perfectly. Nevertheless, we are reviewing our current monitoring reports for SSN errors and looking for opportunities to improve frequency and additional parameters.

   With respect to multiple program ID numbers, MCPA has for a long time searched the claims system monthly and produced a report of paired recipients. We use a manual process to research the cases (to eliminate cases involving similar rather than identical recipients, such as twins and "juniors"), and reconcile all true duplications every month. The RFP for MMIS III, for which procurement is pending, specifies that the successful vendor must identify and resolve problems involving overlapping program ID numbers and missing or otherwise deficient SSNs. [1]

d. The Administration concurs with this recommendation. This recommendation will be a major focus for MCPA and DHR in developing the monitoring and resolution functions of the amended Memorandum of Understanding.

[1] **Auditor's Comment**: MCPA states that it does not concur with the finding and indicates the issue was resolved with a CARES bulletin issued in February 2009. The CARES Bulletin referenced in the response addresses the steps to be used by DHR to help ensure the propriety of applicant data, including social security numbers. While helpful for addressing the missing data, it does not preclude the need for modifications to the MOU to provide for MCPA oversight to help identify and resolve these issues.

Medical Care Programs Administration (MCPA) Audit Responses To Legislative Audit Report for the Period September 1, 2005 – June 30, 2009

Finding 2
MCPA did not take steps to verify enrollee encounter data submitted by the MCOs that was used to calculate capitation rates for calendar years 2008 through 2010.

Recommendation 2:
We recommend that MCPA

a. verify enrollee encounter data submitted by the MCOs, at least on a test basis (repeat);
b. take adequate steps when errors in the data are identified, such as expanding testing, adjusting the encounter data and related capitation rates, and pursuing any discrepancies.

Administration Response:

a. The Administration does not concur with this recommendation. The MCPA already has developed a process that verifies enrollee encounter data submitted by the MCOs, at least on a test basis. The MCPA developed a process to audit 385 CY 2008 encounters to verify the accuracy of encounter data. This sample size represented a 95% confidence level and a 5% confidence interval. The contractor determined the encounters to be audited, which included 4% hospital in-patient, 4% hospital outpatient, and 92% physician encounters. The MCPA contracted with the MCO external quality review vendor to complete a statistically significant validation of encounter data for CY 2008 and CY 2009. Based on the results from the CY 2008 audit, the Administration met with the audit vendor in May 2010 to improve our process and methodology. The CY 2009 encounter data validation has been completed by the vendor, and the final report is in review. Both the CY 2008 and CY 2009 results indicate error rates below national rates. The Administration will provide the final CY 2009 report to the auditors upon completion.[2]

[2] **Auditor's Comment**: MCPA states that it does not concur with the recommendation because it already has developed a process to verify encounter data for calendar years 2008 and 2009. The audit finding focuses on the failure to verify the propriety of encounter data for fiscal years 2005 through 2007, which were used to develop MCO capitation rates for the period under audit (calendar years 2008 through 2010).

b. The Administration concurs in part with this recommendation. The Administration will update the MCOs on the errors found in the test sample. Additionally, we will work with the MCOs to incorporate information on proper medical documentation into their provider education materials.

However, the Administration does not agree with the recommendation that the capitation rates should be adjusted based on errors found. Both the CY 2008 and CY 2009 reports indicate that error rates are below national rates. Further, an encounter data error does not affect the overall payments to MCOs. Rather, encounter data are used to determine how the overall capitation payment should be divided across the population. The overall capitation payment amount is calculated by reviewing the MCO financial records, and local and national cost and utilization trends, not encounter data. Any encounter data adjustment simply shifts money across populations and MCOs, but does not affect overall MCO payments.[3]

[3] **Auditor's Comment**: MCPA states it does not agree with the recommendation that the capitation rates should be adjusted based on errors found. It further states that the encounter data does not impact the rates paid to MCOs. This assertion is not consistent with our understanding of the impact of the data. Specifically, encounter data are used in the determination of the placement into risk adjustment categories which will ultimately determine the rate payments made to the MCO for the recipient. Accordingly, we continue to believe that MCPA should take adequate steps when errors in data are identified.

