Secretary of State Audit Report

Kate Brown, Secretary of State

Gary Blackmer, Director, Audits Division

Adequate Computer Controls in Place for the Medicaid Management Information System

Summary

Medicaid is a government program providing health care to low-income individuals and families. Approximately 530,000 needy Oregonians received Medicaid coverage through the Oregon Health Plan during the first quarter of 2010, including approximately 31,000 who would not be covered under traditional Medicaid rules.

The Oregon Department of Human Services (department) currently administers the state's Medicaid program, but this responsibility will pass to the newly formed Oregon Health Authority by July 2011. Medicaid expenditures for state fiscal year (FY) 2010 were approximately $4.3 billion, of which approximately $2.6 billion were processed through the department's Medicaid Management Information System (MMIS).

The purpose of this audit was to determine whether MMIS computer controls reasonably ensure the completeness, accuracy and validity of Medicaid payments. Our specific audit objectives were to determine whether MMIS controls provide reasonable assurance that:

- Medicaid expenditures processed through the system remain complete, accurate and valid during input, processing and output;
- computer code modifications follow appropriate change management processes; and
- data is protected against unauthorized use, disclosure, modification, damage or loss.

We found that computer controls reasonably ensured the validity, completeness and accuracy of Medicaid payments; computer code modifications followed appropriate processes; and the system and data were adequately protected. We noted that the department has not completed the work to correct some financial transactions that arose from processing errors during system startup.

In addition to this report, we communicated detailed security matters to the department in a separate confidential memo, as provided in ORS 192.501.

Agency Response

The agency response is attached at the end of the report.

Background

Medicaid in Oregon

Medicaid is a government program that provides health care to low-income individuals and families. It is financed through joint federal and state funding and is administered by each state. At the federal level, Medicaid is administered by the U.S. Department of Health and Human Services' Centers for Medicaid and Medicare Services (CMS). At the state level, the Oregon Department of Human Services (department) currently administers the Medicaid program and sets guidelines regarding eligibility and services. However, by July 2011 the Oregon Health Authority will begin administering most health-related programs, including Medicaid.

In February 1994, CMS approved Oregon's proposal to alter the traditional method of covering all medical services for a limited Medicaid population. The Oregon Health Plan (OHP) covers clients normally eligible under Medicaid plus an expanded population using a prioritized list of health services.

The OHP was designed to reduce Medicaid costs by limiting covered services to only those that are clinically proven and cost effective. The plan further controlled costs by using Managed Care Organizations (MCOs) to deliver the agreed upon coverage for a prescribed, actuarially determined monthly fee. Some clients and some specific service types continue to be provided on a fee-for-service basis, which requires providers to submit medical claims for services actually performed.

Department management indicated approximately 530,000 needy Oregonians received medical coverage through the OHP during the first quarter of 2010, including approximately 31,000 who would not be covered under traditional Medicaid rules. Services are provided by approximately 33 MCOs and 55,000 medical providers, including doctors, pharmacies and other professionals.

During state fiscal year (FY) 2010, approximately 73 percent of Oregon's Medicaid costs were funded by the federal government with the remaining funding coming from the state's General and other funds. Total Medicaid expenditures for this period were approximately $4.3 billion, of which approximately $2.6 billion were processed through the department's Medicaid Management Information System (MMIS).

Oregon's New Medicaid Management Information System

In order to receive an enhanced rate of federal funding participation, CMS requires states to use an approved system to process medical claims and maintain the information to effectively manage and administer the Medicaid

program. Some states have chosen to outsource this function to service providers while others own and operate their own MMIS.

Oregon implemented its first MMIS in 1982. The main component of this system was a copy of another state's MMIS developed in the late 1970's and modified to meet Oregon's specific needs. Over time, the department significantly changed this system to facilitate changes in Medicaid, including adoption of the Oregon Health Plan. In addition, other changes to both federal and state requirements and programs required the department to frequently alter its MMIS.

By the late 1990's the department concluded Oregon's original MMIS had reached the end of its useful life and a new system was needed to satisfy Federal requirements and to meet other changes in the health care industry. Planning, development, and testing of Oregon's new MMIS began in 2000 with an approved budget of approximately $80.8 million. The federal government funded approximately 90 percent of the project with the remainder coming from state certificates of participation and the state's General Fund.

