Audit Report

Department of Health and Mental Hygiene
Medical Care Programs Administration

April 2014

OFFICE OF LEGISLATIVE AUDITS
DEPARTMENT OF LEGISLATIVE SERVICES
MARYLAND GENERAL ASSEMBLY

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DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF LEGISLATIVE AUDITS
MARYLAND GENERAL ASSEMBLY

April 25, 2014

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Members of Joint Audit Committee
Annapolis, Maryland

Ladies and Gentlemen:

We have audited the Medical Care Programs Administration (MCPA) of the Department of Health and Mental Hygiene (DHMH) for the period beginning July 1, 2009 and ending June 30, 2012. MCPA administers the Medical Assistance Program which provides low-income Maryland residents with access to a broad range of health care benefits that are financed by State and federal funds. During fiscal year 2012, DHMH spent approximately $7.6 billion for the Medical Assistance Program.

Our audit disclosed that MCPA did not adequately monitor certain vendors contracted to assist in verifying amounts billed by hospitals, long-term care providers, and Managed Care Organizations (MCOs) and to recover related overpayments. For example, audits of medical records to ensure hospital services billed were actually provided were not conducted for hospital claims processed after 2007. MCPA did not adequately monitor another vendor responsible for ensuring hospital charges were for medically-necessary procedures and services. Payments for hospital services totaled approximately $1.1 billion in fiscal year 2012.

Our audit also disclosed that MCPA needs to take certain actions to maximize the recovery of funds from other sources, such as third-party insurers and Medicare, to reduce Medicaid costs. For example, MCPA did not ensure that referrals of potential third-party insurance for Medicaid recipients were properly and timely investigated. Additional actions should also be taken by MCPA to maximize the recovery of Medicare funding for eligible Medicaid recipients.

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MCPA did not adequately monitor the vendor responsible for enrolling new applicants in MCOs to ensure that contractual performance requirements were met. After we identified instances of overstated enrollment results, MCPA determined that the vendor had not met enrollment requirements for any month over a four-year period. As a result, MCPA recovered approximately $900,000 from the vendor.

Our audit also disclosed that MCPA needs to institute certain security measures and controls affecting its information systems. For example, MCPA needs to ensure that firewalls are properly configured and that proper security has been established by the vendor responsible for hosting and managing a certain web-based application.

DHMH's response to this audit, on behalf of MCPA, is included as an appendix to this report. We wish to acknowledge the cooperation extended to us during our audit by MCPA.

Respectfully submitted,

Thomas J. Barnickel III, CPA
Legislative Auditor

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* **Denotes item repeated in full or part from preceding audit report**

Executive Summary

Legislative Audit Report on the
Department of Health and Mental Hygiene
Medical Care Programs Administration (MCPA)
April 2014

- **MCPA did not ensure that hospital bill audits were performed and there was minimal monitoring of hospital utilization reviews. Audits of hospital billings were not conducted for claims submitted after calendar year 2007. Medicaid payments for hospital services totaled approximately $1.1 billion during fiscal year 2012 (Finding 1).**

  MCPA should ensure that audits of hospital claims are conducted in a timely manner. MCPA should also improve its monitoring of hospital utilization reviews to ensure that all reviews billed were conducted and were sufficiently comprehensive.

- **Procedures to ensure the propriety of payments to long-term care facilities were not adequate. MCPA did not conduct patient credit balance audits during an extended period to determine if amounts are due to the State and did not conduct cost settlements with the facilities on a timely basis (Finding 2).**

  MCPA should establish procedures to ensure that patient credit balance audits are performed for all long-term care facilities and that cost settlements to determine amounts due to, or from, the facilities are performed timely.

- **MCPA did not adequately monitor the vendor responsible for enrolling new applicants in MCOs. While the vendor reported full compliance with the contractual enrollment requirements, our tests indicated that the vendor overstated the enrollment results. After we brought this matter to its attention, MCPA conducted an analysis of the vendor billings and recovered approximately $900,000 as a result of damages assessed for not reaching the enrollment requirements during a four-year period (Finding 3).**

  MCPA should verify the performance of its enrollment vendor and take corrective action, including assessing damages, when the vendor does not achieve the required level of performance.

- **MCPA did not ensure that referrals of potential third-party health insurance for Medicaid recipients were properly and timely investigated. (Finding 4).**

  MCPA should establish initial accountability and control over referrals and perform supervisory reviews to ensure timely investigations of referrals were conducted and appropriate conclusions were reached.

- **MCPA did not have sufficient procedures to maximize Medicare funding for eligible Medicaid recipients (Finding 5).**

  MCPA should establish procedures to ensure that all recipients aged 65 and over apply for Medicare coverage and that it pays the correct amount for individuals with both Medicaid and Medicare coverage.

- **MCPA needs to continue efforts to address longstanding deficiencies with the recipient enrollment procedures as well as to improve information system security (Findings 6 - 9).**

  MCPA should continue to monitor the eligibility process. In addition, MCPA should take the recommended actions to address information system security weaknesses.

Background Information

Agency Responsibilities

The Medical Care Programs Administration (MCPA) operates under both Title XIX of the Federal Social Security Act (Medicaid) and State law. Medicaid is a joint federal and state entitlement program for low-income individuals. The program is administered by the states, which are required to provide healthcare coverage to all applicants who meet the program's eligibility criteria.

According to MCPA records as of June 30, 2012, the Medical Assistance Program served approximately one million individuals, through more than 49,000 health care providers. During fiscal year 2012, Medicaid expenditures processed through the Medicaid Management Information System (MMIS II) totaled approximately $7.6 billion (see table) and are primarily processed by MCPA. At least 50 percent of these expenditures were recovered from the federal government.

Fiscal Year 2012

Expenditures Processed via MMIS II

Service Type	Expenditures (expressed in thousands)
Managed Care Organizations	$ 3,110,505
Hospital Services	1,178,546
Long Term Care	1,129,064
Home Health	957,445
Physicians	435,665
Pharmacy	368,350
Dental	151,444
Other	253,311
Total	**$ 7,584,330**

Source: MCPA Records (unaudited)

MCPA is responsible for enrolling the providers (such as physicians), establishing program regulations, setting provider payment rates, reviewing and paying provider claims, and obtaining federal reimbursement for eligible costs. MCPA entered into a Memorandum of Understanding (MOU) with the Department of Human Resources (DHR) which assigns responsibility to DHR, via its local departments of social services, for determining applicants' eligibility for participation in the Medical Assistance Program. Individuals qualifying for cash assistance through the Temporary Cash Assistance program or the federal Supplemental Security Income program automatically qualify for Medicaid benefits. Those eligible for Medicaid through these programs make up most of the Medicaid population and are referred to as "categorically needy." The remaining individuals are referred to as "medically needy" meaning they cannot meet the cost of needed medical care, but are generally self-supporting in other respects.