Medical Care Programs Administration (MCPA) Audit Responses To Legislative Audit Report for the Period September 1, 2005 – June 30, 2009

Finding 3
MCPA did not adequately monitor MCO third-party recoveries and cost avoidance efforts.

Recommendation 3:
We recommend that the MCPA establish procedures to ensure that MCOs

a. accurately report third-party recoveries and cost avoidance, and
b. maximize third-party recoveries and cost avoidance efforts. For example, MCPA could establish recovery and cost-avoidance goals for the individual MCOs.

Administration Response:

a. The Administration concurs with the recommendation and will seek funding in FY 12 to contract with an outside auditor to:

1. Review each MCO's policies and procedures for cost-avoidance and post payment recoveries to assess the adequacy of efforts to maximize third party payments.

2. Test the accuracy of the quarterly TPL reports submitted by the MCOs and verify that the recoveries are properly recorded in the HealthChoice Financial Monitoring Report which is a report submitted by all MCOs recording their expenditures.

3. Make recommendations for improvement in MCO TPL cost-avoidance/recovery procedures and make recommendation for TPL goals to be used in establishment of each MCO's rates.

b. The Administration concurs with the recommendation. However, no data is currently available on which to base TPL recovery goals by category of eligibility by MCO. The rate setting process aggregates expenses for all the MCOs. Capitation payments are not based on the efforts of each MCO individually. The base that MCPA is using to determine the proper amount of TPL recoveries was based on information from the Program's own efforts in TPL recovery before the inception of HealthChoice. As such, the amounts are in total and do not reflect the various types of eligibles such as children, the disabled and adults who could have different recovery patterns and who are represented in differing percentages in each MCO. The Department will utilize the information received from the contractor referenced in 3a to establish goals where possible.

Medical Care Programs Administration (MCPA) Audit Responses To Legislative Audit Report for the Period September 1, 2005 – June 30, 2009

Finding 4
MCPA did not verify the propriety of enrollee placements into risk-adjusted categories and the related capitation rates that were determined by its contractor.

Recommendation 4:
We recommend that the MCPA establish procedures to obtain assurance regarding the propriety of enrollee RAC placements and the related capitation rates that were determined by its contractor.

Administration Response:

The Administration concurs with the recommendation. RAC rates reflect the trended and adjusted MCO cost which also reflects the mix of members which vary among MCOs. The MOU with the contractor will be adjusted to allow for the annual sampling of the prospective RAC payments to validate the placement of members based on their demographics (age, sex) and coverage category beginning with the January 2011 rates.

Medical Care Programs Administration (MCPA) Audit Responses To Legislative Audit Report for the Period September 1, 2005 – June 30, 2009

Finding 5
MCPA lacked adequate procedures to ensure that the correct amount was paid for Medicaid recipients who also had Medicare coverage, resulting in at least 372 claims totaling $231,000 for which MCPA paid providers more than the amount billed.

Recommendation 5:
We recommend that MCPA

a. review crossover claims, at least on a test basis, to ensure that the proper data were recorded, including a verification of the amounts paid by Medicare;
b. establish online controls to help ensure the propriety of crossover claims, such as an edit to identify payments where the payment amounts are greater than the amounts that should have been paid; and
c. review claims processed during the audit period, including the 372 claims noted above, and recover any overpayments.

Administration Response:

a. The Administration concurs with the recommendation. Effective May 1, 2010, the Administration has been conducting weekly reviews on a test basis of electronic and paper crossover claims to ensure that data recorded is proper.

b. The Administration concurs with the recommendation. However, as a result of budget reductions taken by the Board of Public Works in July 2010, the Medicaid program was directed to implement the *Lesser of Medicaid/Medicare* amounts for Part B electronic claim coinsurance payment logic. The Administration implemented this activity in August, 2010. Therefore due to this initiative, staff was unable to complete the online system modification for crossover claims which will consist of creating a reasonableness edit to identify payments where the payment amount is greater than the net claim amount. The anticipated completion date for the online control is February 2011.

c. The Administration concurs with the recommendation. The Administration has reviewed 258 claims to date totaling $235,000 and determined the claims were paid inappropriately. The reviewed claims have been adjusted and subsequently recovered. The remaining 114 claims are in the process of being reviewed and any overpayment will be recovered. The review is scheduled to be completed by December 15, 2010.

