Legislative Audit Division

State of Montana

Report to the Legislature

July 2007

Information System Audit

Medicaid Data Review

Department of Public Health and Human Services

This report contains one recommendation for the implementation of more proactive system controls to strengthen an environment that allowed the following exceptions:

- **Medicaid claims submitted for services provided to deceased recipients.**
- **Deceased providers still enrolled as active providers in the Medicaid program.**
- **Medicaid claims that should have been paid by a Third Party Liability (TPL).**
- **Medicaid claims that should have been paid by Medicare.**
- **Eligible recipients not able to receive Medicaid coverage in a timely manner.**
- **Providers without identifiable licensure or certification receiving Medicaid payments.**
- **Duplicate claims submitted for a single service.**

Direct comments/inquiries to:
Legislative Audit Division
Room 160, State Capitol
PO Box 201705
Helena MT 59620-1705

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Members of the IS audit staff hold degrees in disciplines appropriate to the audit process. Areas of expertise include business, accounting and computer science.

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LEGISLATIVE AUDIT DIVISION

Scott A. Seacat, Legislative Auditor
Tori Hunthausen,
Chief Deputy Legislative Auditor

Deputy Legislative Auditors:
James Gillett
Angie Grove

July 2007

The Legislative Audit Committee
of the Montana State Legislature:

We conducted an Information Systems audit of Medicaid claims, recipient, and provider data stored within the Medicaid Management Information System (MMIS). The focus of this audit was on the review and analysis of data to identify exceptions that might indicate control weaknesses elevating the risk of fraud or abuse. The Department of Public Health and Human Services (DPHHS) is responsible for administering the Montana Medicaid program and the storage and maintenance of Medicaid data.

This report contains one recommendation for the implementation of more proactive system controls to strengthen an environment allowing the following exceptions:

- Medicaid claims submitted on behalf of deceased recipients.
- Deceased providers still enrolled as active providers in the Montana Medicaid program.
- Medicaid paying claims that should have been covered by a Third Party Liability (TPL).
- Medicaid paying claims that should have been covered by Medicare.
- Eligible recipients not able to receive Medicaid coverage in a timely manner.
- Providers without identifiable licensure or certification receiving Medicaid payments.
- Duplicate claims submitted for a single service.

We wish to express our appreciation to the department for their cooperation and assistance.

Respectfully submitted,

/s/ Scott A. Seacat

Scott A. Seacat
Legislative Auditor

Room 160 · State Capitol Building · PO Box 201705 · Helena, MT· 59620-1705
Phone (406) 444-3122 · FAX (406) 444-9784 · E-Mail lad@mt.gov

Legislative Audit Division

Information System Audit

Medicaid Data Review

Department of Public Health and Human Services

Member of the audit staff involved in this audit was Nathan Tobin.

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Appointed and Administrative Officials

Department of Public Health and Human Services	Joan Miles, Director
	John Chappuis, Deputy Director
	Mary Angela Collins, Technology Services Administrator
	Russ Hill, Program Compliance Bureau Chief
	Michelle Gillespie, MMIS Project Manager
	Duane Preshinger, Senior Medicaid Policy Analyst

Executive Summary

The Medicaid Insurance program was implemented in 1965 with the passing of Title XIX of the Social Security Act. Medicaid was created to provide health insurance for individuals and families with limited income and resources. As a last resort, Medicaid provides coverage when there are no other alternatives, including a third party insurer or Medicare. In Montana, Medicaid is authorized by 53-6-101, Montana Code Annotated, and Article XII, Section 3 of the Montana Constitution.

The Department of Public Health and Human Services (DPHHS) is responsible for managing Medicaid in Montana. One of the primary duties of DPHHS is determining who is eligible to receive Medicaid coverage and who is eligible to provide Medicaid covered services. DPHHS has developed a computer system, the Medicaid Management Information System (MMIS), as a tool to assist in the administration of Medicaid. This system is responsible for processing and storing information including Medicaid recipients and providers. The MMIS also processes Medicaid claims data.

DPHSS administered $745,119,542 in Medicaid claims during Fiscal Year 2006. Because the Montana Medicaid program is responsible for distributing nearly $750 million dollars, it is important that some type of control environment is in place to recognize and prevent Medicaid fraud and abuse. At the federal level, both the Office of the Inspector General at Health and Human Services (OIG) and the Governmental Accountability Office (GAO) have identified Medicaid fraud as an ongoing problem. Although no official numbers exist regarding fraud levels in Medicaid, the GAO has estimated that between 3% and 10% of all health care costs are the results of fraudulent activity.

The scope of this audit involved reviewing and analyzing data stored in the MMIS to identify any potential control weaknesses. Using a computer assisted audit tool, we compared the MMIS data with other state databases, reviewed for duplicate Medicaid payments, and reviewed participant data to ensure proper eligibility. The purpose of

the data analysis was to identify control weaknesses that might lead to fraud or abuse of Medicaid funds.