Most Maryland Medicaid recipients are required to enroll in HealthChoice, the statewide managed care program that began in 1997. Under HealthChoice, MCPA

makes specified capitation payments to private Managed Care Organizations (MCOs) that provide services to these Medicaid recipients in Maryland. Populations excluded from the HealthChoice program include the institutionalized and individuals who are dually eligible for Medicaid and Medicare. Populations not covered by an MCO are covered on a fee-for-service basis. Under this system, health providers (such as physicians, hospitals, and medical equipment suppliers) are paid a fee for each service or supply provided. Fees are generally billed at rates established by MCPA or, in the case of hospital stays, at rates established by the Maryland Health Services Cost Review Commission.

Hospital Billing Rates

The rates charged by and paid to the 53 Maryland hospitals are regulated by the Health Services Cost Review Commission (HSCRC), an independent commission under DHMH. HSCRC is responsible for establishing, reviewing, and approving hospital billing rates for all payees, including MCPA and private insurers. MCPA and the private insurers also rely on HSCRC to ensure the amounts billed by the hospitals are in accordance with the HSCRC approved rates.

Our most recent audit report of the Health Regulatory Commissions (which includes HSCRC), dated January 7, 2013, disclosed that the HSCRC did not adequately monitor hospital billings resulting in two hospitals overcharging MCPA for two procedure codes by at least $3.7 million. Consequently, there was a lack of assurance that the rates charged by the hospitals and paid by MCPA were proper.

MCPA management advised us that it does not believe that it is responsible and does not have the resources to monitor HSCRC. MCPA further advised that it followed up with HSCRC regarding this issue and was advised that the deficiencies noted in the aforementioned audit report have been corrected.

Federal Audits

Audits by the federal Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) resulted in recommendations for recoveries from the State. For example, an audit issued in December 2013 disclosed that MCPA drew down $115.3 million in federal funds for fiscal years 2009 through 2011 that were not supported by actual expenditures. MCPA requests federal funds on a weekly basis to pay the federal share of medical and administrative expenditures. On a quarterly basis, MCPA submits reports of expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program report (CMS-64). After each quarter, MCPA performs a reconciliation to compare the total federal funds withdrawn according to its internal records with the federal

share of expenditures reported on the aforementioned CMS-64 report and identifies any differences. Any differences between the federal funds withdrawn and the actual expenditures are supposed to be adjusted for in future withdrawals. However, the audit disclosed that MCPA did not accurately adjust future withdrawals based on its quarterly reconciliations. In addition, the audit noted that MCPA made errors when compiling amounts used in the reconciliations. As a result, the report recommended that MCPA refund $115 million to the federal government.

Another DHHS OIG report issued in November 2013 disallowed $3.5 million of federal reimbursements because DHMH had not complied with federal Medicaid requirements regarding rebates when billing manufacturers for physician-administered drugs. The audit report recommended that DHMH refund the $3.5 million.

MCPA generally agreed with both report findings and advised us that the $115 million noted in the first report was refunded, and that the majority of the $3.5 million noted in the second report would also be refunded.

Status of Findings From Preceding Audit Report

We reviewed the status of the 14 findings included in our preceding audit report dated December 6, 2010. We determined that MCPA satisfactorily addressed 12 of these findings. The remaining 2 findings are repeated in this report.

Findings and Recommendations

Contract Monitoring

Background

The Medical Care Programs Administration (MCPA) uses vendors to assist in verifying amounts billed by hospitals, long-term care providers, and Managed Care Organizations (MCOs) and to assist in the oversight and monitoring of various other aspects of the Medicaid process. The contracts for these services are procured by the Department of Health and Mental Hygiene's (DHMH) Office of Procurement and Support Services, which our office audits in conjunction with DHMH's Office of the Secretary. The monitoring of the related services is conducted by MCPA staff and is subject to review during our MCPA audit.

The vendors are used before, during, and after the medical services are provided. Specifically, vendors are used before services are provided to assist in determining the MCOs' capitation rates, to assist individuals in selecting and enrolling in an MCO, to identify possible third-party insurance, and to pre-approve hospital services. Vendors are used during the period that medical services are being provided to approve ongoing services (such as hospital services) or to monitor performance. Vendors are also used after services have been provided and the related payments were made to help ensure payments were proper and were for necessary services and to identify and recover any amounts due from third parties.

MCPA uses a computerized system, the Medicaid Management Information System (MMIS II), to pay provider claims and to process paid claims for federal reimbursement. While MMIS II contains numerous automated edits that are designed to assist in verifying that claims are complete and legitimate, such automated processes cannot ensure all services paid for were actually rendered and appropriate. To help ensure the propriety of claims paid, MCPA also performs post payment audits and reviews using vendors as well as MCPA staff. For example, vendors are used to conduct audits of hospital claims to identify overpayments (such as duplicate bills and charges for services not documented in the medical records) and patient credit balance audits to identify amounts due to the State for claims paid to hospitals and long-term care facilities by both the State and third parties (such as insurance companies). In addition, MCPA uses vendors to review long-term care cost settlements to identify under or overpayments by reconciling a provider's reported actual costs to the reimbursements it received (based on interim rates).

Finding 1
MCPA did not ensure that audits of hospital bills were conducted for claims processed after calendar year 2007 and did not adequately monitor the vendor conducting hospital utilization reviews.

Analysis
MCPA did not ensure that vendors conducted audits of hospital claims as required, and there was also minimal monitoring of hospital utilization reviews. According to MCPA records, during fiscal year 2012, it paid approximately $1.1 billion for hospital services. Specifically, we noted the following conditions:

- Audits of hospital medical records to verify that the services being billed were actually provided were not conducted for claims processed after calendar year 2007. MCPA had contracted with a vendor to audit the hospital bills for which the vendor was paid a percentage of any overpayments found during the audit (the hospital must pay the vendor's fee and must also return the identified overpayment amounts to MCPA). However, the July 2009 contract for these audits was terminated by MCPA in February 2012 because the vendor failed to conduct the required number of audits. Prior to the vendor's termination, the most recent claims audited by the vendor covered services paid during calendar years 2004 through 2007. The failure to audit these claims is significant because State regulations only require the hospitals to retain documentation of the claims for six years. As a result, certain claim data may no longer be available for review.

