MICHIGAN

OFFICE OF THE AUDITOR GENERAL

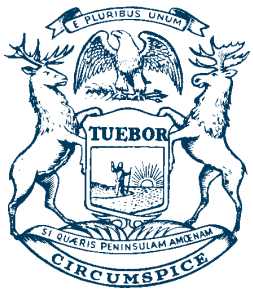
AUDIT REPORT

PERFORMANCE AUDIT
OF

SELECTED MEDICAID MANAGED CARE AND FEE-FOR-SERVICE PAYMENTS

MEDICAL SERVICES ADMINISTRATION
DEPARTMENT OF COMMUNITY HEALTH

April 2005



THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

39-701-04

"...The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof."

– Article IV, Section 53 of the Michigan Constitution

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REPORT SUMMARY

Performance Audit

Selected Medicaid Managed Care and Fee-for-Service Payments

Medical Services Administration

Department of Community Health (DCH)

Report Number:
39-701-04

Released:
April 2005

Medicaid is a program, administered by the DCH Medical Services Administration, that pays for some or all medical bills for certain individuals and families with low incomes and limited resources. The federal government established Medicaid under Title XIX of the Social Security Act. Medical costs of beneficiaries are paid either by Medicaid managed care health plans or on a fee-for-service basis.

Audit Objectives:

1. To assess the effectiveness of DCH's efforts to ensure the propriety of the Medicaid payments for beneficiaries who are entitled to emergency services only.

2. To assess the effectiveness of DCH's efforts to ensure the propriety of Medicaid fee-for-service payments for physician, inpatient hospital, and prescription drug costs for beneficiaries enrolled in managed care.

3. To assess the effectiveness of DCH's efforts to prevent Medicaid managed care and fee-for-service payments for beneficiaries who may have more than one beneficiary identification number or who may be deceased.

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Audit Conclusions:

1. DCH was generally effective in ensuring the propriety of Medicaid payments for beneficiaries who were entitled to emergency services only. However, we noted a reportable condition related to emergency services (Finding 1). We estimated that DCH paid approximately $1.4 million ($568,000 of State General Fund/general purpose funding) for Medicaid claims that did not have emergency diagnosis codes for beneficiaries entitled to emergency services only. DCH has not recovered associated provider mispayments.

2. DCH was generally effective in ensuring the propriety of Medicaid fee-for-service payments for physician, inpatient hospital, and prescription drug costs for beneficiaries enrolled in

managed care. However, we noted reportable conditions related to fee-for-service payments to physicians and inpatient hospitals and payments to pharmaceutical providers (Findings 2 and 3). Estimated fee-for-service overpayments by DCH were between $6.4 million and $8.6 million (between $2.7 million and $3.6 million of State General Fund/general purpose funding) for Medicaid services provided that should have been provided to Medicaid beneficiaries by managed care health plans. DCH has not recovered associated provider overpayments.

3. DCH was generally effective in its efforts to prevent Medicaid managed care and fee-for-service payments for beneficiaries who may have more than one beneficiary identification number or who may be deceased. However, we noted a reportable condition related to multiple beneficiary identification numbers and deceased beneficiaries (Finding 4). DCH paid approximately $578,000 ($237,000 of State General Fund/general purpose funding) for medical services for beneficiaries having multiple beneficiary identification numbers and beneficiaries who were deceased. DCH has not recovered associated overpayments.

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Noteworthy Accomplishments:

In May 2003, Michigan's Medicaid was the recipient of the Foundation for Accountability's (FACCT's) Innovative Financing Award. The award was in recognition of Michigan Medicaid's use of the Contractor Performance Bonus Program, which it implemented in 2002 to reward health plans for delivering quality health care by setting specific health goals. Immunization was chosen as the first "improvement opportunity." Plans that met the immunization goal split a bonus pool of $3.5 million. Every plan in the State improved its immunization rates and met the immunization goal. The result has been improved health care for children in Michigan.

In addition, in December 2004, the National Committee for Quality Assurance (NCQA) identified the nation's highest quality Medicare and Medicaid health plans. The health plans named to the list were the nation's top overall performers on a range of key clinical measures. Of the top 10 Medicaid plans, 3 were Medicaid managed care health plans from Michigan.