Overall, our analysis identified control weaknesses leading to potentially excessive Medicaid payments, deceased recipients who are still eligible, duplicate payments, and eligible recipients not able to receive Medicaid benefits. As a result, we made one recommendation calling for DPHHS to strengthen controls over Medicaid processing and claims payments to ensure Medicaid participant data is accurate, complete, and represent current participation status. Our recommendation stated that DPHHS apply the above recommendation to the specific exceptions we identified.

Chapter I – Introduction and Background

Introduction

Medicaid is a federally and state funded insurance program designed to help individuals and families with limited incomes and resources. When an eligible Medicaid recipient has no other means to pay for health care services, Medicaid will provide partial or full payment. The Montana Medicaid Program is administered by the Department of Public Health and Human Services (DPHHS). The department has contracted with a vendor to assist with administering the Medicaid program, specifically, the development and maintenance of the Medicaid Management Information System (MMIS). The MMIS is a computer system designed to handle claims transactions, as well as maintain Medicaid participant records.

During fiscal year 2006, the department distributed nearly $750 million towards Medicaid claims, of which $208 million was paid by the state. In any given month, roughly 75,000 Montanans participate in this program.

Because the Montana Medicaid program is responsible for distributing nearly $750 million, it is important that some type of oversight is in place to recognize and prevent Medicaid fraud and abuse. At the federal level, both the Office of the Inspector General at Health and Human Services (OIG) and the Government Accountability Office (GAO) have identified Medicaid fraud as an ongoing problem. The GAO has estimated between 3 percent and 10 percent of all health care costs are the result of fraudulent activity. Projecting the three percent rate to Montana Medicaid claims, $22.3 million would have been lost to fraud during the last fiscal year.

With Medicaid considered at high risk for fraud and abuse, DPHHS relies on a combination of computer system and manual controls to identify potential misuse of Medicaid funds by Medicaid participants. These controls include MMIS and TEAMS system controls and oversight through the Surveillance and Utilization Review Subsystem (SURS) in the Quality Assurance

Division of the department. The MMIS is designed to identify claims indicating Medicaid abuse and prevent payment to those claims until further review by department Medicaid examiners. SURS staff also reviews Medicaid claims and recipient eligibility to identify potential misuse of the Medicaid system. SURS is also responsible for recovering any overpayments by Medicaid. During this audit, we reviewed Medicaid claims data to determine the effectiveness of department controls in place to prevent fraud and abuse.

We also looked at controls in place to ensure only eligible recipients and providers are participating in the Montana Medicaid program. State statute (53-6-113, MCA) requires the department to adopt rules regarding the determination and administration of both provider and recipient eligibility. Recipients are those individuals and families deemed eligible for Medicaid services. Both federal and state laws have requirements as to what constitutes eligibility. Federal requirements include:

- Children and pregnant women below a specified income level.
- Low income parents with dependents.
- People with disabilities.
- Foster children.
- Medicare beneficiaries
- Low income individuals with qualifying medical expenses.

The State of Montana has further defined recipient eligibility by requiring recipients to be U.S and Montana residents as well as meet specific financial requirements including income, assets, and resources. They must also fall under one of the following groups:

- Parents or other related adults with dependent children under age 19.
- Children.
- Pregnant women.
- Women diagnosed with breast or cervical cancer or pre-cancer.

- People aged 65 or older.
- People who are blind or disabled (using Social Security criteria).

To become eligible for Medicaid, an individual must submit an application to a department eligibility examiner. The department eligibility examiner will review the application and enter the applicant's data in The Economic Assistance Management System (TEAMS). The department uses TEAMS to administer eligibility to a number of social service programs, including Medicaid. TEAMS feeds recipient eligibility data to the MMIS. Once a recipient is designated eligible in the MMIS, the system will process health care claims on their behalf. We reviewed MMIS recipient records to determine how effectively the department is maintaining current and accurate recipient eligibility information.

Providers are the health care professionals enrolled in the Medicaid program, and are therefore allowed to treat Medicaid recipients and receive Medicaid payment on their behalf. To become an enrolled health care provider, the individual or clinic must show valid licensure or accreditation as defined by state law and provide a valid W-9 form. We reviewed provider data to ensure the department requires Medicaid providers to be licensed to practice in their specified field.

Audit Objectives

Objectives for this audit were to:

- Identify common types of Medicaid fraud and abuse and determine if the department has taken measures to actively mitigate the risk of fraud and abuse.
- Determine if only approved and eligible recipients and providers are participating in the Medicaid program.
- Determine if recipient and provider data is current and accurate.

Audit Scope and Methodology

Within the past year, a third party conducted an audit of MMIS internal controls. We relied on these assurances and conducted no further work in terms of general, administrative, and system controls. During March of 2006, another audit was conducted by the OIG at

the federal level with an emphasis on the security of the MMIS data. To not duplicate efforts, we focused the scope of this audit on MMIS data analysis, specifically, to identify fraud, abuse, or control weaknesses.

We conducted our tests using a combination of extraction and analysis of Medicaid records from the MMIS database using a computer assisted audit tool. This analysis allowed us to identify control weaknesses.

The audit was conducted in accordance with Government Auditing Standards published by the GAO. In addition, we evaluated risk and developed testing based on methodologies developed by other governmental auditing agencies. We also referenced documentation developed by state and federal agencies detailing common types of Medicaid fraud and abuse.

