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Report on Limited Procedures Engagement - Cost of Care, 2013

Maine Office of the State Auditor

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October 29, 2013

Mary Mayhew, Commissioner
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

Dear Commissioner Mayhew,

The Office of the State Auditor conducted a limited procedures engagement of the Department of Health and Human Services' computation and application of Cost of Care amounts to provider payments for the nine month period July 1, 2012 to March 31, 2013.

We have completed our report and DHHS has responded to our concerns in writing. These responses have been incorporated into our report and the report is attached to this letter.

Our report will be available on the Office of the State Auditor website at http://www.maine.gov/audit/reports.htm, in the section for Other Reports.

We thank Deputy Director Michael Frey, Director Bethany Hamm, Acting Director of Policy Beth Ketch, Director Stefanie Nadeau, and their staff; as well as the Department of Administrative and Financial Services (DAFS), Office of Information Technology and Department of Health and Human Services Service Center personnel for their assistance during this engagement.

Sincerely,

Pola A. Buckley, CPA, CISA
State Auditor

cc: Honorable Dawn Hill, Chairperson, Appropriations and Financial Affairs
Honorable Margaret Rotundo, Chairperson, Appropriations and Financial Affairs
Honorable Margaret Craven, Chairperson, Health and Human Services
Honorable Richard Farnsworth, Chairperson, Health and Human Services
Honorable H. Sawin Millett, Commissioner, Department of Administrative and Financial Services
Jim Smith, Commissioner, Office of Information Technology
Michael Frey, Deputy Director, DHHS
Herb Downs, Director, DHHS, Division of Audit
Ray Girouard, Director, Department of Administrative and Financial Services, DHHS Service Center
Bethany Hamm, DHHS, Director, Policy and Programs
Beth Ketch, DHHS, Acting Director of Policy
Stefanie Nadeau, Director, DHHS, Office of MaineCare Services

Office of the State Auditor
Report on Limited Procedures Engagement – Cost of Care
Report Issued On October 29, 2013

Summary

The Office of the State Auditor reviewed internal controls over the calculation, application and review of Cost of Care amounts assessed to long term care (LTC) facility residents for the first nine months of fiscal year[1] 2013. The term "Cost of Care" refers to a MaineCare member's personal monthly required contribution towards his or her nursing home (NH) or private non-medical institution (PNMI) facility care. This amount is separately calculated for each resident based on their financial situation. In effect, Cost of Care is a "deductible" that an individual must pay to live in a Long Term Care (LTC) facility. LTC facilities collect this amount directly from residents eligible for the State LTC program, bill MaineCare for the usual and customary charges; and then, the claims processing system, the Maine Integrated Health Management Solution (MIHMS) is supposed to deduct the Cost of Care. LTC providers are required to return overpayments when MIHMS does not make this deduction.

The Office of Family Independence (OFI) coordinates eligibility for the various LTC Assistance Group programs that provide MaineCare benefits for certain Medicaid or state funded coverable group residents; and the Office of MaineCare Services (OMS) is responsible for payments to the NH and PNMI facilities in Maine. The Office of the State Auditor finds that improvements are needed. These needed improvements are identified in this report.

We found that known logical errors in the Automated Client Eligibility System (ACES) frequently cause income and expense information for LTC residents to be incorrect or missing. This results in Cost of Care assessments calculated by ACES to be incorrect. In order to address this, OFI personnel are required to apply "manual workarounds" to correct any errors they find in client case information pertaining to Cost of Care. Test results indicated that OFI staff did not always apply manual fixes correctly; and that other system errors remained undetected by staff altogether.

Furthermore, we found that MIHMS is not appropriately deducting Cost of Care amounts; and system edits were not appropriately set to deny, pend or re-open claims for review in two circumstances. In both circumstances, providers were or would be paid by both the resident and by MIHMS for the same monthly room and board costs. Immediately following is a description of the audit procedures performed, the results of those applied procedures and our conclusions and recommendations.

Range of Estimated Financial Impact

OFI Assessments: Total Cost of Care assessed to potential LTC residents for the first nine months of fiscal year 2013 was $89 million. Audit procedures applied to our sample indicated that nine (or, about 15%) of the sixty Cost of Care assessments tested remained in error despite manual correction by OFI staff in some cases. The dollars associated with the 15% error rate were minor because income and expense errors offset each other.

