Audit Highlights

Highlights of Legislative Auditor report on the Department of Health and Human Services, Division of Health Care Financing and Policy, issued on February 29, 2008. Report # LA08-10.

Background

Title XIX of the Social Security Act is a federal and state entitlement program, known as Medicaid, that pays for medical assistance for certain individuals and families with low incomes and resources. Nevada adopted the Medicaid program in 1967. The Division of Health Care Financing and Policy (HCF&P) was created during the 1997 legislative session and began administration of the Medicaid program on July 1, 1997.

In general, Nevada makes program services available to low-income persons who are aged, blind, or disabled and to women and children. Total recipients for Medicaid and Nevada Check Up for fiscal year 2007 were 168,198 and 28,364 respectively. Medical costs for these recipients over the same time period amounted to approximately $1.2 billion and $38 million respectively. In fiscal year 2007 the Federal government paid 54.14% of most medical costs and 50% for administrative costs. Other enhanced rates are available for specific types of expenditures.

Purpose of Audit

The purpose of this audit was to determine if HCF&P's Compliance Unit had sufficient procedures to identify fraud, abuse, and over-utilization to ensure control over medical payments. Further, this audit also determined if controls existed to ensure fee-for-service payments for certain managed care enrollees were appropriate. Our audit included the Compliance Unit's activities for fiscal year 2006, although extended testing was performed back to fiscal year 2004 in certain instances. Our review of managed care controls included the period January 2004 to June 2006.

Audit Recommendations

This report contains 18 recommendations to improve controls over Compliance Unit activities and prevent inappropriate payments for managed care enrollees. Specifically, we made seven recommendations for improvements to controls including additional monitoring and review of processes. Further, we made four recommendations regarding the development of policies and procedures to guide HCF&P activities. Additionally, we made seven recommendations including improvements to the claims payment system, enforcing existing policies and procedures, performing necessary reviews of data, and strengthening current processes.

The Division accepted the 18 audit recommendations.

Status of Recommendations

The Division's 60-day plan for corrective action is due on May 23, 2008. In addition, the six-month report on the status of audit recommendations is due on November 24, 2008.

Division of Health Care Financing and Policy

Department of Health and Human Services

Results in Brief

HCF&P had not implemented sufficient procedures to identify improper Medicaid payments resulting from fraud, abuse, or non-compliance with established billing procedures. As a result, our review of certain high risk claims found about $19 million in overpayments and errors. In addition, we estimate HCF&P may have overpaid almost $5 million for certain billing procedure codes that lacked sufficient detail to determine if the charges were appropriate. Overpayments and errors resulted from improper billings, claims payment system problems, and inadequate review of known areas of high risk. Furthermore, HCF&P had not implemented sufficient procedures to monitor and review the managed care enrollment process for newborns. This lack of control has allowed HCF&P to pay about $4.4 million in claims that should have been paid by the managed care organizations. Because HCF&P must also pay managed care organizations a monthly coverage charge for these recipients, it is duplicating medical coverage. Better monitoring, review, and the development of policies and procedures will help HCF&P alleviate these issues.

Principal Findings

HCF&P did not adequately monitor or review claims paid as a percentage of the amount billed by providers. As a result, HCF&P paid providers about $16 million more than they should have. This occurred because providers billed at rates higher than amounts specified in policy. Because the system assumed the amounts billed by providers were accurate and little or no controls existed to ensure payments were proper, significant overpayments resulted.

HCF&P did not monitor or limit the manner or amount in which two unlisted drug codes were used. Specifically, two unlisted drug procedure codes were billed nearly 35,000 times in fiscal year 2006. The next 10 highest drug procedure codes were billed about 6,000 times in total. We also estimate HCF&P could have paid about $4.8 million more than necessary for these drugs due to high utilization and payment methods.

The number of units billed for certain drugs were not always reasonable. We found 16 claims for a drug used for the management of renal disease (Epoetin Alfa) with monthly dosages ranging from 570 to 3,360 per recipient. Medicare literature states the maximum dosage for this drug over a month's time is 500 units. Our calculations indicate HCF&P paid at least $932,000 more than necessary for these claims.

An improper rate for an inpatient hospital charge was entered into the claims payment system. As a result, over 200 claims were paid at the improper rate, resulting in nearly $1 million in overpayments to hospitals.

Keying errors on claims and other data entry resulted in inappropriate payments and the insufficient request of federal funds. As a result, HCF&P's quarterly medical costs were reduced by the keying error. Therefore, HCF&P did not recover about $500,000 in matching federal funds until we brought the error to management's attention.

HCF&P inappropriately paid claims for services on recipients who were covered by Medicare. This resulted in thousands of dollars that were not properly recovered or were paid needlessly because Medicare should have covered a majority of the costs. Payments were made because the claims payment system processed improper claim forms and an inappropriate edit was entered in the system.

Based on a review of recoveries that occurred during fiscal year 2006, the Compliance Unit recovered less than $1.7 million, which is less than ½ of 1% of medical payments for the year. While a specific estimate of fraud, abuse, and over-utilization in Medicaid programs is hard to determine, it is generally considered to be more than 1%.

Payments for medical services were inappropriately paid for newborns who should have been enrolled and covered by managed care organizations. Based on reports generated by HCF&P, these payments amounted to $4.4 million. Furthermore, the managed care organization contracts state monthly coverage payments are due for the month of birth and subsequent months the child is program eligible and enrolled with the managed care organization. As a result, HCF&P could be liable for as much as $2.6 million in additional payments for these newborn recipients. This occurred because HCF&P's claims payment system failed to enroll newborns properly and HCF&P did not have a compensating process in place to monitor, review, and change this information as necessary.

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