Chapter II – Medicaid Data Exceptions

Introduction

Our audit work involved extracting Medicaid recipient data to look for irregularities or anomalies indicating internal control weaknesses, elevating the risk of fraud or abuse. The following sections describe tests we performed based on commonly known Medicaid fraud and abuse, such as:

- Medicaid claims submitted on behalf of services provided to deceased recipients.
- Deceased providers still enrolled as active Medicaid providers.
- Medicaid claims that may have been paid by a Third Party Liability (TPL).
- Medicaid claims that may have been paid by Medicare.
- Eligible recipients not able to receive Medicaid coverage.
- Providers without identifiable licensure or certification receiving Medicaid payments.
- Duplicate claims submitted for a single service.
- Units charged to a claim exceed the maximum units allowed for a specific procedure.

Deceased Eligible Medicaid Recipients

One common type of Medicaid fraud involves providers submitting claims for services provided to deceased recipients. This occurs most often in nursing home environments where a patient will pass on, but the nursing home will continue to receive the monthly nursing home fee from Medicaid. When the department has identified a deceased Medicaid recipient, the recipient's eligibility is deactivated in TEAMS. TEAMS will update the MMIS with the deceased information. The department relies on a number of controls to remove the deceased from Medicaid consideration.

- Notification from county case workers when one of their clients has passed.
- Review of obituary clippings and the vital statistics registry at DPHHS by SURS to identify any deceased recipients.
- Review of federal Medicare data by SURS to identify deceased recipients who were covered by both programs.

To determine the effectiveness of these controls, we compared MMIS recipient data with the vital statistics database also maintained by the department. The comparison returned five individuals who are deceased but still considered eligible Medicaid recipients. Further analysis shows the department continued to make payments on behalf of two individuals for services occurring after their date of death. Eighty-six claims have been paid on behalf of the deceased totaling $277. These claims were paid over a four year period to three different providers, and as recently as January 1, 2007. The claims range from $3 to $3.85 and are paid on the first day of each month.

Deceased Providers

Additional analysis was conducted to determine if any deceased providers were considered enrolled and active. This was accomplished through comparing the vital statistics database with provider records from the MMIS. Our results show three currently enrolled providers have passed away. Additional analysis showed no payments have been made to these individuals. Upon our notification, the vendor individually reviewed each deceased provider record and stated all but one of these providers' enrollments has been terminated; however, these providers have not been inactivated in the MMIS, increasing the risk that these deceased providers could be used to submit and receive payment for fraudulent claims.

Third Party Liability Insurers Not Paying Their Share

Federal law specifies Medicaid is to be the payer of last resort. This means if other avenues of paying health care costs are available, those entities must be billed before Medicaid. Federal law also requires each state take an active role in identifying other responsible entities and ensuring they pay their share.

One type of entity expected to pay health care costs before Medicaid is a third party liability (TPL). A third party liability is a third party insurer, such as Blue Cross and Blue Shield or New West Health. When a prospective Medicaid recipient is applying for Medicaid, the department relies on recipients to notify county health officials if they are covered by a TPL. This information is entered into TEAMS

as part of a recipient's eligibility information. If a recipient does not notify their department eligibility examiner they are covered by a TPL, that information will not be passed on to the MMIS and the department assumes Medicaid is the primary source for payment.

There are approximately 75,000 Medicaid participants per month. Our goal was to identify Medicaid recipients who are covered by a TPL but not identified as such. We did not have access to Blue Cross and Blue Shield or New West Health records, but we were able to obtain the records for all individuals who are covered by Blue Cross and Blue Shield or New West Health through the state healthcare plan (plan). We compared the plan enrollment records with records of Medicaid recipients.

As of March 2007, we identified 244 individuals who are covered by Medicaid and the state health care plan, but only identified as having Medicaid in the MMIS. Between March 1, 2006 and February 28, 2007, the Medicaid program paid 12,183 claims totaling $3,913,095 to these individuals. Of this $3.9 million, at least a portion may have been covered through the state healthcare plan.

It is important to note that the population we tested was from a single insurance plan representing a small percentage of private insurance membership in the state.

Medicare Responsibility

Medicare is another entity responsible for paying health care costs before Medicaid. Medicare is a federally funded health insurance program for individuals over the age of 65, blind, or disabled. The primary way for the department to identify individuals eligible for both Medicaid and Medicare is for the department eligibility examiner to obtain this information from the recipients during the Medicaid application process. If the recipient does not notify the department they are also covered by Medicare, the department relies on Medicaid providers and federal Social Security data to recognize dual eligibility.

Comparing eligibility data to MMIS recipient data, we identified 15 individuals considered eligible for both Medicare and Medicaid in TEAMS, but only identified as having Medicaid in the MMIS. If TEAMS does not feed the Medicare notification, the MMIS does not recognize a recipient has Medicare and Medicaid will pay the bill. Our analysis shows that from January 2003 to February 2007, 1,399 claims totaling $111,454 had been paid by Medicaid on behalf of these 15 individuals while covered by Medicare. A portion of this amount may have been covered by Medicare.

