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.