May 2, 2014

A Performance Audit of Medicaid's Payment and Recoupment for Non-Medicaid Claims

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Report Number 2014-13

STATE OF UTAH

LEE WYCKOFF

Inspector General

Utah Office of Inspector General

Date: May 2, 2014

To: Utah Department of Health

Please see the attached report, **A Performance Audit of Medicaid's Payment and Recoupment Process for Non-Medicaid Claims** (Report 2014-13). The Executive Summary includes the background, objectives, and findings. The Introduction explains the objectives and scope of the audit.

Sincerely,

Lee Wyckoff, CPA, CISA, CFE
Inspector General
Utah Office of Inspector General

cc: David Patton, Michael Hales, Shari Watkins, Gail Rapp, Tracy Luoma, Rick Platt, Shandi Adamson, Janica Gines, Randy Hicks, Darin Dennis, Travis Lansing

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EXECUTIVE SUMMARY

The Department of Human Services (DHS) contracts with the Department of Health (DOH) to administer state only funded medical services at Medicaid rates to recipients of the Custody Medical Care (CMC) and Juvenile Justice Services (JJS) programs. Medicaid first contracted for the JJS program effective July 1, 2010 and CMC in 1995. The Department of Workforce Services (DWS) also contracts with the DOH to administer state funded only medical services at Medicaid rates to recipients of the General Assistance Self-Sufficiency Program (GASSP). All these programs take advantage of the Medicaid infrastructure for non-Medicaid recipients, providing significant savings to taxpayers.

Many JJS and CMC clients receive Medicaid eligibility retroactively, after the clients receive medical services. In these instances, Medicaid manually reprocesses the claims using Medicaid funds.

Federal funding of Medicaid authorizes funding only for Medicaid approved recipients.

Audit Objectives:

1. Determine if Medicaid received compensation from contracted parties adequate to recover costs associated with these programs.
2. Determine if parties to the contracts generally complied with material financial and funding contract terms and conditions.
3. Determine if the transactions for these programs were generally reported properly to CMS.

Audit Findings:

1. Medicaid included Non-Medicaid expenditures for federal match funding and reporting.
The most recent three quarters (January–September 2013) incorrectly included $1,373,003 of JJS and CMC non-Medicaid program costs. The inclusion of non-Medicaid expenditures impacted the federal match and the CMS 64 report causing an overstated amount for multiple years. Medicaid over-reported its expenditures due to incorrect mapping of the non-Medicaid fund types to the Medicaid program codes from the MMIS system.

2. Medicaid did not maximize the recovery of retroactive Medicaid eligibility funding.
The contract requires Medicaid to reimburse DHS in State funds for claims paid "if any recipient should establish Medicaid eligibility." Medicaid reimbursed DHS only for amounts actually recouped and Medicaid did not perform recoupment of all eligible claims. Not maximizing retroactive Medicaid did not cause a loss to Medicaid since DHS, using State funds, reimbursed Medicaid for all costs. The State of Utah, in aggregate, lost the federal match amount on claims not recouped.

INTRODUCTION

BACKGROUND

The Department of Human Services (DHS) contracts with the Department of Health (DOH) to administer medical services at Medicaid rates to recipients of the Custody Medical Care (CMC) and Juvenile Justice Services (JJS) programs. Medicaid first contracted for the JJS program effective July 1, 2010 and CMC in 1995. The Department of Workforce Services (DWS) contracts with the DOH to administer medical services, at Medicaid rates, to recipients of the General Assistance Self-Sufficiency Program (GASSP).

These programs take advantage of the Medicaid infrastructure providing significant savings to taxpayers. State funding pays all costs for these programs.

The client receives a printed form MI706 to give to the healthcare provider. Acceptance of the form MI706 by the medical provider restricts the type of service and the rate; and, acceptance of amounts as payment-in-full.

Medicaid, Bureau of Eligibility Policy (BEP) outsources to DWS the administrative process for determining eligibility for disability, and this service uses the MI706 to obtain medical records, or to authorize Medical services for assessment purposes only, or Medicaid administration.

The CMC and BEP programs allow for non-Medicaid healthcare providers.

Ref	PROGRAM	Medicaid Providers Only	Some Recipients Receive Medicaid Retroactively	Contract Term	Contract	Total Contract Authorized Amount
1	DHS CMC	No	Yes	7/1/12 - 6/30/16	H1206202	$8 Mil
2	DHS JJS	Yes	Yes	7/1/12 - 6/30/16	H1205202	$4 Mil
3	DWS GASSP	Yes	No	7/1/11 - 6/30/14	H1213102	$0.171 Mil As amended
4	DOH / DWS	No	-	2/1/10 - 2/28/13	H111501	Not Specified

Source: Copies of the current contracts obtained from DOH OFO

Many JJS and CMC clients receive Medicaid eligibility retroactively, after the clients receive medical services. In these instances, Medicaid reprocesses the claims using Medicaid funds without consequence to the providers.