  These audits were recognized by the federal Centers for Medicare and Medicaid Services (CMS) as a benchmark best practice and have been an effective mechanism for identifying overpayments. For example, during fiscal years 2011 and 2012 (prior to the termination of the contract), the vendor identified overpayments totaling approximately $10.7 million for claims paid during calendar years 2005 and 2006. We were advised by DHMH management personnel that, as of December 31, 2013, a new procurement was in progress to select a vendor to audit hospital claims, and that the new vendor will be required to audit claims for dates of service subsequent to calendar year 2007 to the extent documentation is available.

  MCPA did not adequately monitor another vendor that was responsible for conducting hospital utilization reviews that ensure hospital charges were for medically-necessary procedures and services. We were advised by MCPA management that as a result of staffing shortages, there was minimal monitoring of the vendor since the inception of the contract in calendar year 2010 to ensure the vendor was properly reviewing and pre-approving hospital

services. MCPA monitoring was generally limited to a review of cases for which the hospital appealed the results of the vendor's review. During fiscal year 2013, MCPA paid the vendor $1.8 million for these hospital utilization reviews (approximately $30 per review).

The vendor was required to perform a medical necessity and appropriateness review prior to all hospital services being provided (for emergency procedures approval must be obtained within two business days). The vendor also performed retrospective reviews for individuals who enrolled in Medicaid after the service was performed and were eligible for retroactive coverage. Finally, the vendor performed periodic concurrent reviews during the hospital stay to monitor the length of stay and related treatments.

The failure to monitor the vendor could result in MCPA paying for hospital services that were not medically necessary and/or paying the vendor for reviews that were not performed. In this regard, MCPA terminated the previous hospital utilization review contract after identifying reviews charged to MCPA that could not be supported, resulting in overpayments to the previous vendor of at least $1 million.

Recommendation 1

We recommend that, in the future, MCPA

a. ensure that audits to verify that billed hospital services were provided are conducted in a timely manner, and

b. monitor vendors responsible for conducting hospital utilization reviews to ensure that all reviews invoiced were performed and that the reviews were sufficiently comprehensive and related conclusions were accurate.

Finding 2

MCPA did not conduct patient credit balance audits at long-term care facilities for an extended period or ensure that cost settlement reviews were completed in a timely manner.

Analysis

MCPA did not conduct patient credit balance audits at long-term care (LTC) facilities for an extended period. In addition, MCPA did not review cost settlements in a timely manner, and certain invoices from the vendor conducting the reviews lacked adequate support.

- MCPA did not conduct patient credit balance audits at LTC facilities prior to October 2011. Credit balance audits are needed to identify funds due to the State from provider billing errors, duplicate billings, and/or third-party collections. For example, if MCPA paid a facility for a service and the facility also collected from an insurance company or from the patient, it would result in a credit balance on the patient's account which would be due to the State since Medicaid is to be the payer of last resort. We were advised by MCPA management that the credit balance audits were suspended sometime around fiscal year 2003 (the exact date could not be determined) due to concerns raised by the LTC providers that the audits were not adequately supported and were not fair because the audits covered claims going back several years. MCPA reinstated the audits in fiscal year 2012 but these audits only covered the prior two and one-half year's activity (resulting in approximately six years of activity not being audited).

  In addition, MCPA did not recover the costs of the audits begun in fiscal year 2012 from the LTC facilities as required by State regulations. MCPA pays the vendor a fee of 11.5 percent of the amount recovered as a result of the audits. These fees totaled $151,000 for the audits performed since 2012. State regulations require the providers to reimburse MCPA for the cost of audits in addition to the overpayments disclosed by the audits. As of August 2013, the vendor has recovered $1.3 million from credit balance audits of approximately 100 (of 225) LTC facilities.

- MCPA did not ensure that cost settlements submitted by the 225 LTC facilities were reviewed in a timely manner. LTC facilities are paid an interim rate based on estimated costs and are required to submit an annual cost settlement at year-end to reconcile the estimated costs to the actual costs. MCPA contracts with a vendor to review these cost settlements. Under the contract, the reviews were to be conducted within one year of receipt of the cost settlement. Our review of MCPA records disclosed that 32 cost settlement reviews were conducted more than two years after receipt of the related cost settlements and, as of January 7, 2013, an additional 99 cost settlement reviews had not been performed at all for periods ranging from 14 to 40 months after receipt of the cost settlements. MCPA management advised us that the delay was caused by a lapse in the contract.

  Similar comments regarding the delay in reviewing cost settlements have been included in our two preceding audit reports. According to MCPA records, cost settlements completed in fiscal year 2012 resulted in net recoveries of $2.9 million to MCPA ($9.2 million due to facilities and $12.1 million due to the State).

- MCPA did not verify a portion of the billings from the cost settlement vendor contracted to verify the accuracy of the cost settlements and to perform other "support services" such as assisting in the rate setting process and handling appeals. Specifically, our review of the 12 invoices during the period from October 2011 through September 2012 disclosed that MCPA paid the invoices without obtaining adequate documentation for "support services" charges totaling approximately $1 million. In this regard, the support service invoices were based on hours worked at rates specified for different levels of personnel. However, the invoices did not provide the nature of the support services, the employees who performed the work, or any adequate documentation of the hours worked. As a result, there was a lack of assurance that the amounts paid were proper.

Recommendation 2
We recommend that MCPA ensure that

a. credit balance audits are performed for all LTC facilities and that the costs associated with the audits are recovered from the facilities as required by State regulations;
b. in the future, cost settlement reviews are completed in a timely manner (repeat); and
c. charges related to support services are properly supported.

Finding 3
MCPA did not ensure that the vendor responsible for enrolling new applicants in MCOs met certain contractual performance requirements.

Analysis
MCPA did not adequately monitor the vendor responsible for enrolling new Medicaid applicants. Specifically, MCPA did not use available MMIS II data to independently verify the number of individuals reported as enrolled by the vendor to ensure compliance with the terms of the contract. MCPA paid the vendor (approximately $9 million during fiscal year 2012) to function as an enrollment broker assisting and enrolling individuals in MCOs. Payments were contingent upon the vendor meeting the Voluntary Enrollment Rate (VER), which is the percentage of individuals the vendor directly enrolled in HealthChoice MCOs.

The contract provided for the broker to enroll at least 80 percent of the new applicants each month. Individuals not enrolled by the broker were automatically assigned to an MCO by MCPA. The contract further provided that MCPA may assess specific damages if the enrollment broker did not meet the minimum enrollment.

Our comparison of the enrollments reported by the broker to the related MMIS II records for the six-month period from October 2011 through March 2012 disclosed that the broker overstated enrollment results and did not meet the 80 percent enrollment rate in any of the months reviewed. Specifically, during this period the actual broker enrollment rates ranged from 59 percent to 74 percent but the broker reported rates from 80 percent to 87 percent on its monthly invoices. For example, for March 2012 the broker reported that it had enrolled 11,191 individuals (83 percent of the new enrollees) but according to MMIS II data, the broker only enrolled 8,194 (60 percent of the new enrollees).