Medical Care Programs Administration (MCPA) Audit Responses To Legislative Audit Report for the Period September 1, 2005 – June 30, 2009

Finding 6 (Policy Issue)
DHMH used inmates for data entry of sensitive claims information, including social security numbers, and did not ensure employees of a data entry contractor had criminal background checks as required.

Recommendation 6:
We recommend that DHMH

a. reevaluate the practice of using inmates to process sensitive claims data, and
b. obtain documentation that all employees of the aforementioned vendor passed the required criminal background investigations.

Administration Response:

a. The Administration concurs with the recommendation to reevaluate the practice of using inmates to process sensitive claims data. MCPA has included the data entry requirements into our recently issued MMIS RFP and will transition the data entry of all claims to the new fiscal agent beginning September 2013. It should be noted that our current vendor, MCE has been keying claims documents for the Department since 2003. Additionally, last fiscal year MCPA received over $750 million in incentive payments as a result of compliance with the clean claims prompt pay provisions of the American Recovery and Reinvestment Act (ARRA). Timely data entry of claims is an essential component of prompt pay compliance. MCPA believes that conducting a procurement and subsequent transition to another contractor during the interim period and then transitioning again to the fiscal agent could unnecessarily put at risk the ARRA incentive payments. As of July 1, 2010, MCPA took steps to strengthen the MOU with MCE by specifically requiring that only inmates with criminal histories not involving embezzlement, extortion, fraud, theft, burglary or any other crimes against persons involving money may perform duties under this MOU. In addition, we incorporated a HIPAA Business Associate Agreement, with associated indemnity provisions, into the revised MOU.

b. The Administration concurs with this recommendation. MCPA will request compliance documentation from the Contract Monitor.

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Finding 7
MCPA did not ensure that claim adjustments were proper.

Recommendation 7:
We recommend that MCPA establish adequate controls over adjustments. Specifically, MCPA should generate output reports of claims adjustments and, on a test basis, ensure that the adjustments were properly supported and processed correctly.

Administration Response:

The Administration concurs with the recommendation. Effective June 1, 2010, a 3% review of all adjustments is being completed by an independent employee to ensure the adjustments were properly supported and processed correctly. Effective January 2011, the 3% sample will be selected from a daily output report which will be generated for all paper adjustments manually processed, exclusive of electronic or system generated adjustments. Documentation of the reviews will be maintained for follow-up.

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Finding 8
Healthcare provider applications were not subject to adequate supervisory review and approval.

Recommendation 8:
We recommend MCPA supervisory personnel review and approve the propriety of manually processed applications, at least on a test basis.

Administration Response:

The Administration concurs with the recommendation. As of April 19, 2010, all manually processed provider applications received are subject to the following review process:

1. Staff person assigned to work the application reviews the application for information required to enroll the provider.
2. A second review is completed by either another staff person or a supervisor for completion of the information required to add the provider to the Medicaid files.
3. The application is then returned to the original staff person for enrollment of the provider.
4. 100 % supervisory review is completed for all daily enrollments.

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Finding 9
MCPA had no procedures in place to help verify drug prices paid to pharmacies under the Maryland Medicaid Pharmacy Program.

Recommendation 9:
We recommend that MCPA establish procedures to verify the reasonableness of drug prices to reimburse pharmacies under the MPP.

Administration Response:

The Administration concurs with the recommendation of implementing procedures to help verify drug prices paid to pharmacies under the Maryland Medicaid Pharmacy Program, however, the verification and accuracy of the drug prices is questionable since this data is self reported by drug manufacturers and wholesalers to the price reference vendors. MCPA and the current POS Claims processor established a weekly notification process to ensure that the POS vendor updates the drug pricing received from the price vendor weekly and uses the most current drug prices. This weekly notification will also identify the drugs that had a change in price, as well as the old and new prices. MCPA staff will use the data from the weekly notification to perform a data-match between the drugs with a price change and a predefined group of drugs (based on program-defined criteria) that the Program had paid claims. The results of the data-match will be compared with available external pricing sources to verify the reasonableness of the drug prices.