OMS Payments: Based on eligibility calculations, the theoretical maximum[2] Cost of Care deduction from LTC provider payments for the first nine months of fiscal year 2013 is $89 million. We estimate that the actual Cost of Care deductions that should have been taken for the first nine months of fiscal year 2013 are $76 million (85%[3] of $89 million). We found that in a sample of sixty randomly selected claims and interim rates set by the Department, providers were overpaid by $16,924 (or about 29%) of the total $57,713 Cost of Care amounts. Twenty-nine percent of $76 million is $22 million, *annualized* this amounts to $29 million. We know that DHHS has some procedures in place to recover these funds since the MIHMS implementation in 2010. However, we believe these procedures are far from adequate and do not address the root causes on a timely basis.

Included in the $16,924 overpayment amount are $6,324 of MIHMS payment processing errors identified in more detail below, for five NH payments and two PNMI facility payments.

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[1] All references to a fiscal year are for the State fiscal year ending June 30.

[2] Not all individuals assessed a Cost of Care amount by OFI reside in a NH or PNMI. Some choose to stay at home, or remain in a hospital or other LTC facility type.

[3] Nine of our original 60 item sample used to test OFI Assessments had to be replaced because they were not yet residing in an NH or PNMI. Therefore, our testing indicates that approximately 15% of individuals for whom a potential Cost of Care was calculated, were not yet residing in a NH or PNMI.

The remaining $10,600 was because Cost of Care was not fully deducted from twenty-two other PNMI claims, or over 75% of the 30 PNMI claims sampled prior to payment. One issue is that although these PNMI payments were for residents eligible for Medicaid, Cost of Care deductions were not applied to all their monthly federal and State charges because such deductions are not allowed by this federal program for residents of PNMI facilities. The other issue is that these PNMI overpayments were primarily due to a nominal amount of $1 per day being paid for room and board on an interim basis until costs are settled annually. Obviously, PNMI providers cannot function on a periodic payment of one dollar per day per resident. Except for the one dollar per day, DHHS classifies the payment as All Inclusive Comprehensive and Other Therapeutic Services, which we find to be misleading, at the least. DHHS has a manual partially effective procedure in place to recover overpayments from these providers. However, MIHMS continues to overpay; OMS continues to seek recoupment from providers; OMS provides some receivable amounts to HHSSC[4] as a limited number of PNMI providers send in payments; OMS continues to track remaining balances and offset amounts; and applicable credits should be applied by HHSSC to the quarterly federal financial report. Some providers are cooperating, and some are not. This "overpay and recover" procedure cannot mitigate the fact that at any given time about $27 million or more of State and federal money is not available for government use. It remains unclear why OMS has assumed sole financial responsibility for these overpayments, rather than with the HHSSC. The Service Center is ultimately responsible for crediting the federal share of these overpayments on the federal CMS-64 reports. This is a serious matter that deserves priority attention by the State.

Background

We originally discovered issues with Cost of Care while auditing Medicaid for fiscal year 2006. These issues might have existed prior to this date. Cost of Care amounts had not been deducted from NH or PNMI facility payments correctly; and the result is that providers were being paid both by the MaineCare member and by MaineCare.

Problems persist in the current MIHMS system.

Procedures

We performed the following procedures[5] for the nine month period ending 3/31/2013:

- reviewed State law pertaining to Cost of Care,
- reviewed relevant sections of the State Medicaid Manual promulgated by the federal government, the MaineCare Eligibility Manual and the MaineCare Benefits Manual,
- evaluated OIT technical design documents that depict how ACES assesses Cost of Care for individuals and related mechanical and human controls,
- evaluated OMS and fiscal agent technical design documents that depict how MIHMS adjudicates Cost of Care for individuals and the related mechanical and human controls,
- determined whether the MIHMS system logic is correct,
- tested the accuracy of a sample of sixty Cost of Care assessments[6] made by ACES for clients that are classified as members of certain DHHS program coverage groups residing in NH and PNMI facilities,
- tested the accuracy and success rate of manual compensating controls[7] over the same sixty Cost of Care assessments,
- tested sixty claim payments to LTC providers to determine whether payments made to providers for monthly resident charges were reduced by Cost of Care amounts[8],
- tested existing compensating controls, such as "pend or deny" edits in MIHMS, that would force resolution of payment errors related to Cost of Care for a sample of sixty NH and PNMI provider payments,
- tested the consistency of eligibility and Cost of Care information from system-to-system (ACES[9] to MIHMS) through the DataHub[10] for a sample of sixty claims,
- reviewed the adequacy of the DHHS process used by a contractor to measure and track the amounts due back from NH facilities that received overpayments because the correct Cost of Care amount was not deducted from payments for monthly resident costs,

[4] HHSSC - Health and Human Services Service Center

[5] not in order of importance

[6] certain types of client income, expenses and allowances are used in this calculation

[7] Part of the typical case management process is for OFI eligibility personnel to determine whether cost of care was computed correctly by ACES for each client, correcting errors as they are encountered and at times in a more directed manner.