The department contracted with Electronic Data Systems (EDS) to modify an existing MMIS from another state for use in Oregon, and to operate the new MMIS. In 2008, Hewlett Packard (HP) acquired EDS and assumed responsibility for Oregon's MMIS contract. The system was originally scheduled for completion in 2007. However, by summer 2008 the new MMIS was not yet ready for deployment because the Managed Care, Recipient, and Third Party Liability subsystems were not fully developed and tested.

Subsequently, CMS notified the department that it would not allow further delays in implementing the system and ceased the enhanced project funding on September 1, 2008. In order to resume the enhanced federal funding, department management opted to implement the new MMIS with the unfinished subsystems on December 9, 2008.

Information System Controls

General controls protect the environment in which software applications operate. Application controls include both manual and automated processes to ensure only complete, accurate, and valid information is entered into a computer system; data integrity is maintained during processing; and system outputs conform to anticipated results. Application controls may include data validity checks, transaction balancing routines, and error detection and correction processes. General controls coupled with application controls provide assurance that transactions processed through the system are authorized, reliable, and complete.

For Oregon's MMIS, the responsibility for general and application controls is shared between the department and its contractor. The department is responsible for business decisions and business controls surrounding MMIS processing, while the contractor controls the technical operating

environment in which MMIS operates. Among other duties, the contractor's programmers are responsible for modifying system code when needed and the contractor's operators schedule and monitor processing jobs.

Audit Purpose and Objectives

The purpose of this audit was to determine whether computer controls reasonably ensure the completeness, accuracy and validity of MMIS payments. Because these payments comprise a large portion of the department's financial transactions, testing the new system is important to the annual financial audit the Audits Division performs.

Our audit objectives were to determine whether information system controls over the Department of Human Services' MMIS provide reasonable assurance that:

- Medicaid expenditures processed through the MMIS are complete, accurate and valid during input, processing and output;
- computer code modifications follow appropriate change management processes; and
- data is protected against unauthorized use, disclosure, modification, damage or loss.

Audit Results

During FY 2010, the department processed over 24 million transactions through its MMIS, generating payments totaling approximately $2.7 billion. Almost 58 percent of this total was for payments to Managed Care Organizations (MCOs) to cover clients enrolled in their programs. An additional 41 percent of the payment total was for fee-for-service claims for care provided to individuals not enrolled with a MCO, or for services not specifically covered by MCO contracts. The remaining one percent was for other expenditures that required manual processing to complete.

The integrity of MMIS processed expenditures depends largely on automated application or business process controls governing transaction input, processing and output. However, these controls are reliable only when security measures are in place to protect the system and when changes to program code are strictly controlled.

Based on tests of controls, we found:

- Application controls reasonably ensured expenditures were valid.
- Computer code modifications followed appropriate change management processes.
- Security measures protected the system and its data.

MMIS computer controls also provided reasonable assurance that Medicaid payments the system processed and transferred to the Statewide Financial Management Application were complete, accurate and valid.

Application Controls Reasonably Ensured Expenditures Were Valid

Generally accepted computer controls provide that transaction data should be subject to a variety of controls to check for accuracy, completeness and validity. In addition, processes should be in place to timely detect and correct potential errors that may occur during processing.

Most payments made through MMIS follow one of two paths. Fee-for-service payment processing begins when a provider submits a medical claim using standardized formats. Each claim contains pertinent information such as the medical procedure performed, date of service, diagnosis code, and information identifying the recipient and provider of the services. Upon receipt, MMIS automatically examines the claim to determine whether it complies with an extensive list of medical and Medicaid specific criteria, applies a price to be paid, creates and transmits a payment file, and stores the information for historical purposes. Most fee-for-service claims process with little or no manual intervention by department staff.

Processing monthly managed care payments is a much less complicated process. Payments to MCOs are based on current client enrollments, client

demographics and predetermined amounts contained in system files. Variations in payments only occur when client eligibility or demographics change. In these instances, the system adjusts prospective payments to compensate for the changes that occurred, such as a client reaching an age that decreases benefits or when a client moves out of the area covered by an MCO.