In response to our concerns, MCPA conducted an analysis of the broker's performance for the period July 2008 through December 2012. The analysis disclosed that the broker did not meet the required 80 percent enrollment for any month (see table for averages for calendar years 2009 through 2012). Under the terms of the contract MCPA could have withheld payments and terminated the contract due to the broker's failure to achieve the required level of performance. MCPA recovered approximately $900,000 by reducing payments to the broker in September and October 2013 as a result of the shortfalls noted in the aforementioned analysis. The contract provisions for specific damages were limited to the base contract period and not to any contract extensions.

MCPA Analysis of Enrollment Broker Performance

Calendar Year	Average Monthly VER	
	Reported	Actual
2009	87%	71%
2010	83%	67%
2011	83%	66%
2012	84%	61%

Source: MCPA Records

MCPA's lack of monitoring of the accuracy of the reported enrollments and the broker's failure to meet the performance requirements is significant because MCPA extended the contract several times beyond what was provided for in the initial contract. Specifically, the contract covered the three years ending June 30, 2008 with the option to extend the contract through June 2011. MCPA attempted to procure a new contract in fiscal year 2011 but a new contract was not executed due to a bid protest. Instead, MCPA decided to extend the existing contract through fiscal year 2015. The Board of Public Works raised concerns with the contract extension and MCPA management responded that the broker "has completely met our [MCPA's] expectations and fulfilled our [MCPA's] requirements."

Recommendation 3
We recommend that MCPA verify the performance of its enrollment broker and take corrective action, including assessing damages, when the broker does not achieve the required level of performance.

Cost Recoveries and Avoidance

Finding 4
MCPA did not ensure that referrals of potential third-party health insurance information for Medicaid recipients were properly and timely investigated.

Analysis
MCPA did not ensure that potential third-party health insurance information received for Medicaid recipients was investigated properly and in a timely manner. MCPA receives referrals of possible third-party insurance from the Department of Human Resources (DHR) as well as from a contractor. These referrals are sent to MCPA employees to investigate whether the other insurance should cover some, or all, of the claims incurred by the recipients. MCPA did not conduct supervisory reviews to ensure that the investigations were completed, that the appropriate conclusions were reached, and that the insurance status was properly recorded on MMIS II for claims processing. In addition, there was no initial accountability established over referrals to ensure all referrals received from the contractor were investigated.

According to MCPA records, which we did not verify, during fiscal year 2013 MCPA received approximately 79,000 insurance referrals from DHR, and 10,000 from its contractor. Our test of 20 referrals received from DHR disclosed that referrals were not investigated for three recipients, including 2 referrals that were received in June 2011 but had not been investigated as of July 2012 (approximately 400 days). Another referral was investigated 268 days after MCPA was notified of the possible insurance. After we brought this to its attention, MCPA management confirmed that two of the three recipients (for which no investigation was conducted) had active insurance coverage that may have covered claims paid by MCPA.

The failure to properly perform timely follow up on health insurance information could result in improper payments on behalf of recipients with other insurance. It also violates federal regulations which require the State to follow up on potential third-party insurance within 60 days.

Recommendation 4

We recommend that MCPA

a. ensure that initial accountability and control is established over all potential third-party insurance referrals,

b. perform supervisory reviews to ensure timely investigations of referrals were conducted and appropriate conclusions were reached, and

c. review cases referred during the audit period and take appropriate corrective action.

Finding 5

MCPA did not have sufficient procedures to maximize the recovery of Medicare funding for Medicaid recipients.

Analysis

MCPA did not have sufficient procedures to maximize Medicare funding for Medicaid recipients. Medicare is entirely federally funded, and the amount paid on fee-for-service claims by Medicaid for recipients with both Medicare and Medicaid coverage is generally less than amounts paid for recipients who only have Medicaid. Providers must submit claims for Medicare reimbursement before submitting them to Medicaid, which generally covers the Medicare coinsurance and deductibles.

- MCPA had not established a process to ensure that recipients age 65 or older had applied for Medicare as required by State regulations. State regulations require Medicaid applicants age 65 years or older, or blind or disabled to furnish proof that they have applied for or are receiving Medicare. During the initial application process and annual redeterminations, DHR employees are supposed to ensure that Medicaid applicants have applied for Medicare. However, prior to August 2012, MCPA made no attempt to identify recipients who did not have Medicare coverage but could potentially be eligible (such as those over 65 years of age) to determine if they had applied for Medicare. In August 2012, MCPA sent notices to recipients age 65 or older with no Medicare number recorded on MMIS II to advise them that they needed to apply for Medicare to retain their Medicaid benefits. As a result of these mailings and follow-up notices, MCPA management advised us that 1,851 new recipients were subsequently enrolled in Medicare as of February 8, 2013.

  Since Medicare covers a significant portion of medical costs, the failure to ensure Medicaid recipients applied for Medicare means that the State Medicaid program, rather than the federal Medicare program, will bear a higher portion of the costs. In this regard, during calendar year 2011, MCPA

paid inpatient hospitalization claims totaling $29 million for 1,200 recipients who were at least 65 years old as of January 1, 2011 but were not enrolled in Medicare per MMIS II. Our test of 50 of these recipients with the highest Medicaid claims disclosed that 40 with claims totaling $6.3 million were potentially eligible for Medicare based on their coverage group and their age. The remaining 10 recipients with claims totaling $1.8 million were not eligible for Medicare due to their citizenship status.

- MCPA lacked adequate procedures to ensure that the correct amount was paid for individuals with both Medicaid and Medicare coverage. During our preceding audit, we identified instances where MCPA paid providers more than the amount invoiced because of data entry errors (such as entering the wrong coinsurance amount in MMIS II) and recommended that MCPA establish online controls to prevent such overpayments. In response to our preceding report, MCPA developed a monthly output report of claims which was used by MCPA supervisors to select cases for review. However, the report only listed claims for which the amount paid by MCPA exceeded the amount invoiced by the provider (which was the specific deficiency identified during our preceding audit). As a result, any data entry error for which the coinsurance did not exceed the total amount invoiced would not be subject to any review.

  We tested 9 claims totaling $58,580 for which the amount reimbursed by MCPA ranged from 62 percent to 100 percent of the amount billed, which was higher than the typical contribution percentage of 10 percent when Medicare participates in the claim payments. Our review disclosed that MCPA overpaid 7 of these claims by $35,004 and could not provide documentation to support the propriety of another claim totaling $4,522. For example, for one claim, the provider submitted a bill for $13,303, for which Medicaid was responsible for $181. Instead, MCPA paid $12,399 because MCPA staff entered an erroneous amount into the coinsurance field. These overpayments were not included on the aforementioned reports because the amount paid was less than the amount billed.