Furthermore, MCPA contacted the State's Office of Personnel Services and Benefits (OPSB,) as recommended by the OLA, in order to explore the possibility of using drug pricing information from the OPSB's PBM so that the verification of the drug prices can be performed. After discussions with OPSB's PBM and their counsel, the OPSB's counsel and the Medicaid Program's counsel, it was determined that the OPSB PBM's contract with their pricing vendor prohibits sharing drug pricing information with MCPA. This information was provided to the OLA on September 17th, 2010. Thus, this recommendation from the auditor cannot be implemented.

Finally, as recommended by the auditor, MCPA has engaged in discussions with its current POS vendor in order to explore the option of contracting with multiple drug pricing vendors (as is the case with the Pennsylvania Medicaid Program) so that we obtain drug pricing and compare the data from the multiple vendors. Once the pricing data is compared and validated, it should be used during the adjudication of pharmacy claims. The POS vendor has investigated the possibility of contracting with multiple pricing vendors and determined that the cost to implement the necessary POS system changes to accommodate drug pricing from multiple vendors in the system would be as follows:

- One time cost for system programming changes: $280,250
- Annual cost for obtaining drug pricing files from two additional pricing vendors: $50,000

Due to the high cost for implementing the recommendation of contracting with multiple drug pricing vendors, the Administration does not concur with implementing it. Furthermore, given that AWP pricing will be eliminated by September 2011, and since State Medicaid Agencies and CMS are in the process of identifying a new price benchmark that will replace AWP, it may not be fiscally appropriate to expend the money at this time to make the changes to the POS system, since in the near future, these changes may become obsolete. In addition, MCPA is concerned about our ability to validate the accuracy of the data, since this data is self-reported by the drug manufacturers and drug wholesalers and does not get certified or approved by a federal or state governmental agency.

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Finding 10
MCPA did not maintain adequate cost settlement records and ensure that all cost settlements were conducted as required.

Recommendation 10:
We recommend that MCPA

a. maintain cost settlement records in a manner that allows it to readily determine the number of outstanding settlements for each year; and

b. ensure that all cost settlements are completed in a timely manner as required, and amounts owed to the State or to the long-term care facilities are promptly settled (repeat).

Administration Response:

a. The Administration concurs with the recommendation. The program has modified a Cost Settlement Issued report which formerly showed the cost reports received and now includes a column for receipt date and includes all cost reports due from 6/30/98 through the current date.

b. The Administration concurs with the recommendation to have all cost settlements completed in a timely manner. Funds were included in the current contract to reduce the backlog (123) at the conclusion of the prior contract. A protest of the awarding of the contract contributed to an increase in the backlog such that 421 cost settlements were not issued when due at the conclusion of the first year of the new contract. Currently, for September 2010, the backlog is 175 of which only 10 cost settlements which are past due have not been started. We intend to increase the number of audits to be completed in the next contract which will begin July 1, 2011 to include funding to complete all past due audits.

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Finding 11
MCPA did not implement sufficient control procedures to address deficiencies in the KDP, as recommended by DHMH's Office of Inspector General. In addition, deficient procedures over pharmaceutical claims resulted in overpayments of at least $161,744.

Recommendation 11:
We recommend that MCPA

a. implement sufficient procedures, controls, and segregation of duties over the KDP to help prevent frauds; and
b. establish additional controls over pharmaceutical claims to help prevent payments on behalf of KDP recipients that were paid by third parties.

Administration Response:

a. The Administration concurs with the recommendation. KDP has developed a weekly mechanism to perform supervisory review/auditing of KDP claims to ensure they were properly paid. This task and procedure was implemented June 1, 2010. In addition, KDP developed a mechanism and implemented a procedure to mail monthly letters to certified KDP recipients requesting verification of the claims KDP paid on their behalf. This task was implemented June 1, 2010.