The DOH Office of Fiscal Operations (OFO) draws cash on the Federal Medicaid Assistance Percentage (FMAP) to finance Medicaid based on a download from MMIS. OFO files the CMS 64 report, which summarizes all Medicaid expenditures. The CMS 64 must agree with the Medicaid cash drawn.

SCOPE AND OBJECTIVES

Scope: The scope of this audit was limited to activity performed during SFY 2011 and forward; however, test samples emphasized the current periods. We conducted fieldwork at the DOH Division of Medicaid and Healthcare Finance (Medicaid) and the DOH Office of Fiscal Operations (OFO).

Objectives:

1. Determine if Medicaid received compensation from contracted parties adequate to recover costs associated with these programs.
2. Determine if parties to the contracts generally complied with material financial and funding contract terms and conditions.
3. Determine if the transactions for these programs were reported properly to CMS.

METHODOLOGY

To determine if Medicaid received compensation from contracted parties adequate to recover costs associated with these programs, Utah OIG:

1. reviewed contract terms and conditions regarding Medicaid's cost of medical services provided, and Medicaid's cost of administration;
2. reviewed the process of authorizing and paying medical services provided for DWS and DHS;
3. inquired of applicable management regarding employee time and administration cost and analyzed the adequacy of cost recovery; and,
4. reviewed the reimbursement processes.

To determine if parties to the contracts generally complied with material financial and funding contract terms and conditions, Utah OIG reviewed the contracts and the applicable operating processes.

To determine if these claims were reported properly to CMS, Utah OIG conducted interviews and traced a sample of selected transactions for each program to the CMS 64 report preparation and the federal match cash draw, including the MMIS crosswalk to FINET and the final preparation process performed by DOH OFO.

FINDING 1 Medicaid included Non-Medicaid expenditures for federal match funding and reporting.

Federal funding of Medicaid authorizes funding only for Medicaid approved recipients. The Medicaid cash draw and the CMS 64 report should not include any non-Medicaid amounts.

The Medicaid cash draw and the CMS 64 report incorrectly included the non-Medicaid claims on the DHS JJS and CMC, and the DWS GASSP[1] programs. OFO performed the Medicaid cash draw and filed the CMS 64 report based on the incorrect, overstated information that included non-Medicaid expenditures reported by Medicaid.

The inclusion of non-Medicaid expenditures impacted the federal match and the CMS 64 report causing an overstated amount for multiple years.

Medicaid over-reported its expenditures due to incorrect mapping of two non-Medicaid fund types to the Medicaid program codes. The Department of Technology Services confirmed that the two non-Medicaid fund types were incorrectly mapped to the Medicaid program codes.

The three quarters (January – September 2013) most recently available during fieldwork incorrectly included the following non-Medicaid amounts. Annualized, the $1.4 million for the three quarters included in the table below calculates to approximately $2 million. On average, the Federal Medicaid Assistance Percentage (FMAP) paid 70 -72% of Utah Medicaid during the ten fiscal years ended 6/30/2013.[2] Audit testing did not quantify periods prior to January 2013.

Table of Program Costs for CMC and JJS

Program	State Fiscal Year and Quarter	Total Claim Lines	Amount Paid
DHS CMC: Non-Medicaid Claims	2014 Q1	4,351	$123,055
"	2013 Q4	3,742	127,425
"	2013 Q3	4,259	113,105
DHS JJS: Non-Medicaid Claims	2014 Q1	8,790	366,240
"	2013 Q4	7,611	342,943
"	2013 Q3	8,120	300,235
	Total	36,873	$1,373,003

Source: Bureau of Financial Services CMS 64 Database

RECOMMENDATIONS

1.1 Medicaid should correct the program design in MMIS that caused the CMC, JJS and GASSP provider claims to be included in the CMS 64 report and the Medicaid cash draw.

1.2 Medicaid should determine the period for which the CMS 64 report and the Medicaid cash drawn included the DHS JJS and CMC non-Medicaid claims, including the specific claims and amounts incorrectly reported.

1.3 Medicaid should correct the CMS 64 and the Medicaid cash drawn for all prior periods impacted, or negotiate a settlement with CMS.

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[1] The DWS GASSP program for SFY 2013 was only $23,151, immaterial but significant.

[2] See 2013 SFY Utah Annual Report of Medicaid and CHIP, dated 12/23/2013, table 2 page 8.

FINDING 2 Medicaid did not maximize the recovery of retroactive Medicaid eligibility funding.