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Agency Response:

Our audit report contains 4 findings and 8 corresponding recommendations. DCH's preliminary response indicated that it generally agreed with 7 of our recommendations and disagreed with 1 recommendation.

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A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at: http://audgen.michigan.gov

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THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

April 27, 2005

Ms. Janet Olszewski, Director
Department of Community Health
Lewis Cass Building
Lansing, Michigan

Dear Ms. Olszewski:

This is our report on the performance audit of Selected Medicaid Managed Care and Fee-for-Service Payments, Medical Services Administration, Department of Community Health.

This report contains our report summary; description of agency; audit objectives, scope, and methodology and agency responses; comments, findings, recommendations, and agency preliminary responses; and a glossary of acronyms and terms.

Our comments, findings, and recommendations are organized by audit objective. The agency preliminary responses were taken from the agency's responses subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a formal response within 60 days after release of the audit report.

We appreciate the courtesy and cooperation extended to us during this audit.

AUDITOR GENERAL

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MEDICAL SERVICES ADMINISTRATION
DEPARTMENT OF COMMUNITY HEALTH

Description of Agency

Medicaid is a program that pays for some or all medical bills for certain individuals and families with low incomes and limited resources. The federal government established Medicaid under Title XIX of the Social Security Act.

Medicaid is a joint federal and state funding effort. The federal government matches the funds that each state spends on Medicaid according to the state's federal medical assistance percentage. Michigan's percentage was 58.84% through June 30, 2004. Starting July 1, 2004, the percentage changed to 55.89% for the remainder of fiscal year 2003-04. If, in the operation of a program, the Department of Community Health (DCH) identifies overpayments of a program expenditure, State law allows DCH six years to recover the overpayments.

The federal government allows Michigan, as well as the other states, to establish its own eligibility standards; determine the type, amount, duration, and scope of services; set the rate of payment for services; and administer its own program. In Michigan, the DCH Medical Services Administration administers Medicaid. Eligibility for Medicaid is determined by local county Department of Human Services (DHS) staff.

In Michigan, as of September 2004, approximately 63% of 1.4 million Medicaid beneficiaries* were enrolled in a Medicaid managed care* health plan (approximately 883,000 beneficiaries). The managed care health plans are responsible for providing a full continuum of physical health services through a network of providers. Beneficiaries who are not in a managed care health plan have their medical costs paid on a fee-for-service* basis and can seek care from any Medicaid-enrolled provider willing to treat them. Beneficiaries who are in nursing homes or in community based care programs as an alternative to a nursing home and beneficiaries eligible for both Medicare and Medicaid cannot be enrolled in a Medicaid managed care health plan.

As of September 2004, there were 16 Medicaid managed care health plans that serviced all of Michigan's counties, except Cheboygan, Clare, Emmet, and Isabella. Two or more managed care health plan options were available to Medicaid beneficiaries in 54 of 68 Lower Peninsula counties.

* *See glossary at end of report for definition.*

Michigan's Medicaid expenditures totaled $7.0 billion for fiscal year 2003-04.

As of September 30, 2004, DCH dedicated 301 full-time equated positions to its Medicaid efforts. DCH expended approximately $10.1 billion for the fiscal year ended September 30, 2004.

Audit Objectives

Our performance audit* of Selected Medicaid Managed Care and Fee-for-Service Payments, Medical Services Administration, Department of Community Health (DCH), had the following objectives:

1. To assess the effectiveness* of DCH's efforts to ensure the propriety of the Medicaid payments for beneficiaries who are entitled to emergency services only.

2. To assess the effectiveness of DCH's efforts to ensure the propriety of Medicaid fee-for-service payments for physician, inpatient hospital, and prescription drug costs for beneficiaries enrolled in managed care.

3. To assess the effectiveness of DCH's efforts to prevent Medicaid managed care and fee-for-service payments for beneficiaries who may have more than one beneficiary identification number* or may be deceased.

Audit Scope

Our audit scope was to examine the program and other records related to selected Medicaid managed care and fee-for-service payments of the Medical Services Administration, Department of Community Health. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances.