We evaluated and tested key application controls that the department relies on to ensure fee-for-service and managed care payments are complete and valid. Based on this work, we concluded that these controls, both manual and automated, were sufficient to ensure proper processing for the vast majority of payments made during FY 2010. However, as the department and HP continued to develop and stabilize MMIS functionality during our audit period, not all automated controls were fully functional. In addition, department staff had not completely identified or resolved all payment errors resulting from these weaknesses and other issues encountered during system startup.

Specifically, we found:

- With exceptions, automated and manual checks reasonably ensured fee-for-service claims were valid.
- The vast majority of managed care payments paid appropriately, but controls were not sufficient to prevent errors from occurring in unique circumstances.
- Controls were sufficient to resolve normal processing errors but did not ensure timely resolution of errors caused by system deficiencies.
- Critical information tables were appropriately updated.

With exceptions, automated and manual checks reasonably ensured fee-for-service claims were valid

When the department implemented the new MMIS, the system was not able to appropriately handle some fee-for-service claim types, necessitating department staff to use manual workarounds to ensure health care providers received timely payments. In these instances, the department issued estimated payments to providers and then reconciled these payments to actual claims once the system was capable of processing them.

For payments that could process through MMIS, the system ensures payments comply with medical and Medicaid specific requirements by applying an extensive series of automated error checking routines. These routines consist of over 800 individual "edits and audits" that test claims according to criteria established in federal and state Medicaid policies, and regulations. Edits review the claim for information such as format, provider and recipient eligibility, consistency, and reasonableness. Audits review the claim against historical information to prevent payment for duplicate services and to ensure service limits are not exceeded.

After claims are processed through the edits and audits, they are sent through a pricing routine that evaluates the specific service provided, the recipient's benefit plan, and the provider's contract with the State of

Oregon. MMIS uses this information to apply an appropriate pricing methodology to assign an amount to be paid.

We tested MMIS edits and audits and found they worked to provide reasonable assurance that:

- Medical procedures were authorized based on Oregon's prioritized list of services.
- The entity submitting the claim was eligible to provide the specific type of service performed.
- Claims did not exceed service limitations established in policy.
- Medical providers were paid appropriate amounts based on Medicaid rules.

However, these automated checks did not function as intended for some client cases having unique or special circumstances. During our audit, department staff identified errors in one edit that allowed some specific types of fee-for-service claims to be paid when services were already covered by managed care contracts. As a result, department staff estimated that approximately $10 million in overpayments occurred from system startup until the programming errors were corrected by October 2010. These errors were significant, but represent less than one percent of the total payments processed during FY 2010. Department management indicated that they had not yet recouped these fee-for-service overpayments as of April 2011.

The vast majority of managed care payments paid appropriately, but controls were insufficient to prevent errors from occurring in unique circumstances

The Managed Care subsystem is programmed to perform automated checks to ensure payments to MCOs conform to Medicaid requirements. For example, the system appropriately denies payments for clients who are not eligible for Medicaid or whose records lack required program codes. However, at system startup, the Managed Care subsystem was incomplete and lacked some system functionality to properly control and process some unique client enrollments and subsequent managed care payments. For example, the system sometimes made inaccurate enrollment and subsequent managed care adjustments when a client's benefit package changed mid-month or improperly adjusted payments when Medicaid or Medicare eligibility changed retroactively.

The department intended MMIS automated routines to be its primary means of controlling managed care payments. However, it also planned to utilize existing MCO reporting feedback regarding potential enrollment problems as another means of ensuring proper payments. This secondary control quickly became ineffective shortly after system startup because the volume of enrollment problems reported by the MCOs overwhelmed department staff assigned to investigate and resolve them. As a result, department management indicated they made a business decision to discontinue their efforts to resolve the erroneous managed care payments until the underlying

system problems could be corrected and the proper capitation adjustments could be processed.

These system problems resulted in erroneous managed care payments through FY 2010. As of November 2010, department staff estimated that these errors resulted in managed care overpayments totaling approximately $10 million and underpayments totaling approximately $17 million. The department indicated these numbers are expected to change as further analysis is conducted. Since most of these transactions qualify for federal funding, only about 31 percent of these amounts will involve charges to or from the department's General Fund when they are corrected.

