Audit Report

Department of Health and Mental Hygiene
Family Health Administration

July 2008

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

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July 18, 2008

Senator Verna L. Jones, Co-Chair, Joint Audit Committee
Delegate Steven J. DeBoy, Sr., Co-Chair, Joint Audit Committee
Members of Joint Audit Committee
Annapolis, Maryland

Ladies and Gentlemen:

We have audited the Family Health Administration (FHA) of the Department of Health and Mental Hygiene for the period beginning September 14, 2004 and ending October 31, 2007.

Our audit disclosed that FHA did not take any substantive action when a vendor failed to attain a national certification for Maryland's Cancer Registry (MCR), as required by the contract. Although the certification was obtained in a subsequent year, critical registry data under the control of the vendor was determined to be deliberately altered to indicate that individuals had cancer when in fact they did not. The Department referred the matter to the Office of the Attorney General – Criminal Division in December 2006. The MCR is the central database for all cancers in the State of Maryland. MCR data is used by the federal Centers for Disease Control and Prevention, the North American Association of Central Cancer Registries, other states, and researchers.

FHA did not exercise adequate oversight of grants awarded to certain local public health departments and academic institutions from the Cigarette Restitution Fund (CRF). Such grants totaled $38.4 million during fiscal year 2007. FHA did not conduct annual site visits of grantees to verify compliance with program goals and fiscal requirements nor take action when grant performance requirements were not met.

Certain internal control deficiencies were identified pertaining to the processing of provider claims for the Breast and Cervical Cancer Detection and Treatment Program. We also noted that grant funds totaling $11.3 million made to Prince George's Hospital Center were not properly monitored and accounted for, in accordance with State law.

Respectfully submitted,

Bruce A. Myers, 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
Family Health Administration (FHA)
July 2008

- **FHA did not take any substantive action when a vendor failed to attain a national certification for Maryland's Cancer Registry (MCR), as required by the contract. Subsequently, certain MCR data under the control of the vendor was deliberately altered to indicate that certain individuals had cancer when in fact they did not. During the period beginning July 2006 and ending January 2008, FHA made payments totaling approximately $1.9 million to this vendor for managing the MCR.**

  In the future, FHA should take substantive action when conditions of a contract are not met or document why no action was taken. FHA should also work in conjunction with the State Office of the Attorney General – Criminal Division, and other appropriate agencies, to investigate and resolve the aforementioned alterations to the MCR data.

- **FHA did not exercise adequate oversight of Cigarette Restitution Fund (CRF) grants.**

  FHA should conduct annual site visits of grantees to verify compliance with program goals and fiscal requirements, take appropriate action when performance requirements are not met, and ensure that the annual expenditure reports are submitted timely.

- **The eligibility criteria for determining if an individual has the financial means to pay for treatment services provided by programs that were funded by CRF was not consistent throughout the State.**

  FHA should establish Statewide eligibility criteria for the CRF Programs that are consistent throughout the State.

- **FHA did not submit reports detailing the effectiveness of the CRF Programs within the timeframe prescribed by State law.**

  In the future, FHA should submit the required reports in a timely manner.

- **Certain internal control deficiencies were noted regarding the processing of the claims for the Breast and Cervical Cancer Detection and Treatment Program (BCCDTP), which totaled approximately $12.6 million for fiscal year 2007.**

  Supervisors should perform, at least on a test basis, reviews of claims that are processed using system overrides and claims should be paid in accordance with the time limits established by State regulations. Periodic patient surveys should be conducted to determine the validity of medical procedures invoiced by providers and automated procedures should be developed to identify questionable claims.

- **FHA did not have adequate procedures to follow up on BCCDTP recipients who failed to respond to requests to apply for Medical Assistance benefits (Medicaid) or to identify all BCCDTP recipients that were retroactively eligible for Medical Assistance.**

  To reduce State treatment costs, FHA should implement appropriate follow-up procedures when recipients do not respond to its request to apply for Medicaid. FHA should also identify and recover all BCCDTP claims paid for Medicaid enrollees in a timely manner.

- **Grant funds totaling $11.3 million made to Prince George's Hospital Center were not properly monitored and accounted for, in accordance with State law.**

  FHA should require the Center to provide a budget detailing how funds will be spent, obtain annual detail reports of grant expenditures, and conduct annual financial audits to verify the propriety of reported expenditures.

Background Information

Agency Responsibilities

The Family Health Administration (FHA) protects, promotes, and improves the health and well-being of all Marylanders and their families by working to assure the availability of quality primary, preventive, and specialty health care services, with special attention to at-risk and vulnerable populations. In so doing, FHA aims to prevent and control chronic diseases, prevent injuries, provide public health information, and promote healthy behaviors.

FHA is also responsible for administering the Tobacco Use Prevention and Cessation Program and the Cancer Prevention, Education, Screening, and Treatment Program, which are designed to reduce tobacco use, cancer deaths, and tobacco-related diseases in the State. These Programs are financed by the Cigarette Restitution Fund.

According to FHA's records, its expenditures totaled approximately $203 million during fiscal year 2007, including $46 million applicable to the Cigarette Restitution Fund.

Status of Findings From Preceding Audit Report

Our audit included a review to determine the status of the 11 findings contained in our preceding audit report dated November 1, 2005. We determined that FHA satisfactorily addressed 9 of the aforementioned 11 findings. The remaining 2 findings are repeated in this report and appear as 1 finding.