[8] Cost of care amounts that should be collected by LTC providers from the clients housed in their facility.

[9] The ACES system electronically transfers cost of care amounts and other eligibility information for each client to the DataHub in an ongoing basis.

[10] The DataHub is Maine's intermediary Health Care Information database system between ACES and MIHMS.

- reviewed the adequacy of the OMS controls in place to measure and track the amounts due back from PNMI facilities that received overpayments because the appropriate Cost of Care amount was not deducted from payments for monthly resident costs, and
- identified other issues that were detected during the audit that pertained to compliance with State law.

Results

Our testing of a sample of 60 randomly selected cases from all clients in a NH or PNMI residence assessed a Cost of Care for the period indicated that ACES incorrectly computed Cost of Care because known system errors caused income or expense information to be incorrect or missing for 13 of the 60 random Cost of Care assessments, as follows:

Instances	ACES Error Observed
10	ACES did not include all or part of State Supplement payments[11] as income for SSI clients.
2	ACES miscalculated the spousal income allocation.
1	ACES failed to update annual SSI[12] income from SVES[13] since 2009; and to list case on the SVES discrepancy report.
13	Total

In response, OFI has established manual workarounds or "fixes" as compensating controls to address such known ACES system design problems in automatically assessing Cost of Care to client cases. Test results indicated; however, that OFI staff did not correctly apply manual fixes or detect system errors for 9 of the 13 system errors, as follows:

Instances	Errors Observed
3	ACES did not include all or part of State Supplement payment as income for SSI clients.
6	OFI personnel did not detect system errors and apply manual fixes to client records.
9	Total

Continued on next page...

[11] A standard applies that is established by the State for the total SSI payment. The federal SSI payment and any countable income are deducted from the State standard. The remainder is the State Supplementation. This is typically an additional $10 or $15 per month, but can be as high as $234 in some client cases.

[12] Supplemental Security Income (SSI) guarantees a minimum monthly income to people who are at least 65 years old, or blind, or disabled with limited income and resources.

[13] State Verification and Exchange System

Our testing of a sample of 60 claim payments for the same clients and period tested above, indicated that Cost of Care for 8 (5 NH and 3 PNMI) claims were not correctly deducted from provider payments, because:

Instances	Errors Observed
4	Situation No. 1: Claims were found submitted for payment in a manner which could potentially be used to force a payment to be improperly paid from both MaineCare and from the client. We are not disclosing specific details of the issue in this report to avoid the possibility of compromising Department data and resources. However, we have notified appropriate Department management of the specific issues.
4	Situation No. 2: Retroactive Eligibility Payment Errors - MIHMS system edits were not actively set to reopen four tested claims when retroactive DataHub information was received by MIHMS and caused client Cost of Care and eligibility information to change only after NH or PNMI providers were paid for monthly resident costs. The end result is that the provider is or ultimately will be erroneously paid by both the client and by the State, so the State needs to recover the excess payment from the provider in some manner. A solution[14] to this retroactive Cost of Care and Eligibility assessment dilemma is being developed.
8	Total

The results of other tests we performed were not found to be problematic; or will be tested further during our testing of the federal Medicaid program.

Conclusions

We found important opportunities for needed improvement. These opportunities relate to key controls over system functionality and compensating controls that are in place to correct for known system deficiencies.

(1) Known system errors, which occur consistently as ACES computes Cost of Care amounts, must be addressed by the Department. Allowing such errors to continue is inefficient and wasteful of financial and human resources. It creates too many opportunities for human error and testing indicates there is no guarantee that system errors will be detected through manual processes.

(2) Systemic errors (caused by MIHMS and ACES system flaws) are predictable and typically can be resolved once identified. The root causes for MIHMS payment errors we detected were systemic and not isolated in nature, indicating these internal control weaknesses should be addressed by the Department. If not, payment errors and an opportunity for improper activity will continue.

(3) Consistent and meaningful exception review on an ongoing basis would allow for timely detection and tracking of payment errors; and the efficient recovery of overpayments.

Root Causes

Systemic ACES and OFI deficiencies include:

- Known ACES system errors which occur consistently for Cost of Care calculations include:

  (1) SSI recipients: not counting State Supplement payments between $10 and $234 per month as income
  (2) NH residents: miscalculation of the monthly spousal income allocation[15] and daily medical rates
  (3) SSI recipients: not consistently updating all SSI income amounts from SVES
  (4) SSI recipients: not reporting all instances of SVES failure on the SVES discrepancy report
  (5) NH residents: computed spousal income allowance is off by about $33 to $37 per month

- Inefficient compensating controls because OFI personnel need additional training

  Manual recalculations of Cost of Care amounts included arithmetic errors and misunderstandings regarding what client information should be considered when performing these computations. Also, correct procedures were not always followed by OFI staff as they applied manual fixes to ACES records.