Many recipients of the DHS CMC and JJS programs receive Medicaid retroactively subsequent to the rendering of state only funded medical services. The contract requires DOH to reimburse DHS in State funds for claims paid "if any recipient should establish Medicaid eligibility."[3]

Medicaid reimbursed DHS only for amounts actually recouped and Medicaid did not recoup all eligible state only funded claims. Medicaid did not recoup all pharmacy claims following the implementation of the Goold Health System in February 2012. The SFY 2014 quarter-two reports listed claims not recouped older than a year for CMC of $113,340 and for JJS $26,596. The report also included some amounts ineligible for recoupment according to management.

Medicaid did not verify that state funded claims eligible to receive Medicaid retroactively were recouped. A MMIS report generated quarterly of JJS and CMC claims included the detail and total amounts recouped. Medicaid did not compare the claims reported as eligible for recoupment the prior quarter to the items reported the following quarter as recouped.

Medicaid policy did not require retaining the "Retro-Active Medicaid Claims" report of items eligible for Medicaid following the recoupment process. Medicaid did not have explanations, as a normal part of the recoupment process, for items not recouped.

Not maximizing retroactive Medicaid did not cause a loss to Medicaid since DHS, using State funds only, reimburses Medicaid for all costs, plus a 3% administrative fee. The State of Utah lost federal match amounts on claims not recouped.

RECOMMENDATIONS

2.1 Medicaid should review activity in past quarters and perform the recoupment process for items eligible but not recouped.
2.2 Medicaid should implement a process to verify that the total quarterly sum of recoupment for the federal match activity reconciles with the prior quarter's reported retroactive Medicaid eligible for recoupment.
2.3 Medicaid should review/establish the policy for retaining the reports and records.
2.4 Medicaid should evaluate the current DHS JJS (H1205202) and CMC (H1206202) contracts for improvements prior to renewal, e.g. liability at the point of eligibility versus actual recoupment.

[3] Contract H1205202 for JJS, special provisions D.5; and Contract H206202 for CMC, special provisions IV g.

APPENDIX OTHER CONTRACT OBSERVATIONS

1. DWS GASSP Contract: Quarterly Billing Required

The contract requires[4] DOH to bill DWS quarterly. During SFY 2013 DOH sent DWS detail records quarterly but waited until after year-end to bill for all 12 months.

2. Medicaid BEP and DWS ESD: Expired Contract

The contract between DOH and DWS, H111501, expired 2/28/13, has no continuation clause. In the absence of a continuation clause, operation between the DOH and DWS became more vulnerable to disruption or dispute. Medicaid management was aware of the expired contract.

The Utah OIG does not require a formal, written response to the two items in this appendix. This page serves to document the discussions with DOH management on these issues.

[4] See attachment B page 1 of 2, paragraph B.

GLOSSARY | ABBREVIATIONS AND TERMS

The report includes a description for each term prior to its first use. The report includes a glossary in the event the reader could not easily locate a description prior to its first use.

Term	Description
BEP	Bureau of Eligibility Policy, a bureau of the Utah DOH DMHF or Medicaid.
CHIP	Children's Health Insurance Program
CMC	Custody Medical Care. A medical program for youth placed in the custody of the Utah DHS Division of Child and Family Services.
CMS	Centers for Medicare & Medicaid Services, the federal division responsible for the State Medicaid programs.
DHS	Utah Department of Human Services
DOH	Utah Department of Health
DMHF	Division of Medicaid Healthcare Financing (or Medicaid)
DWS	Utah Department of Workforce Services
FINET	The Utah State financial information system including general ledger and the related sub-ledgers. Includes all inter-agency transfers.
FMAP	The federal Medicaid assistance percentage provided through CMS to help finance the Medicaid programs. Utah's FMAP is 70-72% overall average, for all Utah Medicaid.
GASSP	The General Assistance Self-sufficiency Program, provided through the DWS to persons between jobs needing medical assistance.
GHS	Goold Health System, the system newly implemented by Utah DOH Medicaid for pharmaceutical coverage. Implemented in early calendar year 2012.
JJS	Juvenile Justice System. A medical program for youth placed in the custody of the Utah DHS Division of Juvenile Justice Services.
MI706	The MMIS online form used for authorizing medical services specifying the CPT codes and limiting pricing to Medicaid rates as payment in full, used by DHS and Medicaid for non-Medicaid recipient clients.
MMIS	Medicaid Management Information System
OFO	Utah Department of Health, Office of Fiscal Operations
SFY	State Fiscal Year, July 1 through June 30.