Audit Methodology

Our audit procedures, performed from April through September 2004, included examination of Medicaid records and activities primarily for the period July 1, 2002 through July 31, 2004. To accomplish our objectives, we reviewed federal regulations, State statutes, Medicaid policies and procedures, audit reports from other states, and publications and periodicals on the topic of Medicaid. Also, we interviewed Medicaid management and staff.

* *See glossary at end of report for definition.*

To accomplish our first objective, we tested a sample of professional provider claims to determine whether their diagnoses were classified as emergencies in accordance with DCH's listing of emergency diagnoses.

In connection with our second objective, we determined that there were significant fee-for-service payments paid for Medicaid services provided to beneficiaries by physicians, inpatient hospitals, and prescription drugs at the same time these beneficiaries were enrolled in a managed care health plan. We tested claims to determine the propriety of fee-for-service payments.

To accomplish the third objective regarding beneficiaries with multiple beneficiary identification numbers, we identified persons incurring Medicaid costs and payments under more than one beneficiary identification number for the same procedures occurring during the same time. To address the third objective regarding deceased beneficiaries, we identified those persons for whom Medicaid payments were made to medical providers or managed care health plans after the beneficiaries' dates of death.

Agency Responses

Our audit report contains 4 findings and 8 corresponding recommendations. DCH's preliminary response indicated that it generally agreed with 7 of our recommendations and disagreed with 1 recommendation.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and Department of Management and Budget Administrative Guide procedure 1280.02 require DCH to develop a formal response to our audit findings and recommendations within 60 days after release of the audit report.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

EFFORTS REGARDING
EMERGENCY SERVICES ONLY PAYMENTS

COMMENT

Audit Objective: To assess the effectiveness of the Department of Community Health's (DCH's) efforts to ensure the propriety of the Medicaid payments for beneficiaries who are entitled to emergency services only.

Conclusion: DCH was generally effective in ensuring the propriety of Medicaid payments for beneficiaries who were entitled to emergency services only. However, we noted a reportable condition* related to emergency services (Finding 1).

FINDING

1. Emergency Services

   DCH did not have sufficient controls to ensure that its Medicaid payments for beneficiaries entitled to emergency services only (e.g., noncitizens of the United States) complied with federal regulations. As a result, we estimated that DCH paid approximately $1.4 million ($568,000 of State General Fund/general purpose funding) for Medicaid claims that did not have emergency diagnosis codes* for beneficiaries entitled to emergency services only. DCH has not recovered associated provider mispayments.

   Title 42, Part 440 of the *Code of Federal Regulations* provides that individuals who meet the eligibility and residency requirements of Medicaid but are not citizens of the United States (e.g., certain aliens) can only receive treatment for an emergency medical condition (diagnosis). Part 440 defines an emergency as the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

   To help ensure its compliance with federal regulations, DCH developed a list of emergency diagnosis codes that it used to edit claims by institutional providers.

* *See glossary at end of report for definition.*

DCH did not use the list to edit the claims of professional providers. Instead, DCH paid professional providers based on an emergency indicator code on providers' Medicaid claims, on which the physician indicated whether a procedure was an emergency.

Because federal regulations did not allow Medicaid payments to providers for nonemergency services rendered to beneficiaries entitled to emergency services only, providers did not have incentive to ensure that their emergency indicator codes were accurate. Therefore, we compared the professional providers' emergency indicator codes to providers' use of diagnosis codes elsewhere in their claims.

Our review of the DCH Medicaid Management Information System database for the period October 1, 2002 through July 31, 2004 showed payments for beneficiaries entitled to emergency services totaling approximately $29 million. Approximately $25 million of these payments were made to institutional providers (e.g., hospitals) and $4 million were paid to professional providers (e.g., physicians). Using a risk-based analysis of the $4 million paid to professional providers (e.g., we excluded childbirth, ambulance, and anesthesia claims because these claims were probably related to emergencies), we identified $1.1 million at highest risk of being for nonemergency services.

