Performance Audit Report

Maryland Department of Health

Efforts to Identify and Analyze Improper Medicaid Payments

June 2020

OFFICE OF LEGISLATIVE AUDITS
DEPARTMENT OF LEGISLATIVE SERVICES
MARYLAND GENERAL ASSEMBLY

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OFFICE OF LEGISLATIVE AUDITS
MARYLAND GENERAL ASSEMBLY

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June 23, 2020

Senator Clarence K. Lam, M.D., Senate Chair, Joint Audit and Evaluation Committee
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Members of Joint Audit and Evaluation Committee
Annapolis, Maryland

Ladies and Gentlemen:

We have conducted a performance audit to determine if the Maryland Department of Health (MDH), including its Division of Program Integrity (DPI), had a comprehensive approach in place to identify and analyze improper Medicaid-related payments for the period beginning July 1, 2015 and ending June 30, 2018. During fiscal year 2018, disbursements for Medicaid-related payments totaled $10.9 billion.

Our audit disclosed that MDH had not established a comprehensive risk-based approach to identify and analyze improper Medicaid payments. Specifically, MDH had not established a periodic risk assessment process to identify and document overall risks and to allocate its resources to areas of highest risk. We also found that DPI's data analytics were not robust, were not tied to a risk-based approach or plan, and did not fully address Managed Care Organization (MCO) encounter data. Furthermore, MDH did not take advantage of data analysis services available through the federal government that could improve the effectiveness of its analytics. Finally, MDH did not implement a formal process to measure and report quantifiable benefits from the operation of DPI, which has the primary responsibility to identify and analyze improper Medicaid-related payments.

In addition, MDH was not adequately identifying and addressing potential improper Medicaid-related payments. We noted numerous areas where claims were paid without validation to ensure the provider was properly enrolled and

qualified for Medicaid, as required by federal or State regulations. For example, during the period July 1, 2015 to June 30, 2018, MDH approved prescription and laboratory claims totaling approximately $175 million submitted by prescribing physicians and referring providers whose enrollment in Medicaid was not validated. We also found that MDH's controls were not adequate to identify and prevent improper Medicaid payments related to incarcerated individuals. We identified approximately $9.6 million of potential improper Medicaid payments related to incarcerated individuals during fiscal years 2016 to 2018.

Our audit also disclosed deficiencies with MDH's Medicaid Management Information System edits that did not trigger a suspension or denial of certain high-risk claims (such as certain potential duplicate claims payments and payments to providers after a credible allegation of fraud was determined). Furthermore, we identified several deficiencies related to MDH's oversight of the MCOs providing Medicaid services. For example, MDH did not ensure that the MCOs included certain critical information in their encounter data and performed required investigations of the encounter data. MDH also did not ensure MCOs had not paid claims for excluded services. Such services are paid directly by MDH, and if an MCO were to pay providers directly for these services, it could improperly increase the MCO's subsequent capitation (per person) rates.

MDH's response to this audit is included as an appendix to this report. We reviewed the response to our findings and related recommendations, and have concluded that the corrective actions identified are sufficient to address all audit issues. While MDH agrees with the recommendations in this report, we identified certain instances in which statements in the response conflict with or disagree with a report finding. We reviewed and reassessed our audit documentation, and reaffirmed the validity of our finding. In accordance with generally accepted government auditing standards, we have included an "auditor comment" within MDH's response to explain our position.

We wish to acknowledge the cooperation extended to us during the audit by MDH and its willingness to address the audit issues and implement appropriate corrective actions.

Respectfully submitted,

Gregory A. Hook, CPA
Legislative Auditor

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Audit Scope, Objectives, and Methodology

Audit Scope

We conducted a performance audit to determine if the Maryland Department of Health (MDH), including its Division of Program Integrity, had a comprehensive approach in place to identify and analyze improper Medicaid-related payments.

This audit was initiated as a result of significant increases in Medicaid expenditures over the past decade and ever increasing healthcare costs. The Centers for Medicare and Medicaid Services (CMS) is currently projecting that total spending for Medicaid will rise an average of 5.5 percent per year from 2018 to 2027.

There is a high risk of significant improper payments and fraud, waste, and abuse in the Medicaid program, which has been identified and reported both at the federal level (such as by CMS and the Government Accountability Office) and by other state audit organizations. These reports also identified insufficiencies, concerns, or needed areas of improvement in other states' program integrity operations to more effectively identify and analyze improper payments.