KDP will implement a process to periodically match the KDP recipient database against the Vital Records database. This reporting mechanism will allow KDP to perform timely updates to the online eligibility file. The anticipated implementation date was scheduled for June 1, 2010; however, due to systemic complexities, the report is scheduled to be available January 1, 2011. Updates to the KDP eligibility file will be performed on a monthly basis.

KDP receives and reviews a daily report of additions and updates to the KDP eligibility file. Additionally, a supervisory review/audit mechanism was implemented in December 2009 to review 10% of the KDP applications for certification that are processed on a daily basis by reviewing the application file/source documents for propriety.

KDP initiated measures to obtain and update the KDP Vendor File with NPI (National Provider Identification) numbers. These numbers are assigned by CMS. This process of adding NPI numbers to the KDP Vendor File was implemented by the staff of the Medicaid Provider Enrollment unit and completed May 7, 2010.

b. The Administration concurs with the recommendation. KDP is receiving monthly mailed reports from ACS, the current point-of-sale system vendor that lists the TPL (third party liability) amounts paid to pharmacy providers by insurance carriers. This reporting mechanism includes all patients and claim information for TPL claims paid to pharmacy providers by KDP. This report is reviewed monthly and allows KDP to identify irregularities in billed amounts and TPL payments. KDP began reviewing these reports as of May 19, 2010.

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Finding 12
Procedures for the Transportation Grant Program were not sufficient to ensure that grant funds were used properly by the local jurisdictions.

Recommendation 12:
We recommend that MCPA enhance the policies and procedures for the Transportation Grant Program to help ensure that grant funds are used properly. These policies and procedures should include adequate guidance to the local jurisdictions, including requiring a separation of responsibilities for the screening and transportation functions, and should require comprehensive, timely monitoring to ensure funds are used properly.

Administration Response:

The Administration concurs with the recommendation and agrees that current policies should be enhanced to document that Medicaid Transportation grant funds are used properly. At this time we are in the process of revising our Non Emergency Medical Transportation guidelines for the local health departments. We also concur that requiring the separation of responsibilities for screening and transportation functions will support a cost effective program. However, the implementation of this enhancement will require more resources and initially result in higher spending. Future local health department contracts will reflect two or more separate entities performing the functions of screening and providing transportation. Contract changes will take place for all new contract periods that begin on or after July 1, 2011. We will address monitoring responsibilities in the future contracts.

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Finding 13
Adequate EDITPS authentication, access, and monitoring controls did not exist.

Recommendation 13:
We recommend that MCPA establish adequate authentication, access, and monitoring controls over the EDITPS web servers and application. We made detailed recommendations to MCPA, which, if implemented, should provide for adequate controls over the EDITPS web servers and application.

Administration Response:

The Administration concurs with several of the individual detailed recommendations and has implemented those recommendations. The Administration does not concur with the remaining recommendations for Account Lockout, Password Age/Complexity and EDITPS Application of the Operating System. The Administration had several discussions with the OLA about our non concurrence with the referenced recommendations and to date has not received any further comments. Therefore, the Administration believes the finding has been resolved and the EDITPS web services and applications are compliant with the State Guidelines.[4]

[4] **Auditor's Comment**: MCPA indicates its concurrence with several individual recommendations, but does not concur with certain other recommendations, which relate to one of the four primary issues cited in the report finding. With regard to this one issue, some of the specific recommendations MCPA identifies were not addressed in the report and, in another instance, we were advised that recommendation has been implemented. Accordingly, we continue to believe all recommendations are appropriate and need to be implemented.

Medical Care Programs Administration (MCPA) Audit Responses To Legislative Audit Report for the Period September 1, 2005 – June 30, 2009

Finding 14
Security software settings were not activated to identify certain changes made to critical MMIS II production database tables.

Recommendation 14:
We recommend that security software flags be activated for all accounts capable of making direct modifications to the MMIS II production database tables.

Administration Response:

The Administration concurs with the recommendation. MCPA has taken the necessary steps to activate logging on logon-ids capable of making direct modifications to the MMISII production tables. The logging was added December 18, 2009. In addition, the Administration periodically reviews employee access and takes necessary steps if appropriate.

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