To determine the appropriateness of the payments of $1.1 million made to professional providers for emergency services provided to Medicaid beneficiaries, we selected 40 claims submitted by these providers' during the period October 1, 2002 through July 31, 2004 and compared the emergency indicator codes to diagnosis codes recorded on the claims. Our review disclosed 33 claims (83%) in which the providers either did not report an emergency diagnosis code or reported a nonemergency diagnosis code. Based on our review, we estimate that professional provider claims of approximately $900,000 ($370,000 of State General Fund/general purpose funding) did not contain emergency diagnosis codes and, therefore, may not have been emergencies.

Likewise, for the period January 1, 1999 through September 30, 2002, we reviewed claims totaling $9.8 million submitted by professional providers. Based on this review, we estimated that claims of $482,000 ($198,000 of State General Fund/general purpose funding) did not contain diagnosis codes or were coded with nonemergency diagnosis codes and, therefore, may not have been emergencies.

RECOMMENDATIONS

We recommend that DCH establish sufficient controls to ensure that its Medicaid payments for beneficiaries entitled to emergency services only comply with federal regulations.

We also recommend that DCH take immediate steps to recover associated provider mispayments.

AGENCY PRELIMINARY RESPONSE

DCH agreed that some claims submitted by professional providers were paid inappropriately as emergencies, but did not necessarily agree with the method used to estimate the potential overpayment and did not agree that front-end edits can and should be implemented for professional providers as suggested by the recommendation. DCH indicated that the $1.4 million in estimated overpayments could just as easily have been estimated at $643,000 by using a different, reasonably valid method; however, DCH indicated that neither method represents a statistically valid projection.

DCH did not agree that diagnosis codes, although helpful, represent a reliable and definitive indicator of an emergency for professional services. Consequently, DCH intends to continue its practice of allowing physicians to utilize the emergency indicator code on the claim form. DCH stated that to reject these claims based on a diagnosis code would unnecessarily delay a large number of valid claims and would serve as a disincentive for professional practitioners to serve Medicaid beneficiaries. DCH indicated that this approach was consistent with other health insurers and, as such, was standard for the industry. To address the inappropriate payments, DCH stated that it will implement and more aggressively review these types of claims through a regularly scheduled postpayment review process. Also, DCH stated that it will aggressively pursue recoveries for any claims found to have been paid that do not meet the emergency criteria.

EFFORTS REGARDING PHYSICIAN, INPATIENT HOSPITAL, AND PRESCRIPTION DRUG COSTS

COMMENT

Audit Objective: To assess the effectiveness of DCH's efforts to ensure the propriety of Medicaid fee-for-service payments for physician, inpatient hospital, and prescription drug costs for beneficiaries enrolled in managed care.

Conclusion: DCH was generally effective in ensuring the propriety of Medicaid fee-for-service payments for physician, inpatient hospital, and prescription drug costs for beneficiaries enrolled in managed care. However, we noted reportable conditions related to fee-for-service payments to physicians and inpatient hospitals and payments to pharmaceutical providers (Findings 2 and 3).

Noteworthy Accomplishments: In May 2003, Michigan's Medicaid was the recipient of the Foundation for Accountability's (FACCT's) Innovative Financing Award. The award was in recognition of Michigan Medicaid's use of the Contractor Performance Bonus Program, which it implemented in 2002 to reward health plans for delivering quality health care by setting specific health goals. Immunization was chosen as the first "improvement opportunity." Plans that met the immunization goal split a bonus pool of $3.5 million. Every plan in the State improved its immunization rates and met the immunization goal. The result has been improved health care for children in Michigan.

In addition, in December 2004, the National Committee for Quality Assurance (NCQA) identified the nation's highest quality Medicare and Medicaid health plans. The health plans named to the list were the nation's top overall performers on a range of key clinical measures. Of the top 10 Medicaid plans, 3 were Medicaid managed care health plans from Michigan.

FINDING

2. Fee-for-Service Payments to Physicians and Inpatient Hospitals

   DCH did not have controls to prevent, or procedures to immediately recover, fee-for-service overpayments made to physicians and inpatient hospitals for Medicaid beneficiaries who were retroactively enrolled in a managed care health plan. As a result, estimated overpayments by DCH were between $6.3 million and

$8.5 million (between $2.6 million and $3.5 million of State General Fund/general purpose funding) for Medicaid services provided during the period July 1, 2001 through June 30, 2004 that should have been provided to Medicaid beneficiaries by managed care health plans.