The scope of our performance audit was limited to reviewing Medicaid claim activity for a three-year period for fiscal years 2016, 2017, and 2018 and focused on the control activities, entities, and data involved with identifying and analyzing improper Medicaid payments. Our audit did not include an evaluation of procedures and controls over recipient eligibility, calculation of payments to Managed Care Organizations (MCOs), or verification of drug rebates. These areas are subject to separate audits our Office performs of MDH.

We conducted this audit under the authority of the State Government Article, Section 2-1221 of the Annotated Code of Maryland and performed it 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.

Objectives and Methodology

Our audit included the following two objectives:

1. To determine if MDH had established a comprehensive documented risk-based approach to focus the efforts of its program integrity operations on areas of highest risk and applied industry best practices in its use of data analytics to effectively identify improper Medicaid-related payments. Additionally, to determine if MDH measured and reported quantifiable benefits of its program integrity operations.

2. To determine if MDH's operations were adequately identifying and addressing potential improper Medicaid-related payments.

To accomplish our objectives, we obtained data extracts from the Medicaid Management Information System (MMIS II) for a three-year period for fiscal years 2016, 2017, and 2018 to perform data analytics of more than 290 million fee-for-service claim payments and MCO encounter data records. The data we obtained were subject to various tests to determine data reliability, including tracing samples of randomly selected claims to MMIS II for accuracy and comparing claim totals to control totals of expenditures for completeness. We also ensured the coding logic we used for extracting the data records from MMIS II was designed properly. Based on these reviews, we determined the claims data were sufficiently reliable for use in our audit. For the encounter data, we determined that the data agreed to the data as maintained in MMIS II. However, our audit work disclosed the encounter data was deficient as it did not include certain critical data elements (see Finding 4).

Additionally, we reviewed reports and documentation pertaining to the Medicaid program, with particular focus on improper Medicaid payments, from other state and federal agencies. Furthermore, we interviewed various MDH employees responsible for identifying and analyzing improper Medicaid payments. We conducted tests, analyses, inspections of documents and records, and observations, as we deemed necessary to achieve our objectives.

More detailed descriptions of the specific objectives and related methodologies are discussed in the Findings and Recommendations section of this report.

Fieldwork and Agency Response

We conducted our fieldwork from May 2018 to May 2019. MDH's response 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 MDH regarding the results of our review of its response.

Background Information

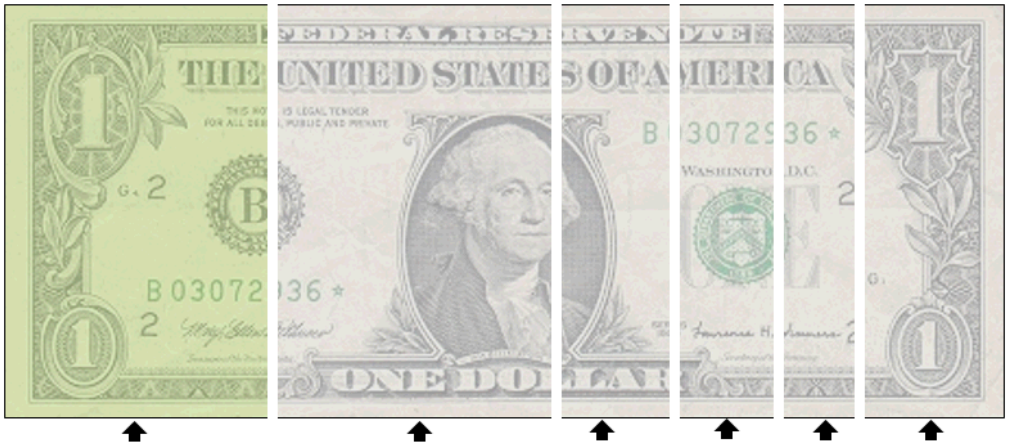
Agency Responsibilities

The Medical Care Programs Administration (MCPA) of the Maryland Department of Health (MDH) 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.