Findings and Recommendations

Maryland Cancer Registry (MCR)

Finding 1
FHA did not take any substantive action when a vendor failed to attain a national certification for Maryland's cancer registry, as required by the contract. In addition, certain registry data under the control of the vendor was determined to be deliberately altered.

Analysis

In 2002, FHA awarded a contract for the management of the Maryland Cancer Registry (MCR), which is the central database for all cancers in the State of Maryland. As a condition of this contract, the vendor was required to attain a national certification for the MCR dataset from the North American Association of Central Cancer Registries (NAACCR). The 2001 MCR dataset submitted in December 2003 was not certified by NAACCR. We were advised by FHA management that, while it made certain inquiries about the certification results with the vendor, no substantive action (for example, termination of the contract) was taken.

Although the certification was obtained in the subsequent year (that is, the 2002 dataset which was submitted to NAACCR in December 2004), critical MCR data under the control of the vendor was determined to be deliberately altered to indicate that numerous individuals had cancer when they did not. As a result, the dataset was erroneously considered to be complete and accurate by NAACCR. With respect to this dataset, we noted the following conditions:

- The 2002 dataset submitted to NAACCR in December 2004 was not reviewed by FHA until August 2005. Upon this review, FHA noted significant increases in the number of cases of cervical cancer and melanoma. Specifically, from 1998 to 2002, there was an overall 8 percent increase for the number of cancers recorded in the MCR. However, there was more than a 90 percent increase in cervical cancer cases and a 70 percent increase in melanoma cases reported in the MCR for the same time period. At the time, the vendor could not provide FHA with an adequate explanation for the increases.

- Beginning in July 2005, as part of the Department of Health and Mental Hygiene's (DHMH) "Study of Breast and Cervical Cancer Diagnosis in Maryland Women" we were advised that approximately 2,300 patients

recorded in the MCR with having breast cancer or cervical cancer were selected and sent letters to participate in the study. After the letters were sent, FHA received approximately 10 calls from women who had received the letters but had never been diagnosed as having cancer. FHA later estimated that up to 400 women who were sent letters under this study stating that they had cervical cancer did not have cervical cancer. According to the 2002 MCR dataset, these women had been diagnosed with cancer in 2002 and were eligible to be included in the study. However, for selected women who were sent letters under the study, FHA subsequently obtained the related reports that clearly stated that the specimens did not contain cancer.

- In May 2006, a former vendor employee informed FHA that MCR data was deliberately altered while under the control of the vendor. At that time, DHMH's Office of the Inspector General (OIG) began an investigation, the aforementioned study was suspended, and the vendor terminated the employee responsible for the MCR data. In December 2006, the results of the OIG's investigation were referred to the Federal Department of Health and Human Services – Office of Research Integrity (ORI) and the State's Office of the Attorney General – Criminal Division.

The vendor also completed its own investigation and deemed that the MCR data (for 2001 and 2002) had been deliberately altered between August 2004 and December 2004. Specifically, over 13 percent of all cases in diagnosis year 2002 showed some sign of alteration, especially cervical, prostate, and melanoma cancer cases. The investigation disclosed that the changes were made after the cases were initially entered into the MCR by the laboratory facility or provider (such as, changes to the codes from non-invasive cancer to invasive cancer and changes to the year that the diagnosis was made). For example, in the 2000 dataset, 4 discrepancies between the laboratory/provider reports to the MCR data for prostate cancer cases were noted in comparison to 3,895 discrepancies and 3,248 discrepancies for such cases in the 2001 and 2002 datasets, respectively. The vendor concluded that these changes were methodical and were made by one or more persons with broad access to the system, and not a result of a random set of events.

As a result of the aforementioned changes, recipients of the MCR data (such as, federal Centers for Disease Control and Prevention, NAACCR, other states, and researchers) were obtaining and using incorrect data. In addition, the MCR data is a factor in allocating and awarding local public health grants to the counties for cancer prevention, education, screening, and treatment programs. During the period beginning July 2006 and ending January 2008, FHA has made payments to

this vendor totaling approximately $1.9 million to manage the MCR. FHA contracted with a new vendor to provide these services effective February 1, 2008.

As of April 15, 2008, we were advised by the Criminal Division of the Attorney General's Office that this matter was still under review.

Recommendation 1
We recommend that, in the future, FHA take substantive action when conditions of a contract are not met or document why no action was taken. We also recommend that, in the future, FHA review the MCR dataset submissions in a timely manner and investigate and resolve any significant changes in the data from one year to the next. Finally, we recommend that FHA work in conjunction with the Office of the Attorney General and other appropriate agencies to investigate and resolve this matter.

Cigarette Restitution Fund (CRF)

Background
In November 1998, five major tobacco companies executed a settlement agreement with numerous states, including Maryland, whereby the companies agreed to pay the states approximately $206 billion over 25 years to settle all outstanding litigation. Chapter 173, Laws of Maryland 1999, effective July 1, 1999, established the Cigarette Restitution Fund as a special non-lapsing fund to distribute funds received by the State under this settlement for a variety of programs and initiatives. Annually, the funds are initially received by the Department of Budget and Management and subsequently distributed to the appropriate State agencies, including FHA.

Section 13 of the Health General Article of the Annotated Code of Maryland established the Tobacco Use Prevention and Cessation Program (TUPCP) and the Cancer Prevention, Education, Screening, and Treatment Program (CPEST) to be funded by the CRF. The intent of the legislation was to coordinate the State's use of these funds to reduce tobacco use, tobacco-related diseases, and cancer deaths in the State.