DCH contracts with managed care health plans to provide basic health care coverage to Michigan's Medicaid beneficiaries. DCH pays each managed care health plan an agreed upon monthly capitated fee for each Medicaid beneficiary enrolled in the plan. Prior to contracting with managed care health plans, DCH made payments directly to physicians, hospitals, and other health care providers on a fee-for-service basis.

DCH moved to managed care to reduce the State's overall Medicaid health care costs while providing beneficiaries with increased access to and flexibility in obtaining health care. However, the success of this arrangement is reduced when DCH makes fee-for-service basis payments for health care services provided to Medicaid beneficiaries that should have been provided under the monthly capitated payments made to the managed care health plans. Also, DCH efforts regarding improper payments should consider the federal Improper Payments Information Act of 2002, which expanded the federal government's efforts to identify and reduce improper payments in the government's programs and activities and is intended to improve the integrity of the government's payments and the efficiency of its programs and activities.

Physicians and inpatient hospitals regularly file Medicaid fee-for-service claims for beneficiaries who belong in a managed care health plan but, at the time the claim is filed, are not yet enrolled in such a plan. Common examples are medical services provided to infants who are born to mothers enrolled in managed care. DCH requires those infants to also be enrolled in the mothers' managed care health plans. However, DCH stated that because it takes time for the infants to be enrolled in the mothers' managed care health plan, the physicians and hospitals file fee-for-service claims directly with DCH rather than waiting for the enrollment of the infants in managed care.

Because the managed care health plan is responsible for medical costs of the infants, DCH should implement controls to prevent fee-for-service payments to providers on behalf of the infants and should recover fee-for-service payments paid by DCH to providers that should have been paid by a managed care health plan.

Controls to prevent fee-for-service payments to providers could include creation of a Medicaid Management Information System edit whereby the provider is required to certify that the mother of the infant is a fee-for-service beneficiary. Such an edit would help prevent DCH from paying fee-for-service claims on behalf of any child whose mother is a managed care beneficiary if any such fee-for-service claims were improperly submitted by the provider. The claims would be rejected and redirected to the applicable managed care health plan.

During the period July 1, 2001 through June 30, 2004, DCH paid fee-for-service claims of approximately $22.1 million that had been submitted by physicians and inpatient hospitals for Medicaid beneficiaries who were retroactively enrolled in a managed care health plan. We sampled 156 of these fee-for-service payments, which totaled approximately $1.9 million, to determine whether these services should have been paid for by the Medicaid beneficiaries' managed care health plans.

As summarized in the following table, our review determined that 99 of these claims represented payments of approximately $870,000 for medical services provided to Medicaid beneficiaries who had been retroactively enrolled in a managed care health plan and for whom the managed care health plan was financially responsible:

12-Month Claim Period Ended June 30	Fee-for-Service Payments for Managed Care Beneficiaries	Claims Tested	Claims Overpaid	Claims - Overpayment Rate	Dollars Tested	Dollars Overpaid	Dollars - Overpayment Rate
2004	$ 6,131,245	78	65	83%	$ 757,706	$488,474	64%
2003	2,784,817	39	29	74%	572,160	297,396	52%
2002	13,141,791	39	5	13%	590,415	84,449	14%
	$ 22,057,853	156	99		$ 1,920,280	$870,318	

As a result, estimated overpayments were between $6.3 million and $8.5 million (between $2.6 million and $3.5 million of State General Fund/general purpose funding) of the total fee-for-service payments of $22.1 million made during the period July 1, 2001 through June 30, 2004 to health care providers for medical services covered by a managed care health plan.

RECOMMENDATION

We recommend that DCH implement controls to prevent, and procedures to immediately recover, fee-for-service overpayments made to physicians and

inpatient hospitals for Medicaid beneficiaries who were retroactively enrolled in a managed care health plan.

AGENCY PRELIMINARY RESPONSE

DCH agreed that it overpaid and did not recover some fee-for-service payments made to physicians and inpatient hospitals for beneficiaries who were retroactively enrolled in a managed care health plan. However, DCH did not agree with the part of the recommendation that suggests that front-end edits be implemented to prevent these payments.