Recommendation 5
We recommend that MCPA

a. establish procedures to ensure all Medicaid recipients who are eligible for Medicare apply for Medicare benefits; and

b. establish comprehensive procedures for identifying improperly billed claims for individuals with both Medicaid and Medicare coverage and take appropriate follow-up action, including the recovery of any overpayments.

Recipient Eligibility

Finding 6
MCPA needs to continue efforts to address longstanding deficiencies with the recipient enrollment process to help ensure that corrective action is taken.

Analysis
MCPA needs to continue efforts to address longstanding deficiencies with the recipient enrollment process to help ensure that corrective action is taken. DHMH and DHR maintain a Memorandum of Understanding (MOU) which assigns responsibility to DHR for determining applicants' eligibility for participation in the Medical Assistance Program.[1] Under the MOU, DHMH is responsible for establishing regulations, guidelines, and procedures to be used by DHR. Deficiencies with the eligibility process and related monitoring have been commented upon in our MCPA and various DHR audit reports dating back to 1992. In addition, federal single audit reports dating from fiscal year 2007 through 2012 identified deficiencies with recipient eligibility determinations. Our preceding audit further noted that the aforementioned conditions occurred, at least in part, because the MOU between DHMH and DHR did not provide for adequate MCPA oversight, did not include comprehensive procedures to ensure problems were corrected, and was generally outdated.

In response to our preceding audit report, MCPA updated its MOU with DHR in July 2011, and started to develop a more comprehensive process to monitor the eligibility process. Specifically, after our current audit period, MCPA created a new unit to monitor DHR activity and developed reports to identify possible issues with the eligibility process. This initiative and related monitoring noted that there was still a significant delay in reviewing enrollees that required investigation (such as for enrollees that applied for coverage in another State). According to MCPA records as of January 2013, there were 2,113 alerts that needed to be investigated that were outstanding for an average of 31 days. In addition, the reports noted that as of January 2013, there were 9,246 redeterminations that were overdue by an average of four months.

As a result of the creation of the Maryland Health Benefit Exchange (MHBE) and the State's decision to use MHBE to enroll new Medicaid recipients, certain aspects of the enrollment process were scheduled to be transferred from DHR to MHBE, including the process for annually redetermining recipient eligibility for Medicaid benefits.

[1] Eligibility for certain MCPA programs, such as the Primary Adult Care Program which represents about six percent of the caseload, is determined solely by MCPA.

However, MHBE has experienced problems with its health insurance enrollment system, and MCPA management advised that, as of March 17, 2014, DHR continued to have an active role in the enrollment process. Also, although the eligibility redetermination process has been temporarily suspended, we were advised that, when it resumes, DHR will continue to be responsible for redeterminations until MHBE can assume this responsibility.

MCPA management also advised that enrollees will always have the ability to enroll for Medicaid benefits via DHR's local departments of social services (such as when enrollees are applying for multiple types of benefits simultaneously). Given the current situation with MHBE and the continued reliance on DHR, MCPA still needs to monitor the DHR enrollment process.

Recommendation 6
We recommend that MCPA continue to monitor the eligibility process and work with DHR to ensure that actions are implemented to correct the aforementioned deficiencies (repeat).

Information Systems Security and Control

Background

MCPA operates the Electronic Data Interchange Translator Processing System (EDITPS), an Internet web-based application that allows health care providers to electronically submit Medicaid claims. After claims data have been received and subjected to limited edits, the EDITPS application delivers the claims data to the MMIS II application, which operates on the Annapolis Data Center (ADC), to complete claims processing and payment. MCPA manages MMIS II's application program development and maintenance and uses the ADC's security software to help secure MMIS II. In addition, MCPA uses the DHMH firewall to protect critical EDITPS servers.

MCPA also contracts with a third party to operate the eMedicaid suite of Internet web-based applications which include the Electronic Verification System and EClaims System both of which support Medicaid's health care provider community. For example, the eMedicaid system is used by providers to verify recipient eligibility and to submit certain types of claims.

Finding 7
DHMH firewall rules allowed unnecessary and insecure connections to the EDITPS servers.

Analysis
Firewall rules applicable to EDITPS servers were not properly configured which allowed unnecessary and insecure connections to the EDITPS servers. For example, numerous DHMH network servers, such as certain email servers, that resided in a neutral network zone could unnecessarily access all EDITPS servers on the internal network via several ports. The Department of Information Technology's (DoIT) *Information Security Policy* specifies that information systems shall be configured to monitor and control communications at external boundaries within the system and at key internal boundaries within the system.

Recommendation 7
We recommend that MCPA request DHMH to configure its firewall to achieve a "least privilege" security strategy giving individuals and devices only those privileges needed to perform assigned tasks.

Finding 8
MCPA lacked assurance that the outsourced eMedicaid system was properly secured.

Analysis
MCPA lacked assurance that the outsourced eMedicaid system was properly secured. Effective August 31, 2010, DHMH entered into an MOU with an independent service provider to host and manage the eMedicaid suite of web applications.

We noted that the MOU did not require the service provider to obtain and/or periodically provide MCPA with an independent review and report. In May 2011, the American Institute of Certified Public Accountants issued guidance concerning examinations of such service organization's controls. Based on this guidance, customers, such as MCPA, may obtain from service organizations an independent auditor's report referred to as a Service Organization Controls (SOC) 2 type 2 report. A SOC 2 type 2 report can address critical measures relating to security, availability, processing integrity, confidentiality and privacy over the hosted environment and system. In addition, although the MOU contained provisions that the service provider must cooperate with State auditors, MCPA did not use DHMH auditors to perform any audits of the service provider.

Without either an independent review and related SOC report or a DHMH audit of the service provider for the outsourced eMedicaid system, MCPA lacked reasonable assurance as to whether the contractor had established and implemented adequate security. Best practices require that service providers demonstrate compliance with industry information security requirements, and that customer entities regularly obtain from service providers related reports that evidence such compliance.

Recommendation 8
We recommend that MCPA

a. either ensure (via contract if necessary) that the eMedicaid system service provider periodically obtains a SOC 2 type 2 report for the provided services or use DHMH audit resources to periodically perform security and control reviews of the service provider, and

b. obtain and review copies of any SOC or DHMH audit reports to ensure all security-related provisions were adequately addressed by the service provider.

Finding 9
Monitoring controls over critical mainframe MMIS II production files were not sufficient.