Medicaid represents a significant portion of Maryland's expenditures. For fiscal year 2018, approximately 27 percent of total State expenditures were for Medicaid. Specifically, of the $41 billion spent by the State (from all funding sources) in fiscal year 2018, $10.9 billion was spent on Medicaid. Funding for Medicaid totaled $6.7 billion from federal funds, $3.2 billion from State general funds, and an additional $1 billion from special and reimbursable funds.

Figure 1

Medicaid Represents 27 Percent of Maryland Expenditures



Source: State of Maryland Comprehensive Annual Financial Report, Fiscal Year 2018

Medicaid Payment Methodologies

MDH uses two methodologies for paying Medicaid claims.

Managed Care Organizations (MCOs)

According to MCPA records as of June 30, 2018, approximately 1.2 million (or 86 percent) of the 1.4 million Medicaid recipients were enrolled in HealthChoice, the statewide managed care program that began in 1997. Under HealthChoice, MCPA makes specified capitation (per person) payments to Maryland's nine private MCOs to cover the cost of services provided to enrolled Medicaid recipients. In general, the MCOs contract with and pay health care professionals and other entities (such as hospitals) to provide these services. The capitation rates vary by recipient based on several factors, including the recipient's demographics and medical history. MCPA also reimburses the MCOs for certain high-cost activities (such as newborn deliveries and Hepatitis C treatments). While the MCOs provide a wide variety of services to enrolled recipients, certain services (such as behavioral health services) are paid for on a fee-for-service basis by MCPA even for recipients enrolled in an MCO. These services are termed "carve outs."

MCOs submit encounter data to MCPA to show what services were performed so outcomes can be measured and future rates can be based on past actual services provided. Encounter data generally represent billed claims that providers submit to MCOs.

During fiscal year 2018, MCPA made payments to the MCOs totaling approximately $5.6 billion, which represents slightly more than half of the costs for Maryland's Medicaid program.

Fee-for-Service

Populations excluded from the HealthChoice managed care 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 the fee-for-service 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. Annually, fee-for-service costs represent slightly less than half of the costs for Maryland's Medicaid program.

Responsibility to Identify and Analyze Improper Payments

The federal government defines improper payments as "any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements." Incorrect amounts include both overpayments and underpayments.

According to 2017 Payment Error Rate Measurement Reviews performed by the Centers for Medicare and Medicaid Services (CMS), the improper payment rate in Medicaid fee-for-service payments nationally was estimated at 12.9 percent. Although Maryland's improper payment rate was almost half the national average, it significantly increased by more than forty percent from the last review CMS performed in 2014. Based on the 2017 review of Maryland, CMS' projected improper payments in Medicaid fee-for-service payments totaled approximately $382 million for fiscal year 2016.

MDH's Office of the Inspector General (OIG) includes the Division of Program Integrity (DPI), which is a key component of MDH's efforts to identify and analyze improper Medicaid-related payments. As of June 30, 2018, the OIG had 64 employees, including 37 employees assigned to DPI. DPI includes the Surveillance and Utilization Review Subsystem (SURS) unit. Using its own information system, the SURS unit performs various data analytics on Medicaid claims (both fee-for-service and MCO encounter data) to identify and analyze improper Medicaid-related payments. The SURS unit performs data analytics, primarily on an ad hoc basis, based on its own ideas and through communications with CMS or other states, or to follow up on investigations initiated by others within DPI and MDH.

Findings and Recommendations

Objective 1 – Effectiveness of Program Integrity Operations

Objective and Methodology

Our objective was to determine if the Maryland Department of Health (MDH) had established a comprehensive documented risk-based approach to focus the efforts of its program integrity operations on areas of highest risk and applied industry best practices in its use of data analytics to effectively identify improper Medicaid-related payments. Additionally, our objective was to determine if MDH measured and reported quantifiable benefits of its program integrity operations.

To accomplish this objective, we reviewed numerous reports by other states and the federal government to identify best practices and recommendations for program integrity operations and oversight activities to effectively identify and analyze improper Medicaid-related payments. We also interviewed multiple MDH staff, including those in the Office of the Inspector General (OIG) and its Division of Program Integrity (DPI), to obtain an understanding of MDH's processes to identify and analyze improper Medicaid-related payments. This included gaining an understanding of DPI's Surveillance and Utilization Review Subsystem (SURS) information system that is used for DPI's data analysis of Medicaid-related payments, and evaluating DPI's use of the system and its capabilities. Additionally, we researched the availability of other data analysis services that MDH could potentially take advantage of through the federal government. Finally, we evaluated whether MDH measures and reports quantifiable benefits of its program integrity operations, a practice that was recommended in a federal Government Accountability Office (GAO) Report.