The law provides for the distribution of grants to various entities (including local public health departments, and certain academic institutions) for services such as screening, treatment, and research, and establishes a public relations component to counteract tobacco industry marketing and advertising efforts. These grants require the grantees to achieve specific performance measures, which are outlined

during the application process. According to the State's records, FHA's fiscal year 2007 expenditures for the two programs totaled approximately $46 million, including $38.4 million in grant expenditures.

Finding 2
FHA did not exercise adequate oversight of CRF grants to ensure compliance with program goals and fiscal requirements.

Analysis
Certain grants paid during fiscal year 2007 were not adequately monitored. Our tests of various CRF grants awarded by FHA disclosed the following conditions:

- FHA did not conduct site visits to the grantees annually, as required by FHA policy, to verify compliance with program goals and fiscal requirements. Specifically, we noted that FHA did not perform annual site visits for grants paid totaling approximately $28 million during fiscal year 2007. Furthermore, for one grantee that has received grants annually during the audit period (for example, $1.3 million during fiscal year 2007), FHA last performed a site visit in June 2005. In addition, when site visits were conducted, instead of conducting surprise visits, FHA provided grantees with advance notice of the date of the site visit and a list of the recipients' data to be reviewed. These site visits are important because they provide an opportunity for FHA to assess how the grant funds are being spent and to obtain supporting documentation for the expenditures and related performance measures.

- Our review of five TUPCP local public health grants totaling approximately $6 million disclosed that in four cases the grantees, which received grants totaling $4.7 million, did not meet specific performance requirements outlined in the grant application and FHA did not take any action, such as obtaining corrective action plans. For example, one grantee that received a grant totaling $994,067 was to implement 14 secondhand smoke programs and educate 1,200 merchants on the youth access laws during fiscal year 2007. However, the grantee only implemented one secondhand smoke program and only educated 51 merchants. No follow-up action was taken by FHA and virtually all of the grant funds were paid out.

  Our test of two CPEST local public health grants totaling $2.4 million disclosed that for one grantee that received a grant totaling $1,218,000, FHA reduced the performance measure to more closely align with the actual results. Specifically, this grantee was to educate 10,000 residents about prostate cancer, to perform 600 screening tests, and to perform 1,200 other prostate cancer examinations. These measures were reduced to 3,000 residents, 500

screening tests, and 1,000 other examinations after the actual results for the grant year were virtually known.

- Our test of 14 grants totaling approximately $12.5 million, awarded under the TUPCP and CPEST programs, disclosed that 2 grantees, with awards totaling $1.47 million for fiscal year 2007, had not submitted annual expenditure reports as of December 27, 2007. In addition, FHA did not take any follow-up actions to obtain the reports. Grantees are required by DHMH's *Local Health Department Funding System Manual* to submit these reports by August 31st. The annual expenditure reports should have included an itemized statement of expenditures showing how the funds were expended.

- FHA did not document its verification that certain grantees spent the mandatory percentage of grant funds for screening, diagnosis, and treatment, as required by State law. Our review of the four largest CPEST local public health grants totaling $3.6 million disclosed that one grantee, that received a grant totaling $788,578, spent 51 percent for the aforementioned purposes, instead of the required 60 percent.

Recommendation 2
We recommend that FHA exercise adequate oversight of CRF grants. Specifically, we recommend that FHA conduct annual site visits without giving advance notice of the date and the documents to be reviewed. We also recommend that FHA take appropriate action (such as, obtain corrective action plans) when grantees do not meet performance requirements and not inappropriately reduce those requirements after they have been established. Finally, we recommend that FHA ensure that the annual reports are submitted timely and document its review and follow-up of these reports as well as its verification that applicable grantees spent the mandatory percentage of grant funds for screening, diagnosis, and treatment.

Finding 3 (Policy Issue)
The eligibility criteria for the CRF Programs were not consistent throughout the State.

Analysis
The eligibility criteria that FHA used to determine if an individual has the financial means to pay for treatment services provided through TUPCP or CPEST were not consistent throughout the State. According to FHA's records, expenditures in these programs for treatment services totaled approximately $27 million during fiscal year 2007. Specifically, according to the grant awards, 11

local health departments (LHDs) anticipated using funds to pay for eligible clients' treatment services for fiscal year 2007 and, thus, were required to submit eligibility criteria to FHA for review. Two of the 11 LHDs set the level of income for eligibility at 200 percent of the federal poverty level, while the remaining LHDs set the level at 250 percent. We also noted inconsistencies among the LHDs regarding who would be included in the family unit for the purpose of determining financial eligibility. Some LHDs included unmarried partners, while others excluded financially-dependent relatives. These disparities occurred because State regulations require LHDs to develop their own written financial eligibility criteria. In our opinion, FHA should establish Statewide eligibility criteria.

Recommendation 3
We recommend that FHA establish Statewide eligibility criteria for both Programs that are consistent throughout the State.

Finding 4
FHA did not submit the required reports to the Governor and General Assembly detailing, in part, the effectiveness of the CRF Programs in a timely manner.

Analysis
FHA did not submit certain performance and evaluation reports to the Governor and General Assembly in a timely manner, as required by State law. Specifically, we noted the following conditions:

- As of January 30, 2008, FHA had not submitted the results of the fiscal year 2007 tobacco study (due September 1, 2007) to the Governor and General Assembly. This study should document the State's progress in reducing tobacco use by specifying the number of individuals using tobacco products and comparing this information with the fiscal year 2000 baseline tobacco study. Subsequent to our review, FHA submitted the tobacco study, dated November 2007, on February 20, 2008.