Analysis
Monitoring controls over critical mainframe MMIS II production files were not sufficient. Specifically, we noted the following conditions:

- We were advised that reports of logged, authorized modifications to critical MMIS II data and program production files were regularly generated and reviewed. However, there was no documentation supporting these reviews or any investigation of questionable items.

- Reports of logged direct changes made to the MMIS II production database were regularly generated but not reviewed. These reviews should include examinations of the before and after images of these changes to ensure the propriety of these changes.

The State of Maryland Department of Information Technology *Information Security Policy* requires that procedures be developed to routinely (for example daily or weekly) review audit records for indications of unusual activities, suspicious activities or suspected violations, and report findings to appropriate officials for prompt resolution.

Recommendation 9

We recommend that the MCPA

a. perform timely, documented reviews and investigations of the reports of logged, authorized modifications to critical MMIS II data and program files;

b. perform timely, documented reviews and investigations of the reports of logged direct changes made to the MMIS II production database including examinations of before and after images of these changes; and

c. retain all such documentation for future reference.

Audit Scope, Objectives, and Methodology

We have audited the Medical Care Programs Administration (MCPA) of the Department of Health and Mental Hygiene (DHMH) for the period beginning July 1, 2009 and ending June 30, 2012. The audit was conducted 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 obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

As prescribed by the State Government Article, Section 2-1221 of the Annotated Code of Maryland, the objectives of this audit were to examine MCPA's financial transactions, records, and internal control, and to evaluate its compliance with applicable State laws, rules, and regulations. We also determined the status of the findings contained in our preceding audit report.

In planning and conducting our audit, we focused on the major financial-related areas of operations based on assessments of materiality and risk. The areas addressed by the audit included provider eligibility, managed care organizations, enrollee eligibility, long-term care, hospital services, post payment verification, kidney disease program, cash receipts, collections, and information system controls.

To accomplish our audit objectives, our audit procedures included inquiries of appropriate personnel, inspections of documents and records, observations of MCPA's operations, and tests of transactions. We also extracted data from the Medicaid Management Information System (MMIS II) for the purpose of testing recipient and provider eligibility and payments to providers and managed care organizations. We performed various tests of the relevant data and determined that the data were sufficiently reliable for the purposes the data were used during the audit. Finally, we performed other auditing procedures that we considered necessary to achieve our objectives. The reliability of data used in this report for background or informational purposes was not assessed.

Our audit did not include certain support services provided to MCPA by DHMH's Office of the Secretary. These support services (such as payroll processing, payment of operating expenses) are included within the scope of our audit of DHMH - Office of the Secretary.

MCPA's management is responsible for establishing and maintaining effective internal control. Internal control is a process designed to provide reasonable assurance that objectives pertaining to the reliability of financial records, effectiveness and efficiency of operations including safeguarding of assets, and compliance with applicable laws, rules, and regulations are achieved.

Because of inherent limitations in internal control, errors or fraud may nevertheless occur and not be detected. Also, projections of any evaluation of internal control to future periods are subject to the risk that conditions may change or compliance with policies and procedures may deteriorate.

Our reports are designed to assist the Maryland General Assembly in exercising its legislative oversight function and to provide constructive recommendations for improving State operations. As a result, our reports generally do not address activities we reviewed that are functioning properly.

This report includes findings related to conditions that we consider to be significant deficiencies in the design or operation of internal control that could adversely affect MCPA's ability to maintain reliable financial records, operate effectively and efficiently, and/or comply with applicable laws, rules, and regulations. Our report also includes findings regarding significant instances of noncompliance with applicable laws, rules, or regulations. Other less significant findings were communicated to MCPA that did not warrant inclusion in this report.

The response from DHMH, on behalf of MCPA, to our findings and recommendations is included as an appendix to this report. As prescribed in the State Government Article, Section 2-1224 of the Annotated Code of Maryland, we will advise DHMH regarding the results of our review of its response.

APPENDIX

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

April 22, 2014

Mr. Thomas J. Barnickel III, CPA
Legislative Auditor
Office of Legislative Audits
301 W. Preston Street
Baltimore, MD 21201

Dear Mr. Barnickel:

Thank you for your letter regarding the draft audit report of the Medical Care Programs Administration (MCPA) for the period beginning July 1, 2009 and ending June 30, 2012. Enclosed is the Department's response and plan of correction that addresses each audit recommendation. I will work with the appropriate Administration Directors, Program Directors, and Deputy Secretary to promptly address all audit exceptions. In addition, the OIG's Division of Internal Audits will follow-up on the recommendations to ensure compliance.

If you have any questions or require additional information, please do not hesitate to contact me at 410-767-4639 or Thomas V. Russell, Inspector General, at 410-767-5862.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: Charles Lehman, Interim Deputy Secretary, Health Care Financing, DHMH
Thomas V. Russell, Inspector General, DHMH
Ellwood L. Hall, Jr., Assistant Inspector General, DHMH
Patrick Dooley, Chief of Staff, DHMH

Contract Monitoring

Finding 1
MCPA did not ensure that audits of hospital bills were conducted for claims processed after calendar year 2007 and did not adequately monitor the vendor conducting hospital utilization reviews.

Recommendation 1
We recommend that, in the future, MCPA

a. ensure that audits to verify that billed hospital services were provided are conducted in a timely manner, and

b. monitor vendors responsible for conducting hospital utilization reviews to ensure that all reviews invoiced were performed and that the reviews were sufficiently comprehensive and related conclusions were accurate.

Administration's Response:

1a. The Administration concurs. In February 2012, the Administration terminated the contract to conduct hospital bill audits. Since that time, the Administration has made efforts to obtain a contractor for hospital bill audits. In 2011, federal regulations were promulgated to require each State to obtain a Medicaid Recovery Audit Contractor (RAC). The RAC is similar to the type of vendor the Administration previously utilized, however under the new regulations, other providers, in addition to hospitals, must be audited. In addition, there are limitations on the amount and type of compensation the vendor may receive. To this end the State has issued two RFP's to obtain a RAC vendor. The first RFP dated May 17, 2013 received no responses. The second RFP issued on October 2, 2013, received one proposal. The proposal was severely inadequate and was submitted by the vendor the State terminated in 2012. The Administration withdrew the RFP. The Administration is now seeking a waiver from CMS to pay a higher contingency rate in order to attract potential vendors.

As an interim solution, the DHMH Office of the Inspector General began conducting limited reviews of hospitals and retained the services of a consultant to provide training to the OIG clinical staff in conducting these reviews.

In addition, to prevent the potential for "unavailable" records prior to auditing, the Administration issued Hospital Program Transmittal 223, dated May 13, 2013 requiring all hospitals to retain all records since January 1, 2007 for audit purposes.