The department reviewed these exceptions and state that six of these individuals are not eligible to receive Medicare because they have not worked the necessary number of quarters in their lifetime. The department also represents that one of the individuals is deceased, but is not included in our count of deceased recipients. Eight of the individuals are exceptions who are eligible for Medicare but not recognized as such in the MMIS.

Over 65 and Not Enrolled in Medicare

Department policy requires all Medicaid recipients who are eligible for Medicare to enroll in that program. The department will periodically review the list of Medicaid recipients for individuals who are about to turn 65. Unless they have not worked a minimum number of quarters during their life, they will be eligible for Medicare. When the department identifies these individuals, they send letters notifying them that once they turn 65, they need to apply for Medicare or their Medicaid benefits will be suspended. If a Medicare eligible individual does not apply for that program, their Medicaid coverage will be suspended. However, data analysis of the MMIS shows exceptions to this policy.

A review of MMIS recipient data identified 34 individuals over the age of 65 that have not enrolled in Medicare but are still receiving Medicaid benefits. Further analysis shows that between March 1, 2006 and February 28, 2007, 1,298 claims totaling $432,486 have been paid by Medicaid on behalf of these recipients, of which a portion should have been covered by Medicare.

The department has reviewed these exceptions and state that 17 of these individuals are not eligible for Medicare because they have not worked a sufficient number of hours in their lives. They also state that 10 of these individuals are dead, although these names are not included in our count of deceased recipients. Of the remaining seven exceptions, the department represents that two recipients have appropriately had their coverage suspended and two recipients were still receiving Medicaid coverage even though they have not enrolled in Medicaid. The department has not identified the status of three of the exceptions.

Eligible Medicaid Recipients Not Receiving Coverage

The department relies on a transfer of data from TEAMS to the MMIS to ensure all eligible recipients are fed to the MMIS. A data comparison between individuals listed as Medicaid eligible in TEAMS and individuals listed as eligible in the MMIS system shows discrepancies. We identified 994 individuals who were eligible for Medicaid, but were not being covered because their information had not been uploaded to the MMIS. This comparison was done on March 6, 2007.

A second comparison was done on April 2, 2007 and five of these individuals had still not been transferred to the MMIS. Department personnel explained new recipients should be uploaded to the MMIS on a nightly basis. Our test has shown a delay between when an applicant is deemed eligible and when they are able to have claims paid on their behalf. This could result in individuals not receiving the Medicaid benefits to which they are entitled.

The department represents that the reason these five individuals had not been added to the MMIS is because their eligibility data from TEAMS contained an error. If a data field is incomplete or inaccurate, the MMIS has controls to identify the exception and then reject the recipient data. TEAMS personnel are notified of the error and required to address it before the MMIS will accept the recipient. For the five exceptions identified during our testing, the process to correct their data took over a month. They were not able to receive Medicaid coverage during this time.

Providers Without Proof of Licensure or Certification

State statute requires the department to adopt rules regarding who can provide Medicaid services. Department administrative rules state that participating Medicaid providers must supply proof of licensure or certification in their field of practice. The department has contracted with the vendor to ensure documentation is provided before allowing participation in the program.

Vendor staff will review provider applications for appropriate materials and proof of licensure. Participants are added to the MMIS system as enrolled Medicaid providers and can begin submitting claims for services provided to Medicaid recipients. Our review of MMIS provider data identified 678 providers that have no identifiable license or certification number in the system. Our analysis does not suggest the providers are not qualified, but the system does not identify a license or certification number. We did not go through 678 files to validate credentials. During the month of February 2007, 3,560 claims totaling $1,136,770 were paid to these providers.

The department has reviewed these exceptions and state that 526 of these providers have been terminated and the remainder of the providers are appropriately licensed. They represent that license or certification numbers are not a required field in the MMIS. However, our review shows they included a field for license numbers and the majority of providers have a license number in the system.

Duplicate Payments

One common type of Medicaid fraud involves providers submitting multiple claims for a single service. The department represents the MMIS system has controls in place to identify duplicate payments. If two claims are found with the same date of service, the same reimbursement amount, the same provider, the same recipient, and the same procedure; the claims will be suspended and not paid until further review. However, our analysis of MMIS claims data identified a number of exceptions. Reviewing claims records from March 01, 2006 to February 28, 2007, we identified 279 sets of duplicate claims that meet the above criteria, but had still been paid. Payments made on these claims total $49,872. Only claims submitted

by two provider types, physicians and dental, were tested. These claims represent only a portion of claims paid by Medicaid during this time period.

The department states that only 13 of these claims were paid in error. The remaining 266 duplicates were deemed acceptable by the department. The department has documentation detailing procedures for which claims can be submitted multiple times in a single day. However, the department does not have a policy supporting or explaining why these specific duplicate claims are allowed.

Department management represents the MMIS has controls in place to prevent duplicate payments. Data analysis identifies exceptions to these controls. The department has procedures in place, but management represents that due to the confusing nature of the procedures, duplicate payments have been erroneously paid.

Excessive Units Charged to Medicaid Claims

Another form of Medicaid fraud involves providers creating claims for services never provided. One way to test for this type of fraud is to look at providers who charged an unreasonable amount of units in a certain time frame. Charging for more hours than there are in a day would be an example. Units can also include fifteen minute internals, mileage traveled, or products sold.