Conclusion

We determined that MDH had not established a comprehensive risk-based approach to focus the efforts of its program integrity operations on areas of highest risk. Specifically, MDH had not established a periodic risk assessment process to identify and document overall risks and to allocate its resources, including DPI resources, to areas of highest risk. We also found that DPI's data analytics were not robust, were not tied to a risk-based approach or plan, and did not fully address Managed Care Organization (MCO) encounter data. Furthermore, MDH did not take advantage of data analysis services available through the federal government that could improve the effectiveness of its analytics. Finally, MDH did not implement a formal process to measure and report quantifiable benefits of its program integrity operations.

Finding 1
MDH's process to identify and analyze improper Medicaid payments through its DPI was not comprehensive and did not incorporate certain best practices.

Analysis
MDH's process to identify and analyze improper Medicaid payments through its DPI was not comprehensive and did not incorporate certain best practices. Specifically, DPI's work was generally limited to reacting to ad-hoc requests from MDH divisions or from within DPI for specific information related to investigations of improper Medicaid payments. DPI did not utilize robust data analytic techniques based on a risk-based approach, did not use available federal data matching services, and did not implement a mechanism to track and quantify measurable benefits of its operations. Based on our research, these practices could help MDH proactively focus its limited resources on areas of greatest concern and risk.

DPI's Data Analytics Need Improvement
DPI's use of data analytics to review Medicaid claims through its SURS unit was not robust, was not tied to a risk-based approach or plan, and did not fully address MCO encounter data.

The tools used by DPI's SURS unit lacked capabilities to perform cross-matching between different datasets (such as cross matching between MDH's own systems and other datasets external to MDH) that could help identify improper payments. Additionally, DPI could not perform geo-mapping and data visualization techniques (summary charts and tables) to proactively highlight trends, patterns, and irregularities in Medicaid payment activity by provider or recipient. For example, a geo-map could help identify a provider who submits a high volume of Medicaid claims for services to recipients who reside long distances from the provider's office, warranting further investigation. Consequently, during our audit, we performed our own advanced data analytics using available commercial software that we determined was more comprehensive than the software available through the SURS unit. For example, in Findings 2, 3, 5, 8, and 9, our data analytics used methods and cross-matching techniques not available through the SURS unit to identify various potential improper payments, and throughout our audit work we analyzed data for trends, patterns, or irregularities in Medicaid payment activity by provider.

Additionally, DPI's data analytics were not tied to a risk-based approach or annual plan. A risk-based approach is important for data analytics activities and can enhance the effectiveness of such activities. According to a July 2015 GAO

report, titled *A Framework for Managing Fraud Risk in Federal Programs,* one of the leading practices for data analytics activities is to take a risk-based approach to data analytics and consider the benefits and costs of investing in specific data-analytic tools and techniques. MDH personnel advised us that they attempted to address areas of risk throughout their work, but did not have a formal or documented approach or an annual plan. Given its limited resources, DPI's primary focus was following up on fraud tips and related investigations instead of proactively addressing areas of known risks.

Furthermore, DPI did not provide effective oversight of the Managed Care Program, since it was not performing comprehensive analytics of MCO encounter data. Instead, DPI's encounter data analysis was generally limited to reviewing a specific issue that came to their attention through a fee-for-service or provider investigation. DPI personnel advised that they rely significantly on the MCOs' investigative units to ensure the propriety of encounter data activity. However, as noted in Finding 7, MDH did not ensure each MCO conducted investigations of encounter data activity, as required.

DPI Did Not Use Available Federal Data Matching Services

DPI did not leverage available data matching resources provided through the United States Treasury's Do Not Pay (DNP) Center. The DNP Center is a free robust analytic tool that helps agencies identify and prevent improper payments by matching agency data to various federal databases (such as multiple death record databases and the *List of Excluded Individuals and Entities*[1]) some of which are only available through the federal government. Additionally, the DNP Center provides pattern and trend analysis, detection of anomalies to identify high risk areas, and detection of duplicates. While MDH obtained extracts from some of the same databases used by the DNP Center (such as the *List of Excluded Individuals and Entities*) and performed its own in-house matches, we concluded that MDH's matches lacked the comprehensive analytical approach performed by the DNP Center such as trend analysis and detection of anomalies. Consequently, we believe MDH could achieve better data matching results through the DNP Center instead of performing its own matches.