- As of December 31, 2007, FHA had not submitted a comprehensive evaluation of the TUPCP and the CPEST programs (due November 1, 2005) to the Governor and General Assembly. This evaluation should detail, in part, the effectiveness of the programs and whether certain benchmarks and goals have been met. The evaluation is also to include DHMH's recommendations regarding modifications to the programs. Subsequent to our review, the report, dated May 2007, was submitted in January 2008.

Recommendation 4
We recommend that, in the future, FHA ensure that all required reports are submitted in a timely manner.

Breast and Cervical Cancer Diagnosis and Treatment Program (BCCDTP)

Background

FHA is responsible for the BCCDTP that uses an automated system (eCMS) to pay BCCDTP authorized medical providers for diagnostic and treatment services provided to eligible individuals. BCCDTP, which is primarily financed with general funds, is designed for low-income individuals whose income exceeds that which is allowable to qualify for the Medical Assistance Program (Medicaid) and who have a qualifying medical condition. According to BCCDTP's written policy, all recipients are required to apply for Medicaid and, if the recipient subsequently becomes eligible for Medicaid, then the provider is to repay BCCDTP for the payments made during the dual eligibility period. The provider then must bill Medicaid for the services provided. According to FHA's records, payments to providers in the BCCDTP totaled approximately $12.6 million on behalf of approximately 4,200 recipients that received services during fiscal year 2007.

Finding 5
Certain internal control deficiencies were noted regarding BCCDTP claims processing.

Analysis

Several deficiencies were noted regarding the processing of BCCDTP claims. Specifically, our review disclosed the following conditions:

- Claims processed for payment using system overrides did not receive supervisory review. Consequently, there was a lack of assurance that such claims, which totaled $7.7 million (or approximately 60 percent of the total claims paid) during fiscal year 2007, were proper. For example, our test of 25 claims totaling $103,225 disclosed that FHA appears to have improperly paid 2 claims totaling approximately $7,025 by overriding system edits that initially denied the claims because the records indicated that the patient had other insurance coverage. The other insurance coverage was not adequately pursued.

Generally, claims are to pass a series of automated payment system edits designed to help determine the propriety of the claims. If the edits reject a claim, FHA nurse consultants are to review the claim and determine if the claims should be paid.

- Claims submitted by providers more than nine months after the related services were rendered were routinely paid by FHA, in violation of State regulations. Specifically, our data analysis of the total claims paid during fiscal year 2007 disclosed that late claims totaling approximately $545,000 were submitted, on average, 13 months after the services were rendered, some of which had service dates dating back to 2003. These claims were paid when FHA overrode system edits and allowed the claims to be paid as previously noted. State regulations require that, for a claim to be paid, it must be submitted within nine months after the service was rendered without exception.

  We were advised by FHA management that these claims were paid because the claims were corrected after they were initially rejected by FHA. Although not in strict compliance with its own State regulations, FHA will pay the corrected claims if submitted more than nine months after the date of service, if the original claim was submitted timely.

- FHA had not established procedures to identify questionable BCCDTP claims. Specifically, FHA did not conduct periodic surveys of recipients to determine the validity of medical procedures invoiced by service providers. The last patient survey was conducted in October 2003. Although eCMS does identify allowable procedures, FHA did not adequately use eCMS (that is, system edits have not be established) to help identify questionable claims. For example, we noted that FHA paid two providers for anesthesia services totaling $333 for two recipients even though there were no surgical or other medical procedures performed for these recipients.

Recommendation 5

We recommend that claims that are processed using system overrides receive supervisory review, at least on a test basis, and that this review be documented and retained for verification purposes. We also recommend that FHA review past system overrides, at least on a test basis, investigate questionable claims, including the two aforementioned claims, and recover any amounts found to have been overpaid. In addition, we recommend that FHA pay claims in accordance with the time limits established by State regulations. We further recommend that FHA conduct periodic patient surveys, on a test basis, to determine the validity of medical procedures

invoiced by service providers. Finally, we recommend that FHA develop automated procedures to identify questionable claims and that all questionable claims be adequately investigated.

Finding 6
FHA did not have adequate procedures to follow up on recipients who failed to respond to its requests to apply for Medicaid or identify all BCCDTP recipients that were retroactively eligible for Medicaid.

Analysis
FHA did not have adequate follow-up procedures when recipients did not respond to its requests to apply for Medicaid. In addition, FHA did not identify all BCCDTP recipients that were retroactively eligible for Medicaid. These conditions may have prevented FHA from maximizing federal recoveries and minimizing State expenditures. Specifically, our review disclosed the following conditions:

- FHA did not require recipients to apply for Medicaid when initially enrolling in BCCDTP because the BCCDTP eligibility had not yet been determined. Although FHA sent letters to recipients after they were enrolled in BCCDTP requesting that they apply for Medicaid, FHA continued to pay claims on the recipients' behalf and continued the recipients' BCCDTP eligibility, even when the recipients did not apply for Medicaid. Furthermore, during the annual re-enrollment process, FHA did not require the recipients to apply for Medicaid. According to FHA's records, 745 BCCDTP recipients did not respond to FHA's letters and could potentially be eligible for Medicaid coverage. By not ensuring that the recipients are applying for Medicaid, FHA may be unnecessarily increasing State general fund costs. In this regard, the federal government shares equally in the costs of Medicaid, but does not provide funding for BCCDTP.