Based on our overall analysis and tests of managed care transactions, the above errors were significant, but not material when placed in the context of total payments processed during FY 2010. In addition, many of these errors actually occurred during the prior fiscal year as the system was being implemented. In contrast, we concluded that controls implemented since then were generally sufficient to ensure proper managed care payments.

Controls were sufficient for resolving normal processing errors but did not ensure timely resolution of those caused by system deficiencies

Data processing error handling procedures should identify erroneous transactions before processing completes. In addition, procedures should be in place to resolve these errors accurately and timely without compromising other system controls. When payment errors have been identified, they should be corrected in a timely manner.

For fee-for-service claims, MMIS resolves errors in claims transactions by rejecting the claim before processing, denying claims that do not meet program requirements, or temporarily halting processing of specific claims until underlying issues are investigated and resolved. Specifically, edits and audits that are set to suspend claims prevent them from further processing until department personnel can review the claim. In addition, claims that satisfy edit and audit requirements but cannot continue through the financial cycle because of an underlying system issue are also prevented from further processing. We found that department staff monitored these claims and took appropriate action to correct or evaluate them.

For managed care payments, the system automatically adjusts payments if client information or enrollments change during the month. For example, should department staff discover a discrepancy in prior client enrollment information, such as an inaccurately reported birth date, the system is designed to automatically calculate adjustments for up to six prior months. The Managed Care subsystem is also programmed to automatically remove clients from Managed Care plans when it detects changes, such as a client moving to a location not covered by the plan or when a client is determined not eligible for Medicaid.

For both payment types, MMIS controls provided reasonable assurance that errors identified during system processing would be timely and appropriately resolved before they are paid. However, they were not

designed to resolve the over or under payments that occurred as a result of the underlying system problems we reported above. Timely resolution of these errors would require implementing alternative controls to identify and correct them.

For the fee-for-service claims paid when services were already covered by managed care contracts, department management indicated they had not recovered the overpayments because they had not yet completed all the analysis necessary to determine the proper adjustments. For managed care payment problems, department management said they made a business decision to expend resources to resolve the underlying MMIS programming issues and then allow the system to adjust prior payments rather than implement alternative manual controls. Although this approach had its merits, the department was not able to pay for some services rendered or recover overpayments in a timely manner.

Critical information tables were appropriately updated

MMIS edits and audits and pricing functions use information from various data tables within the system to evaluate claims and to apply the appropriate prices. Other tables provide rates for managed care payments.

When processing routines use data from supporting tables, generally accepted computer controls indicate processes should be in place to ensure updates are made as required and are appropriately requested, approved, and monitored.

Department staff uses various procedures for updating table data. Some updates are automated and built into daily, weekly or monthly processing routines. These are regularly performed without manual intervention. Most recipient eligibility information is loaded through this method.

For most other updates, department staff requests the contractor to upload the required files into the system. Updates made in this manner include procedure code updates obtained from outside sources and managed care rate updates the department derives.

Staff also has the ability to manually enter some system information through a user interface. This type of update typically occurs when the volume of transactions is low or when there is no automated method of loading the information.

Controls governing the above processes provided reasonable assurance that critical file updates were performed as required or needed.

Computer Code Modifications Followed Appropriate Change Management Processes

Changes to computer systems should follow formal change management procedures to ensure they are secure, authorized, tested and approved prior to implementation.

The department works with its contractor to modify the MMIS when defects are discovered or additional functionality is needed. After desired changes are identified, the department prioritizes them and provides the contractor with formal requests for the work. The contractor is responsible for providing appropriate program change management controls such as system testing, version control, and code promotion.

Program changes are tracked through an on-line database that allows the department and the contractor to view and change the status of program modifications as needed. The database also provides a central location for documentation such as implementation plans and test results.

We tested the department's change management controls and found:

- The department authorized changes to the system.
- Changes were tested by the contractor and user prior to approval for implementation.
- The contractor had appropriate controls in place to ensure that only authorized changes were promoted to production and that unauthorized production of code changes would be detected.