The MMIS has controls in place to identify claims where excessive units are charged. The MMIS has parameters defining the maximum number of units a provider can charge for a specific procedure. To verify the effectiveness of this control, we reviewed MMIS claims records to determine if any providers have charged for more units than the maximum allowed. We reviewed all claims paid to physicians for January and February of 2007. The analysis returned no claims where units charged exceeded the maximum allowed.

Conclusion

Data exceptions are a symptom of a greater cause. Based on our extraction and analysis of data residing in the MMIS, we determined TEAMS is a significant control for determining eligibility and providing MMIS with recipient data for payment and claims.

Chapter II – Medicaid Data Exceptions

Exceptions indicate TEAMS is not providing the control structure on which management relies. These control weaknesses increase the risk of Medicaid fraud and abuse. Department management recognizes TEAMS is an outdated system and is required to perform too many tasks. The department has received funding for a new eligibility system for the Medicaid program. When a new Medicaid eligibility system is developed, automated controls should be included to address the findings in this report. We conducted a survey of TEAMS users and compiled their comments regarding TEAMS. Survey results can be seen in Appendix A.

Based on our analysis, provider data in the MMIS is not being maintained in an accurate and complete manner.

We have identified data exceptions resulting in overpayment by Montana Medicaid. State law (53-6-111, MCA) charges the department with supervision responsibilities of the Medicaid programs and the responsibility of recovering overpayment. It is the department's responsibility to investigate these findings and identify and recover any overpayment.

Recommendation #1

We recommend the department:

A. Strengthen controls over Medicaid processing and claims payment to ensure Medicaid participant data is accurate, complete, and represents current participant status, including:

- **Ensuring deceased recipients and providers are not eligible to participate in the Medicaid program;**
- **Identifying Medicaid recipients who are covered by a TPL or Medicare;**
- **Ensuring all eligible recipients are able to receive Medicaid benefits in a timely manner;**
- **Ensuring all providers have identifiable licensure or certification; and**
- **Identifying duplicate claims for a single service.**

B. Investigate exceptions and recover any overpayments made by Medicaid, including:

- **Claims paid to deceased recipients;**
- **Claims paid by Medicaid that should have been paid by a TPL or Medicare; and**
- **Duplicate claims for a single service.**

Appendix A – TEAMS Survey

Vulnerabilities in the Data Input Process

TEAMS is a mainframe system developed in 1990. Because The Economic Assistance Management system (TEAMS) is considered a vital control in establishing eligibility for a number of federal programs, the Information Systems audit staff conducted a preliminary review of the application. During initial interviews, we verified that eligibility determination and benefit calculations for food stamps, Medicaid and Temporary Assistance to Needy Families (TANF) are directly affected by the codes entered by the eligibility examiners. Because of the intricacy of the federal and state regulations addressing the federal programs administered by TEAMS, the considerable number of applicable input codes, and the need to force the system to obtain accurate output depending on the program, the input process is vital and complex. We determined a number of concerns related to the input process for TEAMS, for example,

- We determined the data input process requires examiners to implement "work-arounds" for effective processing. A 'work-around' is a way to enter information in a way not originally designed, to get the desired outcome until the system can be updated to accomplish the same outcome using the codes as designed.
- We determined some work-arounds become permanent if it is determined that the benefit of manipulating the input is more cost-effective than paying for a programming change.
- We determined the communication of 'work-arounds' to examiners is not always consistent. Responsibility lies with the Policy Bureau, but sometimes the helpdesk will notify when a problem call is received and a work-around has been designed to fix.
- We determined eligibility and/or benefit amounts can be incorrect if a work around is not performed.
- We determined the number of specific work-arounds eligibility examiners apply is not certain.

One of the risks associated with public assistance is the potential for benefits to be provided to ineligible individuals. Because of the concerns with the data input process, we conducted a survey of TEAMS users to identify vulnerabilities within the system that create

opportunities for ineligible benefit issuance. The intent of the survey is to obtain information from system users and to provide the department the opportunity to use this information and design controls in the anticipated replacement system to address the risks.

Survey Results

Two hundred and eighty-nine users responded to the survey and 35 percent of the respondents feel there are weaknesses within TEAMS that would allow an individual to obtain public assistance when they should not. The following is a representation of the weaknesses disclosed in the survey results. These statements are generalized comments and testing was not conducted to verify the validity of each comment.

1. Please describe the weakness or weaknesses within TEAMS that would allow public assistance to be inappropriately awarded. (92 responses)

- TEAMS users have the ability to create fictitious applicants and obtain benefits for themselves.
- TEAMS users could obtain benefits through fictitious applicants by creating cases with information that has already been verified from closed cases.
- TEAMS users could obtain the benefits of applicants, by neglecting to close the case and redirect the benefit to them.
- TEAMS does not interface with other state's benefit applications so an individual could collect benefits in multiple states.
- There is no TEAMS report that compares residence address to mailing address.
- TEAMS functionality can pull forward outdated applicant information (i.e. income, resources, etc) into the next month and inaccurately determine eligibility and benefit amounts.
- Social Security benefits do not interface with TEAMS. Workers are required to 'dummy' the unearned income screen to authorize benefits at the previous months' amount.
- TEAMS is very cumbersome and confusing, especially for a new worker. This complexity is error prone.
- Able Bodied Adults without Dependents (ABAWD) is a type of food stamp public assistance that is time limited. TEAMS does

not track the number of months an applicant has received ABAWD and this must be manually tracked by agency workers.