- When the recipients were enrolled in Medicaid, FHA was not always aware of these benefits. Specifically, the weekly automated matches of BCCDTP's database of new recipients with the Medicaid database—used to determine recipients that became retroactively eligible for Medicaid—did not identify all eligible recipients. In this regard, once a recipient is included on the match report, the recipient will not appear on subsequent reports as being Medicaid eligible. This is problematic because the recipient's Medicaid eligibility status could change from month to month. Furthermore, FHA would not be aware of the Medicaid eligibility until a claim is submitted to eCMS. A similar condition was commented upon in our preceding audit report.

Recommendation 6
We again recommend that FHA implement appropriate follow-up procedures to ensure that recipients apply for Medicaid. We again recommend that deficiencies in the computer program that generates the weekly match be corrected so that the reports include all recipients that became eligible for Medicaid.

Prince George's Hospital Center Grants

Finding 7
Grant funds awarded to Prince George's Hospital Center were not properly monitored and accounted for, in accordance with State law.

Analysis
FHA did not properly monitor and account for grant funds totaling $11.3 million ($6.3 million general funds and $5 million special funds) awarded to Prince George's Hospital Center for fiscal years 2006 and 2007. In addition, the grant agreement was not complete. These grants were appropriated to FHA to help support the Center's critical operational needs.

- The grant agreement did not include a provision that required the Center to provide a budget detailing how the grant funds were to be spent. This would enable FHA to identify the critical operations being supported by the funds.

- The annual reports of grant expenditures submitted by the grantee did not detail how the grant funds were spent. We were advised by FHA management that they had requested detailed expenditure reports on several occasions but the grantee was not responsive.

- FHA did not perform annual financial audits of the grants awarded to the Center, as allowed by the grant agreements. The Center disclosed that fiscal year 2007 State grant funds totaling $701,103 were used for expenditures related to two other hospitals due to a system error. This allowed expenditures related to the other hospitals, which are served by the Center's purchasing department, to be posted to the Center's accounts. The Center subsequently reimbursed the State based on the Center's calculation. FHA had not conducted an investigation to determine the extent and impact of the system error, and to ensure that the funds were reimbursed in full.

- The Center had not established a separate bank account for the fiscal year 2006 grant funds totaling $1.32 million, as required by the grant agreement. Instead, the grant funds were commingled with the Center's other funds. As a result, expenditures related to the State grant could not be readily identified. A separate account was established for the fiscal year 2007 grant funds.

As a result of these conditions, FHA lacked assurance that the funds were expended to support the Center's critical operational needs as intended.

Chapter 680, Laws of Maryland 2008, established the Prince George's County Hospital Authority as a State entity to implement a competitive bidding process for transferring the Prince George's County Health Care System (including the Center) to a new owner(s). It also requires that the State to provide funding totaling $24 million during fiscal years 2009 and 2010.

State law requires that each social organization (for example, hospitals) that receives State aid (for example, grants) shall submit to the unit of State government to which the money for the State aid has been appropriated, a report containing an itemized statement that fully and accurately accounts for how the State aid was spent.

Recommendation 7
We recommend that FHA properly monitor grant funds provided to the Prince George's Hospital Center. Specifically, we recommend that the grant agreement require the Center to provide a budget detailing how the grant funds will be spent. We also recommend that FHA ensure that the annual reports of grant expenditures contain sufficient details to provide assurance that the grant funds were expended as intended. We further recommend that FHA conduct annual financial audits of past and future grants to verify the propriety of reported expenditures and to ensure that State funds used for unintended purposes are properly reimbursed. Finally, we recommend that, in the future, FHA ensure that separate bank accounts are established when required by the grant agreement.

Family Planning

Background

FHA provides State general fund grants and contracts to each local health department (LHD) and a vendor to provide comprehensive family planning services throughout Maryland. These agreements require the providers to achieve specific levels of performance, which are determined during the application process. Throughout the year, the grantees record patient information (such as patient visits and demographic information) in FHA's patient care database. This database is used by FHA to determine if certain performance measures have been met. According to the State's records, during fiscal year 2007, FHA awarded approximately $7.2 million in Family Planning grants and contracts.

Finding 8
FHA did not adequately monitor Family Planning grants and contracts.

Analysis

FHA did not adequately monitor the Family Planning grants and contracts. Specifically, we noted the following conditions:

- FHA did not determine if the performance requirements proposed by the grantees and contractor during the application process and incorporated into the agreements represented an appropriate level of effort in relation to the funds to be provided. Consequently, FHA lacked assurance that the grantees and contractor were making efficient use of State resources. Specifically, we noted that two LHDs that received grants totaling $2.9 million easily attained all of the performance requirements for fiscal year 2007. For example, one LHD had approximately 40 percent more patient visits (per the database) than required by the agreement.

- A certain methodology used by FHA to verify the propriety of the information in the patient care database was inadequate. Specifically, the grantees generated reports of patient cases from which FHA selected cases to verify. As a result, the grantees controlled the cases eligible for testing (that is, the grantees could exclude certain cases from the report and thus exclude them from the audit).

Recommendation 8

We recommend that FHA adequately monitor the Family Planning grants and contracts. Specifically, we recommend that FHA determine the reasonableness of the submitted performance measures prior to awarding grants. We also recommend that FHA generate the reports from which cases are selected for verification.

Audit Scope, Objectives, and Methodology

We have audited the Family Health Administration (FHA) of the Department of Health and Mental Hygiene for the period beginning September 14, 2004 and ending October 31, 2007. 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 FHA'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. Our audit procedures included inquiries of appropriate personnel, inspections of documents and records, and observations of FHA's operations. We also tested transactions and performed other auditing procedures that we considered necessary to achieve our objectives. Data provided in this report for background or informational purposes were deemed reasonable, but were not independently verified.

