OVERVIEW

Financial Audit of the Med-QUEST Division of the Department of Human Services

Report No. 01-10, May 2001

Summary

The Office of the Auditor and the certified public accounting firm of KPMG LLP conducted a financial audit of the Med-QUEST Division of the Department of Human Services (division) for the fiscal year July 1, 1999 to June 30, 2000. The audit examined the financial records and transactions of the division; reviewed the related systems of accounting and internal controls; and tested transactions, systems, and procedures for compliance with laws and regulations.

We found deficiencies in the financial accounting and internal control practices of the division. One deficiency included a material weakness, the worst possible type of reportable condition. In this weakness, we found a high error rate (30 percent) in the adjudication of Medicaid fee-for-service claim payments processed by the division's fiscal agent, the Hawaii Medical Service Association (HMSA). This high error rate raises serious concerns over the propriety of reported Medicaid expenditures, which amounted to about $392 million for the fiscal year. Based on our test sample, we concluded that the overpayment rate could have resulted in a potential loss of over $7 million.

We also found a pervasive non-compliance with established policies and procedures and the existence of weak internal controls that could cost the State and Hawaii's taxpayers millions of dollars. We found ineligible enrollees may be receiving medical benefits due to either non-performance or inconsistent performance of (1) required eligibility verification procedures, (2) reviews of eligibility determinations, and (3) required annual eligibility re-verifications. We previously brought these deficiencies to the attention of the division in 1996.

We also found that the division has not performed periodic risk analyses or system security reviews of the Medicaid Management Information System (MMIS) in accordance with federal regulations. In addition, the MMIS edit functions need updating.

During fiscal year ended June 30, 2000, we found approximately 1,100 QUEST applications outstanding over 45 days with an average wait period for eligibility determination of 15 to 16 weeks. Moreover, there is also a significant amount of uncollectible receivables outstanding as QUEST participants are not being disenrolled from the program on a timely basis and the collection efforts of the division are poor. The total premiums receivable at June 30, 2000, amounted to $5.6 million.

We found that the internal controls to protect the division from capitation overpayments diminished when the division transferred the responsibility of reconciling capitation payments to the health plans. There is no existing internal control procedure to verify that capitation payments are accurate. Total expenditures on capitation payments were about $225 million during the fiscal year.

The division also receives over $10 million per year in drug rebates; however, cash is not consistently deposited on a timely basis. Deposits were delayed up to 11 working days, leaving the cash susceptible to potential theft or misuse and a loss of potential interest income.

We also found that over half of the balance of the division's trust fund suspense account of $208,865 cannot be substantiated.

After six years, the division's new information system, which cost about $12 million, remains incomplete. The division will have to continue to pay HMSA (currently about $8 million annually) to process Medicaid fee-for-service claims until the division can add this function to its new system.

Finally, the division continues to pay Medicaid providers without executed provider agreements. Twenty-two provider contracts with Medicaid nursing and acute care facilities expired between July 1 and December 1, 1996.

Recommendations and Response

We recommend that the division establish a well documented and concise claims review processing system, adequately train employees responsible for claims review processing, and ensure that HMSA is notified immediately of any discrepancies identified. The division should hold HMSA accountable for any errors in its claims processing, review all claims for which the division made fee determinations, update the MMIS edit functions, and perform overall risk analyses and system security reviews of the MMIS.

The division should also reduce processing time for eligibility determinations to less than 45 days, perform annual re-verifications of eligibility, award presumptive eligibility to applicants when appropriate, disenroll ineligible enrollees in a timely manner, and implement procedures to actively pursue delinquent premium receivables or consider referring these accounts to collection agencies. The division should resolve the remaining member count discrepancies with health plans and collect all amounts due to the division. Also, the division should deposit cash receipts in a timely manner, investigate outstanding issues related to the trust fund suspense account, and maintain adequate supporting documentation for all claims.

The division should initiate a contract for the Medicaid fee-for-service claims processing system as soon as possible. The division should execute agreements with nursing and acute care facility providers and should also consider appropriate action for non-compliant facility providers.

The Department of Human Services (department) generally agrees with most of our findings and recommendations. For some of the findings the department did not respond. The department also indicated that the division has implemented or is in the process of implementing some of our recommendations.

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