MANAGEMENT RESPONSE

State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health

W. David Patton, Ph.D.
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

April 30, 2014

Lee Wyckoff, CPA
Inspector General
Office of the Inspector General of Medicaid Services
P.O. Box 14103
Salt Lake City, Utah 84114

Dear Mr. Wyckoff:

Thank you for the opportunity to respond to the audit entitled "A Performance Audit of Medicaid's Payment and Recoupment for Non-Medicaid Claims" (Report # 2014-13). We appreciate the effort and professionalism of you and your staff in this review. Likewise, our staff has spent time collecting information for your review, answering questions, and planning changes to improve the program. We believe that the results of our combined efforts will make a better, more efficient program.

We concur with the recommendations in this report. Our response describes the actions the Department plans to take to implement the recommendations.

The Department of Health is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need to be improved.

Sincerely,

Michael Hales
Deputy Director, Department of Health
Division Director, Medicaid and Health Financing

UTAH DEPARTMENT OF HEALTH

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FINDING 1

Recommendation 1.1

Medicaid should correct the program design in MMIS that caused the CMC, JJS, and GASSP provider claims to be included in the CMS 64 report and the Medicaid cash draw.

Department response:

We concur with this recommendation.

Upon discovery of the MMIS program design error, Medicaid immediately submitted a DOT request which corrected the issue.

Contact: Rick Platt, Director, Bureau of Financial Services, 801-538-7015
Anticipated Implementation Date: Completed

Recommendation 1.2

Medicaid should determine the period for which the CMS 64 report and the Medicaid cash drawn included the DHS JJS and CMC non-Medicaid claims, including the specific claims and amounts incorrectly reported.

Department response:

We concur with this recommendation.

Medicaid will determine the time period for which these specific non-Medicaid claims were included in the CMS 64 report and Medicaid cash draws.

Contact: Rick Platt, Director, Bureau of Financial Services, 801-538-7015
Anticipated Implementation Date: October 1, 2014

Recommendation 1.3

Medicaid should correct the CMS 64 and the Medicaid cash drawn for all prior periods impacted, or negotiate a settlement with CMS.

Department response:

We concur with this recommendation.

Medicaid will work with CMS to determine any necessary adjustments to the CMS 64 report and Medicaid cash draws.

Contact: Rick Platt, Director, Bureau of Financial Services, 801-538-7015
Anticipated Implementation Date: October 1, 2014

FINDING 2

Recommendation 2.1

Medicaid should review activity in past quarters and perform the recoupment process for items eligible but not recouped.

Department response:

We concur with this recommendation.

Medicaid will review past quarter outstanding claims on the retro-active Medicaid eligibility reports (CP060 & CP067). Additionally, Medicaid will make the applicable adjustments for the JJS and CMC claims, as allowed by Medicaid regulations.

Contact: Shandi Adamson, Director, Bureau of Medicaid Operations, 801-538-6308
Anticipated Implementation Date: December 1, 2014

Recommendation 2.2

Medicaid should implement a process to verify that the total quarterly sum of recoupment for the federal match activity reconciles with the prior quarter's reported retroactive Medicaid eligible for recoupment.

Department response:

We concur with this recommendation.

To ensure accurate reporting between the CP060 & CP067 to the CP159A & J, Medicaid will review the quarterly reconciliation process for the JJS and CMC claims. This review will identify the necessary improvements to ensure an accurate recoupment is made each quarter.

Contact: Shandi Adamson, Director, Bureau of Medicaid Operations, 801-538-6308
Anticipated Implementation Date: December 1, 2014

Recommendation 2.3

Medicaid should review/establish the policy for retaining the reports and records.

Department response:

We concur with this recommendation.

Medicaid will submit a DOT task requesting the CP060 & CP067 reports be imported into BMI.

Contact: Shandi Adamson, Director, Bureau of Medicaid Operations, 801-538-6308
Anticipated Submission Date: May 1, 2014

Recommendation 2.4

Medicaid should evaluate the current DHS JJS (H1205202) and CMC (H1206202) contracts for improvements prior to renewal, e.g. liability at the point of eligibility versus actual recoupment.

Department response:

We concur with this recommendation.

Medicaid will evaluate the current *DHS JJS (H1205202) and CMC (H1206202)* contracts for potential improvements.

Contact: Shandi Adamson, Director, Bureau of Medicaid Operations, 801-538-6308
Anticipated Implementation Date: December 1, 2014

EVALUATION OF MANAGEMENT RESPONSE

Management concurs with the findings and recommendations of this report. Management has designated a responsible person to implement changes within a reasonable deadline. Management's response is adequate.

UTAH OIG CONTACTS AND STAFF ACKNOWLEDGEMENT

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UTAH OIG AUDIT SERVICES MISSION

We conduct audits to reduce or eliminate waste, abuse and fraud in the Utah Medicaid Programs for the benefit of taxpayers, Medicaid providers and recipients.

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