Our audit did not include certain support services provided to FHA by the Department of Health and Mental Hygiene's – Office of the Secretary and related units. These support services (such as payroll, purchasing, maintenance of accounting records, and related fiscal functions) are included within the scope of our audits of the Department's Office of the Secretary.

Our audit did not include an evaluation of internal controls for federal assistance programs and an assessment of FHA's compliance with federal laws and regulations pertaining to those programs because the State of Maryland engages an independent accounting firm to annually audit such programs administered by State agencies, including FHA.

Our audit scope was limited with respect to FHA's cash transactions because the Office of the State Treasurer was unable to reconcile the State's main bank accounts during a portion of the audit period. Due to this condition, we were unable to determine, with reasonable assurance, that all FHA's cash transactions

prior to July 1, 2005 were accounted for and properly recorded on the related State accounting records as well as the banks' records.

FHA'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 relating to conditions that we consider to be significant deficiencies in the design or operation of internal control that could adversely affect FHA'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 FHA that did not warrant inclusion in this report.

The Department's response to our findings and recommendations, on behalf of FHA, 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 the Department 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 – John M. Colmers, Secretary

July 14, 2008

Bruce A. Myers, CPA
Legislative Auditor
Office of Legislative Audits
301 West Preston Street
Baltimore, MD 21201

Dear Mr. Myers:

Thank you for your letter regarding the draft audit report for the Department of Health and Mental Hygiene's Family Health Administration. Enclosed you will find the Department's response and plan of correction that addresses each audit recommendation. I will work with the appropriate Directors of Administration, Program Directors, and Deputy Secretary to promptly address all audit exceptions. In addition, the Department's Office of the Inspector General, 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 410-767-6505 or Thomas Russell, Inspector General for the Department, at 410-767-5862.

Sincerely,

John M. Colmers
Secretary

Enclosure

cc: Arlene Stephenson, Acting Deputy Secretary, PHS, DHMH
Valerie A. Roddy, Assistant Director to Deputy Secretary, PHS, DHMH
Russell W. Moy, M.D., M.P.H., Director, FHA, DHMH
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Department of Health and Mental Hygiene
Family Health Administration
Legislative Audit Report: Findings and Responses
July 8, 2008

Maryland Cancer Registry (MCR)

Finding 1
FHA did not take any substantive action when a vendor failed to attain a national certification for Maryland's cancer registry, as required by the contract. In addition, certain registry data under the control of the vendor was determined to be deliberately altered.

Recommendation 1
We recommend that, in the future, FHA take substantive action when conditions of a contract are not met or document why no action was taken. We also recommend that, in the future, FHA review the MCR dataset submissions in a timely manner and investigate and resolve any significant changes in the data from one year to the next. Finally, we recommend that FHA work in conjunction with the Office of the Attorney General and other appropriate agencies to investigate and resolve this matter**.**

Adminstration Response:
The Administration concurs with the recommendation, however, disagrees with the finding that FHA did not take action regarding the 2001 MCR dataset. When the FHA identified a problem of increased cancer cases that appeared in the 2002 data set, the contract monitor requested that the contractor review and explain these increases. The collection and analysis of data were investigated at length, and there was no suspicion of fraudulent data. When it came to light that fraud was involved, FHA immediately contacted the Department's Office of Inspector General and the Department's Attorney General. The FHA staff was not implicated in the reporting of fraudulent data and was instrumental in both the detection and the investigation of the fraud. Further, the MCR staff worked with the contractor to ensure that missing cases were identified and included in the dataset, which was then resubmitted to NAACCR and received the Gold Standard for 2001 data from that organization the following year.

The Administration concurs with the second recommendation but disagrees with the finding. It should be noted that Cancer Registry data processing is a complicated endeavor, requiring data collection from a number of sources and coding, matching, and finally analysis. The process takes two years from the close of the reporting year to the completion of the year's data set. This data set must then be checked for quality and completeness prior to being analyzed. Thus, it is not surprising that analysis of the MCR data set submitted in January 2005 was not begun until the Spring of 2005, with problems identified in the Summer of 2005.

The Administration concurs with the third recommendation. FHA staff was responsible for bringing the allegations to light, and has fully cooperated with and will continue to cooperate with the Department's OIG to investigate and resolve the allegations related to fraudulent data submissions**.** FHA will continue to work in conjunction with the Office of the Attorney General and other appropriate agencies to investigate and resolve this matter.

Please note the analysis indicated that "the 2001 MCR dataset submitted in December 2003 was not certified by NAACCR." However, completeness is only one of five criteria used by NAACCR for certification of cancer registries. The analysis also indicated that the DHMH was advised that approximately 15,000 patients recorded in the MCR with having breast cancer or cervical cancer were sent letters to participate in the Study of Breast and Cervical Cancer Diagnosis. While there were approximately 15,000 patients eligible to be selected for the study based on study criteria, 1,163 women with cervical cancer findings and 1,256 women with breast cancer findings were sent letters of invitation to participate in the study. The analysis also indicated that for women who were sent letters under the study, "FHA subsequently obtained the related reports from the laboratory facility that clearly stated that the specimens did not contain cancer"; however, these reports came from laboratory and hospital facilities. It was further indicated that changes to the codes from non-invasive cancer to invasive cancer and changes to the year that the diagnosis was made were made after the cases were initially entered into the MCR by the laboratory facility or provider; however, the changes made were not to the year of diagnosis but rather to the type of cancer diagnosed. [**Auditor's Comment**: Changes were made to the report to address certain Department concerns in this paragraph.]