DCH stated that the methods used to estimate the range of overpayments, i.e., between $6.3 million and $8.5 million, resulted in rough estimates and did not reflect a statistically valid projection of the amount of overpayments.

For the amounts overpaid, DCH indicated that it has developed the capability and will be implementing a process to identify and recover the overpayments en masse through a batch claim adjustment process. DCH indicated that inappropriate claims will be recovered; however, DCH does not intend to pursue a front-end edit to prevent these payments as suggested in the recommendation. DCH stated that such an edit would put providers in the unenviable position of not being able to get paid from anyone until the beneficiary eligibility and enrollment process has been completed. DCH stated that because this process is often time-consuming, delaying provider payments would serve as a disincentive for providers to participate in the Medicaid program.

FINDING

3. Payments to Pharmaceutical Providers

DCH controls did not ensure that its Medicaid managed care health plans provided all required pharmaceutical services to enrolled Medicaid beneficiaries. As a result, DCH paid approximately $135,000 ($55,000 of State General Fund/general purpose funding) on a fee-for-service basis for services that should have been provided to Medicaid beneficiaries by managed care health plans. DCH has not recovered associated provider overpayments.

DCH contracts with managed care health plans to provide basic health care coverage to Michigan's Medicaid beneficiaries. DCH pays each managed care

health plan an agreed upon monthly capitated fee for each Medicaid beneficiary enrolled in the plan. DCH's main goal in contracting with managed care health plans is to reduce the State's overall Medicaid health care costs while providing beneficiaries with increased access to and flexibility in obtaining health care. Prior to contracting with managed care health plans, DCH paid for most Medicaid related health services on a fee-for-service basis.

In exchange for monthly capitated payments from DCH, each managed care health plan provides health care services, including pharmaceutical services, to its enrolled beneficiaries. However, in accordance with section 9.7 of the DCH Medicaid Provider Manual, certain pharmacy and related services prescribed by providers (e.g., psychotropic medications*) are not covered by the managed care health plans and are instead paid for by DCH on a fee-for-service basis.

DCH paid approximately $213 million in pharmacy claims on a fee-for-service basis for recipients enrolled in a Medicaid managed care health plan during the period July 1, 2002 through June 30, 2004. We reviewed these pharmacy claims to determine whether DCH had paid, on a fee-for-service basis, any claims that should have been provided under the monthly capitated amounts received by the managed care health plans.

Based on our review of pharmacy fee-for-service claims paid by DCH during the period July 1, 2002 through June 30, 2004, DCH paid approximately $135,000 ($55,000 of State General Fund/general purpose funding) for nonpsychotropic pharmaceutical services that should have been provided under the monthly capitated payments that DCH made to the managed care health plans.

RECOMMENDATIONS

We recommend that DCH improve its controls to ensure that its Medicaid managed care health plans provide all required pharmaceutical services to enrolled Medicaid beneficiaries.

We also recommend that DCH take immediate steps to recover associated provider overpayments.

* *See glossary at end of report for definition.*

AGENCY PRELIMINARY RESPONSE

DCH agreed that some very small overpayments were made to pharmaceutical providers. However, DCH stated that an estimated error rate of about six one-hundredths of one percent would suggest that the controls over these claims were working fairly well. DCH responded that all of the errors were attributed to two different situations, one of which related to the retroactive enrollment of newborns into a managed care health plan that was addressed in the previous finding. DCH also responded that the other situation, which DCH indicated has already been corrected, related to a systems error in the logic used by the First Health Corporation, the DCH-contracted pharmacy benefits manager. DCH stated that an error in the payment logic was made when the First Health Corporation converted to a new claims processing system in 2002. DCH informed us that the error was subsequently identified and corrected.

DCH stated that inappropriate payments to pharmaceutical providers paid on behalf of beneficiaries retroactively enrolled in a managed care health plan will be identified and recovery pursued as deemed appropriate. DCH indicated that recoveries for overpayments made as a result of the problem with the edit will also be reviewed and recoveries pursued as appropriate.