MDH Did Not Perform a Risk Assessment and Lacked Measurable and Quantifiable Benefits for its Program Integrity Operations

MDH did not periodically perform a risk assessment of potential improper Medicaid payments to identify and document overall risks and use that information to allocate its resources, including DPI resources. Additionally,

[1] The DNP Center includes death databases beyond what is used by MDH. The *List of Excluded Individuals and Entities* identifies entities excluded by the federal government from participating in federal healthcare programs.

MDH did not implement a formal process to measure and report quantifiable benefits of its program integrity operations. Furthermore, MDH could not accurately support how it developed its reported savings from DPI efforts of $68.6 million over the five-year period from 2014 to 2018.

According to a January 2015 GAO report, titled *Medicaid Information Technology*, Maryland was identified as one of seven states that could not identify any steps taken to quantify improvements in the outcomes or effectiveness of its program integrity efforts attributable to the use of information systems. Such steps should include conducting a formal annual risk assessment and tracking the measurable and quantifiable benefits of its systems. Without these steps, MDH lacked assurance that its limited resources were used effectively to identify and analyze improper Medicaid payments.

Recommendation 1
We recommend that MDH take steps to effectively identify and analyze improper Medicaid payments through its program integrity operations by

- **a. implementing a robust system of data analytics based on a risk-based approach that incorporates cross-matching, geo-mapping, and trend analysis to proactively highlight irregularities in Medicaid payment activity;**
- **b. performing comprehensive analytics of MCO encounter data as part of its oversight of MCO activities;**
- **c. taking advantage of data matching services available through the United States Treasury's DNP Center; and**
- **d. performing a periodic documented risk assessment and implementing a formal process to measure and report reliable quantifiable benefits of its program integrity operations.**

Objective 2 – MDH's Operations to Identify and Address Potential Improper Medicaid Payments

Objective and Methodology

Our objective was to determine if MDH's operations were adequately identifying and addressing potential improper Medicaid-related payments.

To accomplish this objective, we reviewed State and federal laws and regulations and interviewed MDH staff to obtain an understanding of various processes critical to ensuring the proper payment of claims. This included gaining an understanding of processes and controls and performing a walkthrough of claims processing, the Medicaid Management Information System (MMIS II) edit controls, and post payment reviews (such as data matches) performed to identify potential improper Medicaid-related payments. We also obtained an understanding of provider enrollment processes and related system controls to ensure claims are only paid for services rendered by qualified providers meeting federal and State requirements. We obtained and extracted claims data and encounter data from MMIS II for the period July 1, 2015 through June 30, 2018 and performed numerous analytics and matches to identify potential improper Medicaid-related payments. Certain of these potential improper payments were selected on a test-basis for further investigation to determine the propriety of claim payments.

Conclusion

We determined that MDH's operations were not adequately identifying and addressing potential improper Medicaid-related payments. We noted numerous areas where claims were paid without validation to ensure the provider was properly enrolled and qualified for Medicaid, as required. We also found that MDH's controls were not adequate to identify and prevent improper Medicaid payments related to incarcerated individuals. Our audit also disclosed deficiencies in MMIS II system edits that did not trigger a suspension or denial of certain high-risk claims (such as certain potential duplicate claim payments and payments to providers after a credible allegation of fraud was determined). Furthermore, we identified several deficiencies related to MDH's oversight of the MCOs. For example, MDH did not ensure that the MCOs included certain critical information in their encounter data and performed required investigations of the encounter data. MDH also did not ensure MCOs had not paid claims for excluded services.

Finding 2
MDH did not ensure that prescribing physicians and referring providers were enrolled in Medicaid, as required by federal regulations. During the period July 1, 2015 to June 30, 2018, MDH approved prescription and laboratory claims totaling approximately $175 million submitted by prescribing physicians and referring providers whose enrollment in Medicaid was not validated.