Cigarette Restitution Fund (CRF)

Finding 2
FHA did not exercise adequate oversight of CRF grants to ensure compliance with program goals and fiscal requirements.

Recommendation 2
We recommend that FHA exercise adequate oversight of CRF grants. Specifically, we recommend that FHA conduct annual site visits without giving advance notice of the date and the documents to be reviewed. We also recommend that FHA take appropriate action (such as obtain corrective action plans) when grantees do not meet performance requirements and not inappropriately reduce those requirements after they have been established. Finally, we recommend that FHA ensure that the annual reports are submitted timely and document its review and follow-up of these reports as well as its verification that applicable grantees spent the mandatory percentage of grant funds for screening, diagnosis, and treatment.

Administration Response
The Administration concurs that FHA exercise adequate oversight of CRF grants and conduct annual site visits. However, we believe that advance notice should be given to the grantees to ensure that information requested from the funding administration is available at the time of the site visit for review. The Administration has a notification procedure that requires the local health department to collect certain information and have selected staff available for the site visit. Additionally, local staff needs to reserve meeting space and retrieve all programmatic, clinical, and fiscal records to expedite the site review.

The Administration concurs with the second recommendation. FHA will take appropriate action when grantees do not meet performance requirements and not inappropriately reduce those requirements after they have been established. The funding administration will review progress of performance measures on a periodic basis and where performance measures are not on target; a corrective action plan will be developed and implemented to meet the program targeted performance measures. Corrective action plans and progress on corrective actions shall be maintained on file.

The Administration concurs with the third recommendation and will ensure that the annual reports are submitted timely and document its review. Furthermore, FHA will verify that the applicable grantees spent the mandatory percentage of grant funds for screening, diagnosis, and treatment. Specifically, the Annual Report (Form DHMH 440) notice is sent by the Office of General Accounting to all vendors that receive State funds. On or about October 1st of each year, the Office of General Accounting will send a notice to vendors who have not submitted their DHMH 440 Annual Reports, with a copy to the Administration. The Administration will use a variety of methods to ensure timely submission of annual reports. Methods include written notice, site visit, grant guidance instructions, and conditions of award. A procedure has been instituted to verify mandatory percentage expenditures on a semi-annual basis. In addition, the Administration staff will review the DHMH 440s for each cost center to ensure grantees' compliance in spending the mandatory percentage of grant funds for cancer screening, diagnosis and treatment. The Administration has instituted a verification document used at the end of each fiscal year that describes how verification was conducted. This document will be included with each year's close-out information.

Finding 3 (Policy Issue)
The eligibility criteria for the CRF Programs were not consistent throughout the State.

Recommendation 3
We recommend that FHA establish Statewide eligibility criteria for both Programs that are consistent throughout the State.

Administration Response
The Administration does not concur with this recommendation that FHA establish statewide eligibility criteria for both programs. The Administration considered options for determining eligibility in the CRF at the onset of the program in fiscal year 2001. Several findings were made: the local public health component is a local component with local control to ensure that services are tailored to the unique needs of each jurisdiction; there is considerable variance in poverty, uninsurance and underinsurance rates in the jurisdictions; local control encourages local

contributions to expand the reach of services; local control provides flexibility among the local health departments to adjust their programs to meet the changing needs of each jurisdiction. Two decisions were made. In the Tobacco Program it was decided that all tobacco cessations services will be free. They are listed on DHMH's current non-chargeable list. In the Cancer Program it was decided to allow the 24 local jurisdictions to determine eligibility. Cancer screening was determined to be free and is listed in the DHMH current non-chargeable list.

Finding 4
FHA did not submit the required reports to the Governor and General Assembly detailing, in part, the effectiveness of the CRF Programs in a timely manner.

Recommendation 4
We recommend that, in the future, FHA ensure that all required reports are submitted in a timely manner.

Administration Response
The Administration concurs with the recommendation and will ensure that all required reports are submitted to the Governor and General Assembly detailing the effectiveness of the CRF Programs in a timely manner. The CRFP report was due insufficient funding until FY 2006. The second report, Tobacco Report, was delayed due to the overwhelming data analysis performed by the evaluator.

Breast and Cervical Cancer Diagnosis and Treatment Program (BCCDTP)

Finding 5
Certain internal control deficiencies were noted regarding BCCDTP claims processing.

Recommendation 5
We recommend that claims that are processed using system overrides receive supervisory review, at least on a test basis, and that this review be documented and retained for verification purposes. We also recommend that FHA review past system overrides, at least on a test basis, investigate questionable claims, including the two aforementioned claims, and recover any amounts found to have been overpaid. In addition, we recommend that FHA pay claims in accordance with the time limits established by State regulations. We further recommend that FHA conduct periodic patient surveys, on a test basis, to determine the validity of medical procedures invoiced by service providers. Finally, we recommend that FHA develop automated procedures to identify questionable claims and that all questionable claims be adequately investigated.

Administration Response:
The Administration concurs with the first two recommendations that processed claims using system overrides receive supervisory review, at least on a test basis, and that this review be documented and retained for verification purposes. An electronic report was created in July 2008. The first report was submitted to the Program Manager for review. This random sample, based on certain criteria highlighting specific overrides, will be reviewed on an on-going basis by the Program Manager and all questionable overrides will be investigated promptly by an independent employee. The Program Manager will review, sign, and date the report and include a record of any issues requiring investigation as well as the results of that investigation. These reports will be kept available for review. The Program Manager will also provide training for the nurses reviewing claims that will include specific instructions regarding the use of the notes section of the eCMS reporting system when specific overrides are performed. The Administration concurs with the third recommendation and pays all complete and accurate claims within nine months after the date of service. The referenced claims were submitted in a timely manner but were originally rejected for missing or incomplete information.