[14] TR#5620 - A trouble report (TR) is a system defect that the system contractor must fix for free, without additional negotiated funding.

[15] This known system issue is referred to by OFI as, ACES task #13658.

Systemic MIHMS claim processing errors detected:

- No MIHMS system edit is set to pend or deny claims when they are submitted by a NH or PNMI facility provider in a certain way that we are intentionally not disclosing to protect Department resources

  System edits that could resolve this matter were set to ignore during our testing. In all 4 instances detected within our sample, no Cost of Care amount was deducted from room and board costs prior to payment. The result is that the provider erroneously got paid by both the client and by the State.

- Compensating controls to detect and reopen claims for retroactive Cost of Care or other eligibility changes are insufficient

  Electronic methods to detect instances when DataHub client eligibility and Cost of Care information is received by MIHMS exist only after payments are made are not set to reopen such claims for review by OMS to force resolution. Another 4 of the 60 claims we tested were such instances. It was also discovered that no State personnel were instructed to regularly generate and review exception reports or use other tools that can detect such retroactive eligibility or Cost of Care assessments to force resolution of claims previously paid in error.

- Fractured Communication

  Improvement of cross system communication and review processes should continue to expand the pockets of understanding to a less selective group of personnel within the Department and in certain DAFS[16] entities. The path from eligibility determination to MaineCare provider payments and ultimately to proper financial reporting is complicated involving multiple systems and complex business rules, which requires a large and diverse team of management, program, policy, financial and Information Technology (IT) experts, internal and external to the Department. The decision to outsource payment processing to a fiscal agent and the limitations of State agency resources adds additional complexity to this communications process. While the State and its contractors have developed communication channels, defining all user roles and responsibilities will need to continue in an ongoing basis, unless a more centralized approach to operations is put into place.

Recommendations

We recommend that OFI continue to improve internal controls to ensure that Cost of Care amounts are computed correctly for clients residing in LTC facilities, such as:

- coordinating the remediation of ACES system problems with DAFS - OIT[17],
- continuing their efforts to review and correct client records related to income, expenses, personal needs allowances, and daily medical rates to compensate for ACES deficiencies in computing Cost of Care amounts, and
- providing additional training to staff who must make manual corrections to Cost of Care information in ACES.

We recommend that OMS continue to implement additional controls and system corrections that would allow Cost of Care amounts to be properly deducted from monthly NH and PNMI facility payments. These include:

- directing Molina to activate certain system edits that will cause LTC claims to pend, deny or reopen for manual review prior to paying providers (this will allow for more offsets against future claims),
- assigning more personnel to review exception reports or use other tools to detect and track errors for adjustment against future claims,
- ensuring that an adequate number of staff is assigned to track and manage the significant balances due back to the State from overpaid PNMI facilities, that staff is adequately educated, qualified, and employed on a permanent basis, and

[16] DAFS (Department of Administration and Finances) - HHSSC (Health and Human Services Service Center) and OIT (Office of Information Technology).
[17] Office of Information Technology

- providing comprehensive receivable, payment and offset information to the HHSSC; and consider transferring responsibility for overpayment accounting and collections activities to the HHSSC, subject to internal audit oversight.

Agency Responses

Agency contact, Acting Director of Health Care Management and Policy, OMS.

- The State's Change Management staff is researching a variety of solutions (to the undisclosed situation). No estimated date can be provided for a decision or implementation of a system change. In the interim, we will implement a manual review by State Quality Assurance staff to research and identify claims that meet the (undisclosed) criteria for adjustment. Also, the State is actively involved in a redesign of the reimbursement methodology for Private Non-Medical Institutions.

- Retroactive Cost of Care determinations obviously create collection problems. As was discussed in our 5/29/13 meeting with Molina and State staff, most claims in this situation have finalized before the COC information is received. The State has a dedicated resource who works on COC issues. She does not use the certain report that Molina referred to in our meeting, as we believe other tools are more useful; (but she does use) a different Molina-generated report and coordinates her findings with the State adjustment supervisor. Because your audit did show that our current efforts are incomplete, we will be reconsidering our overall COC review to see where it can be strengthened.

- The Cost of Care process has been corrected for members with Cost Reimbursement Boarding Home (Rate Code 53) coverage.