1b. The Administration concurs. On January 8, 2014, a Nurse Program Consultant Administrator was hired specifically for the review of cases that have been approved by the hospital utilization review vendor. The MCPA is now monitoring all vendor reviews for sufficiency and accuracy, and to ensure all reviews invoiced were performed.

Finding 2
MCPA did not conduct patient credit balance audits at long-term care facilities for an extended period or ensure that cost settlement reviews were completed in a timely manner.

Recommendation 2
We recommend that MCPA ensure that

a. credit balance audits are performed for all LTC facilities and that the costs associated with the audits are recovered from the facilities as required by State regulations;
b. in the future, cost settlement reviews are completed in a timely manner (repeat); and
c. charges related to support services are properly supported.

Administration's Response:
2a. The Administration concurs to ensure that credit balance audits are performed for all LTC facilities and that the costs associated with the audits are recovered from the facilities as required by State regulations. The Administration now has in place a contract to perform the credit balance audits and expects the contract to continue in the future. Additionally, LTC facilities will be notified that contingency fees will be charged commencing with the quarter following completion of the first round of credit balance audits, beginning April 2014.

2b. The Administration concurs. A protest of the contract award did not allow the current Contractor to complete timely settlements. This was not a deficiency in MCPA administration, but rather a procurement issue outside MCPA's control.
An agreement was reached to integrate the old settlements into the new contractor's inventory. Regarding the 32 Cost Settlements that were conducted more than 2 years after receipt of the related cost reports, the FY 2012 budget was increased to include funds for the current vendor to reduce the backlog (total 167) that resulted from protest of the contract award. To date, of the 167 backlogged case settlements to be completed, 156 have been completed, leaving a balance of eleven (11). Additionally, there can be several unanticipated factors that could affect the timeliness of the completion of cost settlements such as change of ownership, facilities in bankruptcy, providers under investigation, and those referred to the Central Collection Unit.

2c. The Administration concurs. The Contractor continues to submit supporting documentation as per the RFP and contract requirements. The MCPA obtained additional supporting documentation for the 12 invoices during the period of October 2011 through September 2012 to support services charges totaling approximately $1 million. The additional documentation includes the nature of the support services and names of employees who performed the work which was determined to adequately support the submitted charges.

The MCPA has established procedures with the vendor to regularly attach to its support services invoices additional subsidiary documents (i.e. list of employees and related timesheets). These additional subsidiary documents will be used to verify the accuracy and appropriateness of the support services invoices received from the vendor.

Finding 3
MCPA did not ensure that the vendor responsible for enrolling new applicants in MCOs met certain contractual performance requirements.

Recommendation 3
We recommend that MCPA verify the performance of its enrollment broker and take corrective action, including assessing damages, when the broker does not achieve the required level of performance.

Administration's Response:
The Administration concurs with the recommendation.

As previously shared with the auditors, MCPA was advised of an increase in auto assigned enrollments sent to the Managed Care Organizations (MCOs) beginning in July 2012. Upon further investigation, it was discovered that the Enrollment Broker was not accurately counting all of the auto assigned enrollments that were attached to new enrollments for a given month by not extending the time frame long enough to capture them all.

Subsequently, MCPA reviewed the enrollments reported by the Enrollment Broker for a period of July 1, 2008-December 31, 2012. Once MCPA was able to align the data elements and reconcile the information for the audit period, it was revealed there was a difference in the reported voluntary enrollment rate (VER) percentages, sometimes as much as a 20% variance in the calculation. This discrepancy resulted in the Enrollment Broker miscalculating the VER and overbilling MCPA in the amount of $909,073.01 for the above referenced audit period. Additionally, because of the miscalculation, the Enrollment Broker failed to meet the 80% VER contract performance standard for this period.

As a result of our findings, MCPA implemented a corrective action plan (CAP) for service level improvement in April 2013 which included refinement of the report criteria to allow for a more accurate count of enrollments. On a monthly basis, MCPA compares the Enrollment Broker's calculated results with MMIS data to ensure the Enrollment Broker continues to meet the contract requirements. Additionally, the Enrollment Broker has increased outreach initiatives in an effort to voluntarily enroll more recipients per month to lessen the overall monthly auto assignment rate. To date, the Enrollment Broker has successfully met the requirements of the CAP and continues to achieve the required service levels. If in the future the Enrollment Broker does not achieve the required service levels, then MCPA will assess the appropriate amount of liquidated damages pursuant to contract provisions.

Moreover, the total overpayment amount of $909,073.01 was fully recovered by MCPA in October 2013.

Cost Recoveries and Avoidance

Finding 4
MCPA did not ensure that referrals of potential third-party health insurance information for Medicaid recipients were properly and timely investigated.

Recommendation 4
We recommend that MCPA

a. ensure that initial accountability and control is established over all potential third-party insurance referrals,
b. perform supervisory reviews to ensure timely investigations of referrals were conducted and appropriate conclusions were reached, and
c. review cases referred during the audit period and take appropriate corrective action.

Administration's Response:

4a.The post-payment recovery vendor is now required to provide additional control documents that enable MCPA to reconcile referrals provided with referrals processed.

4b**.** The Administration partially concurs with the recommendation. Procedures were in place during the last audit period, however, additional steps will be implemented to strengthen our procedures. DRAFS will increase Quality Assurance efforts and put in place procedures to ensure that cases are started within the Federal regulations.

4c. The Administration concurs with the recommendation. MCPA has completed a review and made corrections.

Finding 5
MCPA did not have sufficient procedures to maximize the recovery of Medicare funding for Medicaid recipients.

Recommendation 5
We recommend that MCPA

a. establish procedures to ensure all Medicaid recipients who are eligible for Medicare apply for Medicare benefits; and
b. establish comprehensive procedures for identifying improperly billed claims for individuals with both Medicaid and Medicare coverage and take appropriate follow-up action, including the recovery of any overpayments.

Administration's Response:

5a. The MCPA concurs. It has been Maryland Medicaid policy to require recipients age 65 and over, to provide proof that they have applied for Medicare Part A and B, in order to continue to be eligible for Medicaid benefits. Under this policy and the implementing regulation at COMAR 10.09.24.04O, the case worker is responsible for ensuring that the individual is Medicare eligible or has applied.

The Department believes it is important to note that 100% enrollment for all recipients over the age of 65 is highly unlikely for the following reasons:

1. The X02 category (undocumented or ineligible aliens) will never meet Medicare eligibility requirements.

2. Recipients who have not been in the United States legally for 5 years will also be restricted from Medicare enrollment.

3. An applicant must present proof from the Social Security Administration that an application has been filed. Although the applicant is required to apply for Medicare Part "A", there is no requirement to purchase this benefit. Persons who have not earned sufficient quarters of coverage under Social Security are not eligible for free Part A coverage. Nevertheless, the applicant must apply for, but may reject this coverage if payment of a premium is required.