- The policies governing the public assistance programs TEAMS manages (TANF, Food Stamps, and Medicaid) are very different and the TEAMS vehicle screen (used in TEAMS financial eligibility determinations) is not designed to accommodate each programs unique requirements.
- Expedited food stamps can be issued with little or no verification of applicant eligibility factors, which may result in benefit issuance to ineligible individuals.
- Income is an eligibility factor for some public assistance programs. TEAMS does not contain functionality to calculate an applicant's income and income must be manually calculated by eligibility examiners. The calculated income is then entered into TEAMS. If income is inaccurately calculated, eligibility may be inappropriately granted or denied.
- Incorrect code selection can result in inaccurate eligibility determinations.
- TEAMS eligibility determination process is based on codes selected and input by eligibility examiners.
- TEAMS does not perform cross referencing between cases to determine if residential addresses are registered to more than one applicant. As a result, multiple benefits could be issued to the same household.
- Applicants can be entered into TEAMS more than once under different cases and potentially receive duplicate benefits.
- TEAMS does not require input of applicant income and resource information (factors in benefit eligibility determinations) and benefits could be authorized inappropriately.

2. Based on your knowledge of the Food Stamp, Medicaid, and TANF programs, are there weaknesses within the program rules and/or benefit policy manuals that would allow an individual to obtain public assistance to be inappropriately awarded.
   (256 responses)

- Policy rules are different for almost every program. Very complex and dynamic changes.
- There is no black or white for staff to follow. Everything is gray.

- These are complicated policies that are being applied to a limited computer system that is how old?
- The policy manuals are available on-line so a household can figure out a way to become eligible for assistance.
- Supervisor review should be required on all newly opened cases as a deterrent.
- Policy is often given to agency staff after the implementation date or without time to review and learn the new requirements.
- Ability to revert a case that legitimately closed to open and send benefits to themselves.
- Training is inconsistent and often confusing, questions cannot be answered.
- Mostly within Medicaid, there are a lot of loopholes regarding resources.
- Policy can be very confusing and different among programs. Either similar rules or separate systems.
- It is becoming increasingly difficult to communicate with other states on potential duplicate benefits.
- No consistent application of policy. First reviewer says I was wrong, second reviewer says my correction was wrong. Who's correct?
- Since food stamp policy is hammered into workers' heads, workers often apply food stamp policy to all programs. For example, food stamp policy tells people not to report changes for 6 months, while other programs require changes to be reported every 10 days.
- The cryptic codes in TEAMS do not help with applying policy correctly for all programs.
- Policy regarding joint assets needs to be reviewed. Clarification on policy regarding self-employment income.
- Inconsistent training on policies. There are too many grey areas as far as the user manual is concerned. Much is left up to the case worker's interpretation which differs from management interpretation.
- Food stamp policy does not require resource verification.
- Reference to an approval on the Medicaid waiver program where the parents claimed $293,000 in resources.
- A worker can enter through all the screens and benefits can be authorized.

- No penalties for transfer of assets, no time limits or work requirements for Medicaid.
- Take someone's word on resources, benefits from another state, whether someone is living in the household, etc.
- Policy or procedure regarding client statement verification instead of hard copy verifications.
- Misrepresentation and inaccurate information from policy specialists.
- Require picture ID for all adults on the system.
- Disregard sources of income such as student grants. TANF is time limited and supposedly the program of last resort but several sources of income are disregarded for all programs.
- Six month reporting requirements are taken advantage of all the time. Self-employment applicants should be reviewed for a more favorable position than normal wage earners.
- Student eligibility criteria are confusing.
- The sanctioning process is not strong enough and has many loopholes.
- Cases can be fabricated and benefits incorrectly issued.
- Policy regarding vehicles is a weakness. Medicaid recipients can be driving very expensive cars.
- Encouraged not to fish for verification information. Even when appropriate, this is considered client harassment.
- The honesty and integrity of employees is key.

Department Response

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

BRIAN SCHWEITZER
GOVERNOR

JOAN MILES
DIRECTOR

STATE OF MONTANA

www.dphhs.mt.gov

July 6, 2007

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LEGISLATIVE AUDIT DIV.

Mr. Scott A. Seacat
Legislative Auditor
Office of the Legislative Auditor
State Capitol, Room 160
Helena, Montana 59620-1705

Dear Mr. Seacat:

I have reviewed the final report of the Information Systems Audit of the Medicaid Data. We appreciate the review by the Legislative Audit Division and appreciate the opportunity to discuss the Medicaid Management Information System (MMIS). Below is our response to the findings listed in the report.