EFFORTS REGARDING MULTIPLE BENEFICIARY IDENTIFICATION NUMBERS AND DECEASED BENEFICIARIES

COMMENT

Audit Objective: To assess the effectiveness of DCH's efforts to prevent Medicaid managed care and fee-for-service payments for beneficiaries who may have more than one beneficiary identification number or who may be deceased.

Conclusion: DCH was generally effective in its efforts to prevent Medicaid managed care and fee-for-service payments for beneficiaries who may have more than one beneficiary identification number or who may be deceased. However, we noted a reportable condition related to multiple beneficiary identification numbers and deceased beneficiaries (Finding 4).

FINDING

4. Multiple Beneficiary Identification Numbers and Deceased Beneficiaries

DCH controls did not always prevent duplicate Medicaid payments for persons having multiple beneficiary identification numbers. Also, DCH did not ensure that deceased Medicaid beneficiaries who received full Medicaid benefits were identified on a timely basis and promptly removed from the beneficiary eligibility databases. As a result, DCH paid approximately $578,000 ($237,000 of State General Fund/general purpose funding) for medical services for beneficiaries having multiple beneficiary identification numbers and beneficiaries who were deceased. DCH has not recovered associated overpayments.

We reviewed selected Medicaid claims:

a. From our comparison of names and birth dates of Medicaid beneficiaries for the period January 1999 through June 2004, we noted that DCH paid 5,769 payments totaling $770,000 for 201 beneficiaries who each had two beneficiary identification numbers. Because there were two beneficiary identification numbers for each person, we estimated that half of the Medicaid payments, or $385,000 ($158,000 of State General Fund/general purpose funding), were inappropriate.

   Federal allowable cost requirements allow only one payment per eligible claim. To help ensure that DCH does not make duplicate payments on behalf of an eligible beneficiary, the State requires that each Medicaid-eligible person be supplied with only one beneficiary identification number, with which the provider, managed care health plans, and the State are able to maintain Medicaid payment information.

   Through a grant from DCH, the Department of Human Services (DHS) is responsible for performing Medicaid eligibility determinations and assigning beneficiary identification numbers. DCH informed us that multiple beneficiary identification numbers occur when, for example, individuals apply for Medicaid and do not inform DHS that they had been previously enrolled in Medicaid.

b. From our match of full-benefit Medicaid recipient records to DCH death certification records for the period June 1, 2002 through July 31, 2004, we found that 244 full-benefit Medicaid beneficiaries had died during this period

but had not been removed from the applicable eligibility database. Our review further disclosed that during this period, DCH processed payments totaling approximately $193,000 ($79,000 of State General Fund/general purpose funding) for services purportedly provided to deceased full-benefit Medicaid beneficiaries.

State Medicaid eligibility procedures require that DHS be notified within 10 days of a beneficiary's death so that the beneficiary can be removed from the applicable eligibility database.

According to DCH, approximately 44,500 Medicaid beneficiaries died during the period October 1, 2002 through July 31, 2004. To help ensure the accuracy of its eligibility databases, DCH periodically has performed matches between Medicaid beneficiary eligibility records and death certificate records obtained from DCH's Division for Vital Records and Health Statistics. However, our review determined that as of August 2004, DCH had not recovered payments made for deceased beneficiaries for periods after September 30, 2002.

These results are consistent with an audit by the Office of Inspector General, U.S. Department of Health and Human Services, for the period September 1, 1998 through September 30, 2000, which stated that DCH "did not identify all payments to providers for medical services provided after the recipients' death."

RECOMMENDATIONS

We recommend that DCH improve its controls to prevent duplicate Medicaid payments for persons having multiple beneficiary identification numbers.

We also recommend that DCH improve its efforts to ensure that deceased Medicaid beneficiaries who received full Medicaid benefits are identified on a timely basis and promptly removed from the beneficiary eligibility databases.

We further recommend that DCH take immediate steps to recover associated overpayments.

AGENCY PRELIMINARY RESPONSE

DCH agreed with the finding and recommendation related to the inappropriate payments made on behalf of beneficiaries with multiple identification numbers as described in part a. of the finding and only technically agreed with the finding and recommendation related to inappropriate payments made on behalf of deceased beneficiaries described in part b. of the finding.