Security Measures Protected the System and its Data

Logical access to computer applications should be restricted according to each user's individual need to view, add or alter information. In order to maintain this principle of "least privilege," organizations should have formal processes for timely granting, issuing, suspending and closing user accounts. In addition, management should periodically review and confirm users' access rights to ensure they remain appropriate.

We found that the department appropriately restricted access to MMIS to broad categories of users with similar job duties. Use of this role-based model properly restricted access to the system as a whole, but did not always ensure users received only the access they needed to perform their duties.

Because of the sensitive nature of system security, we communicated additional detail regarding our specific findings and recommendations regarding this matter to the department in a confidential letter in accordance with ORS 192.501 (23), which exempts such information from public disclosure.

Recommendations

We recommend that department management:

- Take action to further expedite resolution of the erroneous transactions that resulted from system errors.
- Implement the recommendations provided in our confidential security letter.

Objectives, Scope and Methodology

Our audit objectives were to determine whether information system controls over the Department of Human Services' Medicaid Management Information System (MMIS) provide reasonable assurance that:

- Medicaid expenditures processed through the MMIS remain complete, accurate and valid during input, processing, and output;
- computer code modifications follow appropriate change management processes; and
- data is protected against unauthorized use, disclosure, modification, damage or loss.

Our review primarily covered the subsystems that process the two major types of payments generated from the MMIS. These were the Claims subsystem for fee-for-service claims and the Managed Care subsystem for per capita payments based on enrollment. We reviewed portions of other subsystems in the context of how those subsystems supported payment processing from Claims and Managed Care.

We conducted interviews with department personnel and the personnel from the contractor and observed department operations and processes. In addition, we examined technical documentation relating to the MMIS and its architecture.

To evaluate fee-for-service processing controls, we:

- obtained a sample of 60 paid claims and evaluated whether they met basic Medicaid requirements and were appropriately priced;
- evaluated and tested processes used to modify the parameters of system edits and audits;
- observed and tested processes that identify, monitor and resolve errors that may occur during the claims processing cycle;
- evaluated and tested processes used to update supporting tables; and
- evaluated the status of edits and audits in the system to determine whether they were turned on and functioning.

To evaluate per capita managed care payments, we:

- obtained a sample of 60 managed care payments and evaluated whether they used the correct rate type based on recipient demographic and provider characteristics;
- reviewed whether the rates included in the MMIS matched the rates provided by the department's actuarial unit; and
- evaluated managed care adjustment processes to determine whether they applied retroactive changes that were appropriate based on changes in recipient information.

To test program change management controls, we reviewed the department's change management policies and procedures, reviewed logical

access to file locations, and performed a limited review of supporting documentation for selected changes.

To determine whether logical access to the MMIS was provided in accordance with a demonstrated need, we:

- evaluated the content of user roles and the description of roles;
- reviewed whether users who had been granted update-level access to certain portions of the system had used their access during FY 2010; and
- tested whether terminated employees had their access removed from the system.

We used the IT Governance Institute's (ITGI) publication, "Control Objectives for Information and Related Technology," (CobiT) and the United States Government Accountability Office's (GAO) publication, "Federal Information System Controls Audit Manual," (FISCAM) to identify generally accepted and applicable internal control objectives and practices for information systems.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence we obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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June 6, 2011

Neal Weatherspoon, Audit Manager
Secretary of State Audits Division
255 Capitol Street NE, Suite 500
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RE: Department of Human Services (DHS) Response to the *Adequate Computer Controls in Place for the Medicaid Management Information System* Draft Report

Dear Mr. Weatherspoon:

The department appreciates the opportunity to respond to the May, 2011, Secretary of State draft audit report entitled *Adequate Computer Controls in Place for the Medicaid Management Information System*. In general, we agree with the findings and recommendations identified in the draft report. Below are our detailed responses to the findings and recommendations.

Recommendation:
We recommend that department management take action to further expedite resolution of the erroneous transactions that resulted from system errors.

Agency Response:
The department generally agrees with the recommendation.

Discussion:
The department supports the findings and timelines of the SOS auditors; however emphasizes that efforts to complete the payment reconciliation process have been underway for several months and are scheduled to be completed by June 30, 2011. The new Medicaid Management Information System (MMIS) was brought on-line before all functionality was fully operational. This decision was made to ensure the enhanced Federal funding for this project continued.