Recommendation #1

A. We recommend the Department of Public Health and Human Services strengthen controls over Medicaid processing and claims payment to ensure Medicaid participant data is accurate, complete, and represents current participant status, including:

Ensuring deceased recipients ...are not eligible to participate in the Medicaid program;

Concur
The audit identified $277 in system-generated claims paid on behalf of deceased recipients. These automatic claims, ranging from $3 to $3.85, are generated monthly by MMIS to pay for certain Medicaid functions, such as Disease Management and Passport. We are taking the appropriate actions to correct our systems and repay the federal government.

Please note that the only claims paid for these individuals by the MMIS are system-generated; there were no provider-submitted claims paid for service dates following the participants' death.

Technical Correction
We have one technical correction related to the identification of deceased recipients. The report stated that Surveillance and Utilization Review (SURS) unit takes steps to identify deceased recipients, however this is incorrect; identification of deceased recipients is the responsibility of the Third Party Liability (TPL) unit.

Ongoing Efforts
Currently, the Department utilizes the following services to identify deceased recipients:

- Obituary clipping service
- Daily automated match with Social Security through BENDEX
- Monthly automated transactions with Centers for Medicare and Medicaid Services (CMS) via Medicare buy-in
- Manual access to vital statistics
- Notification to identify deceased individuals through Department staff

New Efforts
The Department will continue to review this area to determine if there are additional processes that can be developed or utilized that would enhance our ability to quickly and efficiently identify when a Medicaid individual is deceased. The development of the new Medicaid eligibility determination system (CHIMES) will provide new opportunities for automated verifications and more efficient business processes.

Ensuring deceased ...providers are not eligible to participate in the Medicaid program;

Concur
All of the deceased provider numbers identified in the audit have been terminated. The Department will continue to look for cost effective processes that would enhance our ability to quickly and efficiently identify when a Medicaid provider is deceased.

Ongoing Efforts
The Department currently terminates provider numbers under the following scenarios:

- mail is returned and research shows the provider is deceased;
- a provider does not receive a 1099 for two years;
- information is found during the course of verifying a provider's licensure; or
- we are notified of the death of a provider.

Scheduled Improvements
The department will increase our assurance that provider information is accurate and up to date by:

- completing the reenrollment of all Medicaid providers;
- utilizing information received from the clipping service;
- recertifying all providers every two years; and
- terminating any provider who does not receive a 1099 report in any given year.

Identifying Medicaid clients who are covered by a TPL…;

Concur
We will strengthen our efforts to identify Third Party Liability (TPL) and work to recover all verified Medicaid overpayments.

Ongoing Efforts
The Department uses many processes to identify, investigate and verify third party coverage for Medicaid clients including ongoing reviews of:

- the Medicaid application;
- claims with evidence of other payers;
- information received from providers;
- a list of absent parents with court ordered insurance coverage of the children; and
- a list of SSI individuals.

New Efforts
Several business process improvements have been implemented during or since the period covered in the audit including strengthening the request-for-coverage-information language on the Medicaid-only application and implementing two new automated data matches. Department personnel utilize the Public Assistance Reporting Information System (PARIS) and National Directory of New Hires to identify employment with potential health coverage, veteran's benefits, federal employee health coverage, military health coverage and multiple state benefits.

Scheduled Improvements
The Department has several measures planned to continue to improve on the identification of Third Party Liability coverage including:

- updating the language on the generic public assistance application at the next printing and
- including TPL specific sessions in the upcoming training conference planned for OPA workers in September, 2007.

During the 2007 Legislative Session, the Department worked with Representative Edith Clark to introduce House Bill 77. HB77 was successfully passed and will become law effective July 1, 2007. This new law enhances the Department's authority to work proactively with health carriers operating in the State of Montana. With the passage of this bill, the Department has embarked on system development to automate data matches with the largest health carriers operating in Montana.

Identifying Medicaid clients who are covered by …Medicare;

Do Not Concur
We believe our process for ensuring Medicare coverage functions well and do not agree that any overpayments or control weaknesses were identified during this review.

We researched the records for all 15 individuals identified in the audit report as being eligible for both Medicaid and Medicare, and determined eight are not eligible for Medicare, one is deceased, and six are still open and active for both Medicare and Medicaid. For each of the 15 individuals the information on TEAMS matches the information in MMIS.

We also reviewed the records for all 34 individuals identified as being over age 65 and not enrolled in Medicare, potentially resulting in an overpayment in the amount of $432,486. The Department does not agree with this finding and through additional research has found there is no error or overpayment for the following reasons:

- 17 of the 34 individuals are not eligible for Medicare. An individual can be 65 and not eligible for Medicare due to not having worked a sufficient number of quarters.
- 10 of the differences occurred as a result of a date of death closing Medicare one month before the Medicaid span closed. For individuals whose date of death occurs in the last 10 days of the month, they may have their Medicare spans close at the end of the month in which they die; however, their Medicaid spans can not be closed without giving 10 days notice. Therefore it is possible for a person's Medicare span to be closed at the end of one month and their Medicaid span to close at the end of the following month. In each of the 10 cases identified the date of death was entered in a timely manner and MMIS has safeguards in place to prevent the payment of a claim for dates of service after the person's date of death.
- The remaining 7 cases have Medicare spans that have subsequently been properly identified and entered in both TEAMS and MMIS. The issue we face in these cases is related to timing of receiving data. In the event Medicare eligibility is loaded retroactively, the Department has a mechanism to reprocess claims that should have been paid by Medicare and not Medicaid.