As part of efforts in the Monitoring & Special Projects Division created in April of 2012 within the Office of Eligibility Services (OES), 8,086 Medicaid recipients over age 65 without Medicare were identified. In August 2012 an over 65 project was initiated to assist applicants/recipients apply for Medicare if and when applicable. A new report is received every quarter and it is noted that many of the recipients listed are in Long Term Care facilities.

A portion of applicants/recipients had been denied Medicare by Social Security in error. As a result, we reached out to our Social Security partners to advise them of our findings and shared our outreach initiative with them. We also identified individuals who had not applied, and educated applicants/recipients on the requirement and assisted them with the process. Finally, for recipients who do not respond to our outreach efforts, we provide DHR notice to proceed with follow-up which could result in closing the eligibility span of the recipient until they are able to comply.

OES will continue to have ongoing dialogue with DHR and case workers to address the need to monitor this population. The regulation and work flow requirement is addressed in MA training conducted by DHMH. The Monitoring & Special Projects Division will continue to monitor case worker/applicant/recipient compliance and continue working with our Social Security partners to ensure that applicants/recipients are receiving the benefits for which they may be entitled to.

MCPA conducted a review on 40 of the 50 cases for the recipients 65 and over cited with "no Medicare." It is noted there was a case where the recipient expired prior to the CY2011 review period, and the MA case was closed. There were other cases that DHR workers demonstrated efforts to inform recipients of the requirements for enrolling into Medicare. For cases where the recipient did not comply with the Medicare requirements, an adverse action was taken and the MA case was closed. In addition, some of the recipients have Medicare Buy-in coverage that was active during the CY2011 review period. Findings to support our analysis are available upon request.

5b. The Administration concurs to develop more comprehensive procedures. The MCPA has procedures in place for identifying improperly billed claims for individuals with both Medicaid and Medicare. As stated in your analysis, the MCPA developed a monthly report which is used by MCPA supervisors to select cases for review. The examples cited in your finding pertain to claim information that was keyed incorrectly by MCPA staff. To identify overpayments in the future for crossover claims, the MCPA is researching additional ways to identify keying errors. The MCPA will take appropriate follow-up action including the recovery of any overpayments if required.

Recipient Eligibility

Finding 6
MCPA needs to continue efforts to address longstanding deficiencies with the recipient enrollment process to help ensure that corrective action is taken.

Recommendation 6
We recommend that MCPA continue to monitor the eligibility process and work with DHR to ensure that actions are implemented to correct the aforementioned deficiencies (repeat).

Administration's Response:
While the Administration concurs with the recommendation to continue monitoring the eligibility process and correct the deficiencies noted in the report, we note there will always be issues to resolve with the eligibility process. Since the last audit, significant progress has been made to address the previously cited issues

For example, MCPA updated the MOU with DHR in response to the most recent audit report. The monitoring efforts also have been greatly enhanced with the establishment of a Monitoring & Special Projects Division within the Office of Eligibility Services (OES) which was fully staffed in June 2012. As a result of the unit's efforts, there has been a significant improvement with the eligibility processes, particularly in a documented 90% decrease in outstanding redeterminations.

Additionally, since establishing the Monitoring Unit, it should be noted that there were no eligibility related findings for the 2013 State Single Audit resolving a long-standing finding since 2007. Several new systems such as the PIRAMID (Program Integrity Reporting and Management Information Database), which replaces monthly reviews of the small retroactive samples with a review mechanism applied to all eligibility determinations before they are finalized, and the Enterprise Content Management Solutions (ECMS) system, which helps to guard against record losses by converting all records into an electronic format to reduce reliance on paper records have been developed to address eligibility issues. Effective February 2014, MCPA now has access to ECMS. It is expected that the implementation of these systems will allow MCPA to monitor case processing faster and more efficiently.

The Division generates reports which are shared monthly via email and in-person at bi-monthly DHR/DHMH Joint Collaboration Workgroup Meetings and at quarterly Corrective Action Panel (CAP) meetings which allows us to continue to work on opportunities for improvements.

Information Systems Security and Control

Finding 7
DHMH firewall rules allowed unnecessary and insecure connections to the EDITPS servers.

Recommendation 7
We recommend that MCPA request DHMH to configure its firewall to achieve a "least privilege" security strategy giving individuals and devices only those privileges needed to perform assigned tasks.

Administration's Response:
MCPA concurs with the recommendation and has provided the audit recommendation to the Department's OIT for review as this audit finding/recommendation is outside the scope of MCPA's control. It is our understanding from OIT that the recommended corrections are being implemented in response to OLA's audit of the DHMH Office of the Secretary. MCPA will work with OIT to ensure that this issue is resolved.

Finding 8
MCPA lacked assurance that the outsourced eMedicaid system was properly secured.

Recommendation 8
We recommend that MCPA

a. either ensure (via contract if necessary) that the eMedicaid system service provider periodically obtains a SOC 2 type 2 report for the provided services or use DHMH audit resources to periodically perform security and control reviews of the service provider, and

b. obtain and review copies of any SOC or DHMH audit reports to ensure all security-related provisions were adequately addressed by the service provider.

Administration's Response:

8a**.** The Administration concurs with the recommendation**.** A security and controls review of eMedicaid, including a penetration test, will be incorporated into the annual MMIS Risk Assessment review.

8b. The Administration concurs with the recommendation. The above-referenced report will be reviewed to ensure that all security-related issues are adequately addressed by the service provider.

Finding 9
Monitoring controls over critical mainframe MMIS II production files were not sufficient.

Recommendation 9
We recommend that the MCPA

a. perform timely, documented reviews and investigations of the reports of logged, authorized modifications to critical MMIS II data and program files;
b. perform timely, documented reviews and investigations of the reports of logged direct changes made to the MMIS II production database including examinations of before and after images of these changes; and
c. retain all such documentation for future reference.

Administration's Response:

9a**.** The Administration concurs with the recommendation. The MCPA will review the critical dataset report timely and document the review via email notification to the DHMH Security Officers.

9b. The Administration concurs with the recommendation**.** The MCPA will require all database updates to capture the "before" and "after" images. All database updates will be centrally logged along with supporting documentation, and before and after images.

A LOG ANALYZER job will be created that will run 7 days a week which will generate a report that displays logon id(s) that modify production database tables.

The Administration will review and match the LOG ANALYZER report against the update log and supporting documentation daily. Any discrepancies will be investigated immediately.

9c. The Administration concurs with the recommendation. The MCPA will retain all related documentation as noted above for future reference.

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