The Administration concurs with the concepts of determining the validity of medical procedures invoiced by service providers, but does not concur with the methodology recommended in the third and fourth Recommendations. Instead, FHA recommends that the Program Manager, in conjunction with the nursing staff, prepare a review template for patient records in anticipation of sending a review team into the field periodically to perform provider record reviews. The eCMS can be used to randomly select providers utilizing criteria created to identify potential areas of abuse and/or interest such as isolated claims from one provider without supporting documentation.

Finding 6
FHA did not have adequate procedures to follow up on recipients who failed to respond to its requests to apply for Medicaid or identify all BCCDTP recipients that were retroactively eligible for Medicaid.

Recommendation 6
We again recommend that FHA implement appropriate follow-up procedures to ensure that recipients apply for Medicaid. We again recommend that deficiencies in the computer program that generates the weekly match be corrected so that the reports include all recipients that became eligible for Medicaid.

Administration Response
The Administration concurs with the first recommendation. While the BCCDTP already has follow-up procedures in place, in order to address the audit, an additional field has been added to the CARES tracking system documenting the reason the client is ineligible for Medicaid. For example, “undocumented alien,” “financially over scale,” or “has creditable insurance” may be used. All recipients, both new and renewal, receive a series of letters (initial and again 60 days later) instructing them to apply for Medicaid. Their compliance is tracked and recorded via the CARES tracking system for both new and renewal clients.

The Administration concurs with the second recommendation. A report has now been developed for the electronic claims management system (eCMS) that pulls the patients who received Medicaid eligibility from the MMIS II eligibility file using the transaction date (the date the

patient information is added to the eligibility file) as well as the claims in eCMS that fall within this dual period. This report provides a list of patients and the claims paid during the Medicaid eligibility period so that the monies spent by the Program during the dual period can be recouped. Using the transaction date allows the Program to identify all of the Program patients who received Medicaid in a timely fashion.

Prince George's Hospital Center Grants

Finding 7
Grant funds awarded to Prince George's Hospital Center were not properly monitored and accounted for, in accordance with State law.

Recommendation 7
We recommend that FHA properly monitor grant funds provided to the Prince George's Hospital Center. Specifically, we recommend that the grant agreement require the Center to provide a budget detailing how the grant funds will be spent. We also recommend that FHA ensure that the annual reports of grant expenditures contain sufficient details to provide assurance that the grant funds were expended as intended. We further recommend that FHA conduct annual financial audits of past and future grants to verify the propriety of reported expenditures and to ensure that State funds used for unintended purposes are properly reimbursed. Finally, we recommend that, in the future, FHA ensure that separate bank accounts are established when required by the grant agreement.

Administration Response
The Administration concurs with the recommendation that, in the future, FHA require and obtain a budget from the Center and will include a provision in all future grant agreements requiring that the Center submit a budget detailing how grant funds will be spent within 30 days of disbursement of funds to the Center.

The Administration does not concur with the finding that FHA ensure that the annual report of grant expenditures provide details because the grant agreement dated March 16, 2006 did stipulate that the Center provide an annual report of grant expenditures with sufficient details to provide assurance that the grant funds were expended as intended. FHA staff made telephone calls and sent several written reminders of the accountability requirements and impending deadline to the hospital, beginning in May 2006. A copy of the standard funds accountability format (Form 440) was included with these reminders with a request that that type of detail be provided. However, the grantee did not comply with the level of detail requested.

The Administration concurs with the recommendation that annual financial audits be conducted for future grants. In any future grant agreements with the Center, FHA will include a provision that requires the Center to have grant expenditures audited annually by an independent auditor, with reports submitted to the Center and the State on the propriety of reported expenditures within 6 months of the end of the grant award. In reference to conducting annual financial audits of past grants, the Administration does not concur with the recommendation since the statute does not require that the unit audit financial records of an organization (7-402), only that a unit may audit.

The Administration concurs with the final sentence of the recommendation concerning the Center establishing a separate bank account. FHA staff will ensure that future grant awards require a separate account be established as was the case for the FY 2007 grant. The recommendations with which the Administration concurs will be implemented in the FY 2009 grant agreement with the Center.

Family Planning

Finding 8
FHA did not adequately monitor Family Planning grants and contracts.

Recommendation 8
We recommend that FHA adequately monitor the Family Planning grants and contracts. Specifically, we recommend that FHA determine the reasonableness of the submitted performance measures prior to awarding grants. We also recommend that FHA generate the reports from which cases are selected for verification.

Administration Response
The Administration concurs that written guidance with instructions should be issued to grantees/contractors regarding the selection of performance measures that can be tracked using the Family Planning Data System and/or other program reporting mechanisms. Reasonable performance measures would be a substantial percent (90%) of the average number of clients and visits reported over a three-year period.

The Administration also concurs with the recommendation that FHA generate the reports from which cases are selected for verification of services. The program arranged with the Family Planning Data System vendor for Central Office program staff to access client names as of January 1, 2008. All data audits done as part of the QA process from February 1, 2008 onward will be through data report lists generated by the Center for Maternal and Child Health, and this eliminates the possibility of local programs introducing bias into the data audit record selection process.

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