During the post-implementation stabilization and subsequent maintenance periods, all operational decisions, were made to ensure the critical services provided to our clients and the financial solvency of our servicing providers were maintained. An example of this support was creation of the "transitional payments" process, allowing estimated payments to be made to Managed Care plans, with a subsequent reconciliation effort to resolve discrepancies. Owing to the anticipated operational effects of these decisions and the impact they would

have to our servicing providers, many of these decisions were made after consultation and planning with Managed Care plan representatives.

The Managed Care subsystem for enrollment and disenrollment was especially problematic in unique circumstances. The corrective programming required to correct these complex enrollment discrepancies was not completed until October, 2010. These Managed Care enrollment and disenrollment errors are directly linked, and have compounded, the Fee-For-Service (FFS) errors identified by the SOS auditors, by paying claims as FFS when the correct payer should have been (but was unknown at the time due to the enrollment errors) a Managed Care plan. The sequential logic used in the processing of these incorrect capitation and FFS payments must now be sequentially reversed during the corrective action period to ensure additional errors are not created.

Corrective Action:
Starting in October, 2010, following correction of the majority of system defects, the labor and systematic intensive reconciliation process for Managed Care Organizations (MCO) enrollment errors began. After extensive consultation and planning with our Managed Care partners to develop and execute this large effort, the department expects to complete the enrollment/disenrollment and subsequent capitation adjustments (both overpayments and underpayments) by June 30, 2011.

The exact amount of the FFS payment errors, and the corresponding corrective action, cannot be fully defined until the MCO reconciliation process is complete. For example, if a FFS claim was paid for a client who was, during the MCO reconciliation process, determined to be covered by a MCO, then the payment associated to the FFS claim will be recovered and the appropriate capitation payment processed. If a FFS claim was paid for a client who was determined to not be covered by a MCO at the time the service was rendered, then the FFS payment was appropriate.

Once the MCO reconciliation process is finalized in early to mid June, 2011, then the last sequential step in the payment reconciliation plan will begin. This last step is to overlay the corrected MCO client enrollment onto the FFS claims payment history and determine the appropriateness of each FFS payment made for these enrollment-adjusted clients. Incorrect FFS overpayments will be recovered and any appropriate FFS claims that were previously denied will be paid. This final reconciliation step is expected to be completed by June 30, 2011.

Please contact Dale Elder, DMAP Operations Section Manager at 503-945-6589 or by email at Dale.Elder@state.or.us if you have any questions regarding this response or corrective action.

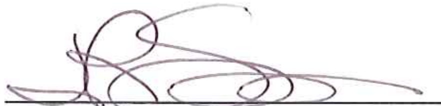
Recommendation:
We recommend that department management implement the recommendations provided in our confidential security letter.

Agency Response:
The department agrees with the recommendations provided in the confidential security letter provided to the department per ORS 192.501.

We have taken and will continue to take corrective actions as discussed in our confidential response to the security letter. Please contact David G. Stauffer, Senior Security Architect at 503-269-4552 or by email at David.G.Stauffer@state.or.us if you have any questions regarding these actions.

Thank you again for the opportunity to address the concerns identified in the draft audit report entitled *Adequate Computer Controls in Place for the Medicaid Management Information System*. Please contact David M. Lyda, Chief Audit Officer at 503-945-6700 or by email at Dave.M.Lyda@state.or.us if you have any general questions regarding this response.

Sincerely,



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cc: Judy Mohr Peterson, Director of Medical Assistance Programs
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About the Secretary of State Audits Division

The Oregon Constitution provides that the Secretary of State shall be, by virtue of her office, Auditor of Public Accounts. The Audits Division exists to carry out this duty. The division reports to the elected Secretary of State and is independent of the Executive, Legislative, and Judicial branches of Oregon government. The division audits all state officers, agencies, boards, and commissions and oversees audits and financial reporting for local governments.

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The courtesies and cooperation extended by officials and employees of the Oregon Department of Human Services during the course of this audit were commendable and sincerely appreciated.