Technical Correction
The report notes that the primary method for identifying Medicare eligibility information is from the participants. While the Department does collect insurance information from the participants, the Department also uses a nightly Medicare data match with Social Security Administration. As a result of this data match, the Department is more assured that the Medicare information is entered in the TEAMS system timely and accurately.

Ensuring all eligible recipients are able to receive Medicaid benefits in a timely manner;

Partially Concur
We agree that it is imperative the Department ensures all eligible recipients are able to receive benefits in a timely manner; however, we are meeting this goal with the tools currently available to us.

The Department has a policy in place to ensure that Medicaid client information is accurately loaded. The policy prohibits participant information from being electronically exchanged between TEAMS and MMIS if there is any indication of an error. It is imperative that duplicate or inaccurate records are not loaded into the MMIS system. If the data exchanged between the TEAMS system and the MMIS system does not match, the eligibility data is not

loaded and the information is reported on a reject report. Department policy requires that any discrepancies are resolved prior to loading questionable data into the claims processing system. While this investigation takes time it is invaluable in ensuring only eligible participants receive benefits.

While discrepancies between the two systems are being resolved, the local Office of Public Assistance frequently provides assurance of eligibility to providers via written, faxed or verbal communications. While these alternative confirmation processes are not ideal, they do ensure the participants have access to medical care.

The Department is currently developing a new eligibility system, CHIMES, which is being designed to alleviate many of the discrepancies. We are projecting the new system will be operational by fall, 2008.

Ensuring all providers have identifiable licensure or certification;

Partially Concur
We agree that is our responsibility to ensure all providers have the appropriate licensure or certification. However, the Department does not concur that we have any providers enrolled without identifiable licensure or certification. All providers enrolled meet licensure and credentialing criteria approved by the Department for each provider type. The type of credentials required is determined by the type of provider enrolling, and is verified during the enrollment process. The information is not a required field in MMIS due to the variety of licensure and certification types.

We reviewed all 678 providers listed on the reports as not having appropriate licensure and have verified that:

- 530 provider numbers are terminated providers that were properly credentialed while they were active,
- one provider number is used by Department and Fiscal Agent staff for systems verification but cannot be used to bill claims as the number has no category of service spans, and
- the remaining 147 providers listed have current credentials appropriate for the provider type.

Identifying duplicate claims for a single service

Concur
The duplicate edit system in the MMIS is a labor intensive process and requires a claim examiner to follow written instructions regarding whether a claim with a duplicate payment is either paid or denied. Our MMIS system was implemented in 1985 and lacks certain functionality to process the duplicate claims edit electronically. With funding passed by the 2007 Legislature, the Department is pursing a consultant to assist in the analysis of our current MMIS and provide recommendations and a cost-benefit analysis regarding whether to continue with our existing system, implement a major system enhancement or proceed with a replacement of our MMIS system. This analysis should be complete by April, 2008. Should

the Department decide to pursue a major enhancement or system replacement, funding would be requested through the 2009 Legislature.

Of the 279 duplicate payments identified, 13 of the services identified were true duplicates and paid in error. The overpayments on these claims have been credited and the money has been recovered. The remainder of the payments has been re-verified as appropriate and in accordance with the department's written instructions.

New Efforts
Fiscal agent staff assigned with completing the duplicate claim review process have received additional training related to the written instructions.

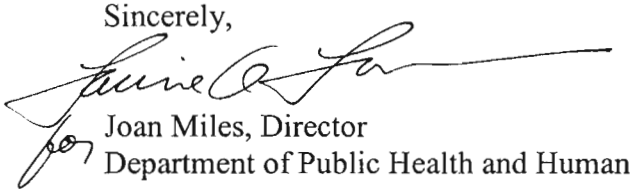
B. Investigate exceptions and recover any overpayments made by Medicaid, including:

- **Claims paid to deceased recipients;**
- **Claims paid by Medicaid that should have been paid by a TPL or Medicare; and**
- **Duplicate claims for a single service.**

Concur
We have completed an extensive review of the audit errors identified. We have or will recover all verified overpayments.

If you have any questions regarding our response, please contact Marie Mathews, Business Services Bureau Chief at (406) 444-5369 or Duane Preshinger, Senior Medicaid Policy Manager at (406) 444-4145.

Sincerely,



Joan Miles, Director
Department of Public Health and Human Services

cc: John Chappuis, State Medicaid Director
Gail Briese-Zimmer, Office of Planning, Coordination & Analysis Administrator
Duane Preshinger, Senior Medicaid Policy Manager
Mary Angela Collins, Technology Services Division Administrator
Michelle Gillespie, MMIS Coordinator
Laurie Lamson, Business and Financial Services Division Administrator
Marie Matthews, Business Services Bureau Chief
Jeff Buska, Quality Assurance Division Administrator
Russ Hill, SURS Compliance Bureau Chief