With respect to part a. of the finding, DCH stated that it has taken several actions over the last several years to reduce the number of beneficiaries with multiple identification numbers. DCH informed us that these steps have included meetings between staff from the Medical Services Administration and those who assign beneficiary identification numbers to discuss ways to reduce the number of people with multiple identification numbers (2002); DHS implementing a more extensive search method to identify beneficiaries with multiple identification numbers (2003); utilization of birth records to activate the case, rather than "Baby Boy" or "Baby Girl" (2003); and the Medical Services Administration assigning additional staff to investigate cases of multiple identification numbers (2003).

Additionally, DCH stated that a "Corrected ID" table has been added to the DCH data warehouse. DCH noted that the table contains all beneficiary identification numbers for people whom DHS has identified as having multiple identification numbers and for which DHS has determined the correct identification number. DCH stated that this table will enable staff to identify duplicate payments on behalf of the same beneficiary. DCH indicated that it will continue to work with DHS to reduce the number of beneficiaries who are assigned multiple identification numbers, explore options for using the DCH data warehouse to identify beneficiaries who may have been assigned multiple identification numbers, and take action as appropriate. Finally, DCH stated that it will work with DHS to review the list of beneficiaries with multiple identification numbers identified through the audit, take action to identify the correct identification number for each beneficiary, and end-date eligibility for the remaining identification numbers. DCH indicated that it will aggressively pursue recoveries, as appropriate.

While DCH stated that it technically agrees that it had not processed recoveries made on behalf of deceased beneficiaries as of August 2004 as described in part b. of the finding, DCH indicated that it was in the process of actively addressing this problem. DCH indicated that actual recoveries of approximately

99% of these inappropriate payments were processed in October 2004, just one month after the Office of the Auditor General completed fieldwork for this audit in September 2004. DCH stated that it is actively pursuing recoveries of the remaining expenditures. DCH stated that, in February 2004, it completed a match between Medicaid beneficiary eligibility records and death certificate records obtained from DCH's Division for Vital Records and Health Statistics for 2002 and 2003. DCH also stated that, in March 2004, it completed a match with the Social Security Administration's master file of proven deaths. DCH indicated that actual recoveries were not made because it became aware that some of the death information was inaccurate and needed to be corrected before pursuing collection.

DCH stated that it has been actively working on this issue since the Office of Inspector General, U.S. Department of Health and Human Services, completed its review. DCH informed us that the following procedures have been implemented: a monthly electronic match of the Medicaid eligibility file with both the death certificates from DCH's Division for Vital Records and Health Statistics and the Social Security Administration's master file of proven deaths (began March 2004); same-day updating of the Medicaid eligibility file with the date of death as a result of these matches; implementation of an edit in the Medicaid payment system to reject claims for deceased beneficiaries (March 2004); and recovery of payments to providers for deceased beneficiaries, back to January 1, 2002 dates of service (October 2004). DCH indicated that several of these procedures were implemented prior to the April 2004 entrance meeting for the Office of the Auditor General audit.

GLOSSARY

beneficiary	A person who is enrolled in Medicaid who can receive medical services that are paid for with Medicaid funds.
beneficiary identification number	The one-of-a-kind number provided by DHS that is distinct to one person enrolled in Medicaid.
DCH	Department of Community Health.
DHS	Department of Human Services.
diagnosis code	A code that the provider uses to indicate the provider's diagnosis for a beneficiary's medical condition.
effectiveness	Program success in achieving mission and goals.
fee-for-service	The method of paying a medical provider for each service rendered.
managed care	The method of paying a provider using managed care health plans (a.k.a., managed care organizations). DCH pays managed care health plans a capitated rate per month per eligible Medicaid beneficiary. Managed care health plans, in turn, pay medical providers for contractually specified medical services provided to beneficiaries enrolled in the plans.
performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve public accountability and to facilitate decision making by parties responsible for overseeing or initiating corrective action.

psychotropic medication	A drug having an altering effect on a person's perception, emotion, or behavior.
reportable condition	A matter that, in the auditor's judgment, represents either an opportunity for improvement or a significant deficiency in management's ability to operate a program in an effective and efficient manner.

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