Analysis
MDH did not ensure that prescribing physicians and referring providers were enrolled in Medicaid prior to approving claims, as required by federal regulations established by the Affordable Care Act in 2011. During the period July 1, 2015 to June 30, 2018, of the 17 million pharmacy and laboratory claims totaling approximately $2 billion, MDH approved 1.6 million claims totaling approximately $175 million submitted by prescribing physicians and referring providers whose enrollment in Medicaid was not validated. Since MDH did not have an approved Medicaid number to identify the prescribing physicians and referring providers at the time of the claim, MDH's MCPA allowed the claims to be processed in MMIS II with a general number (known as a dummy number). The information identifying the provider associated with these claims was not provided to DPI which prevented DPI from performing comprehensive data analysis to oversee Medicaid claim activity and to identify improper payments.

Ensuring that prescribing and referring providers are prescreened and enrolled in Medicaid helps to reduce fraud and lowers risk to consumers. For example, identifying the prescribing physician on pharmacy claims can help detect if opioids and other high-risk prescription medications are being prescribed by certain physicians in a questionable manner. Additionally, our cursory review of the laboratory providers with the highest dollar amount of claims for which the dummy number was applied disclosed at least 5 laboratories of the top 15 that were subsequently under investigation or had settlements against them for improper billing or claims. This included two laboratories that were investigated by the federal government resulting in large settlements.

MDH management advised they were aware of their non-compliance with requirements that prescribing physicians and referring providers be enrolled in Medicaid and are working to address this issue. For example, MDH planned to take steps to verify Medicaid enrollment of prescribing physicians on submitted pharmacy claims, and MDH sent a memorandum to the Centers for Medicare and Medicaid Services (CMS) in June 2018 indicating its difficulty getting providers to comply and seeking CMS' guidance. As of April 2019, MDH advised they had not received a response.

Recommendation 2

We recommend that MDH

a. ensure that prescribing physicians and referring providers are enrolled in Medicaid, as required by federal regulations prior to paying related claims;

b. ensure required enrollment information identifying the prescribing physicians and referring providers is provided to DPI to perform comprehensive data analysis of claim activity; and

c. continue to pursue guidance from CMS or consider contacting other states for guidance to assist in meeting enrollment requirements for prescribing physicians and referring providers.

Finding 3

MDH did not ensure that rendering providers for certain group practices were enrolled in Medicaid, as required by State regulations.

Analysis

MDH did not ensure that rendering providers for certain group practices (physical, occupational, and speech therapy) were enrolled in Medicaid, as required by State regulations. Specifically, of the approximately 846,000 claims paid, totaling $46.2 million, during the period from July 1, 2015 to June 30, 2018 for certain therapy group practices services, we determined that approximately 835,000 claims totaling $45.6 million related to approximately 21,700 Medicaid recipients did not include identification of the rendering providers. As a result, there was lack of assurance as to whether the services were performed by properly qualified medical practitioners enrolled in Medicaid.

We noted that claim amounts related to these therapy group practices increased by 89 percent from fiscal year 2016 to fiscal year 2018. Also, as shown in Table 1, these claims were submitted by 125 practices, with 10 practices or 8 percent of the practices representing 67 percent of the claim activity.

Table 1
Medicaid Claims Submitted by Therapy Practices
Without Identification of Rendering Providers
July 1, 2015 to June 30, 2018
(claims amount in millions)

	Practices		Claims		Claims	
	Number	Percentage	Number	Percentage	Amount	Percentage
Top 10 Practices	10	8%	557,000	67%	$30.5	67%
Remaining Practices	115	92%	278,000	33%	$15.1	33%
Totals	**125**		**835,000**		**$45.6**	

Source: Office of Legislative Audits analysis of MDH records

According to State regulations, physical therapists, occupational therapists, and speech therapists are required to be enrolled in Medicaid in order to render services to Medicaid recipients. MDH management advised us that they were aware of this issue and distributed a written notification to therapy group practices in August 2017 stating the requirement that rendering providers needed to be enrolled in Medicaid by November 15, 2017. Additionally, the notification specified that effective January 1, 2018, Medicaid claims were required to identify the rendering provider information on each claim. However, as of our review in February 2019, MDH advised us that it had not enforced either of these requirements.

Recommendation 3
We recommend that MDH

a. ensure rendering providers are Medicaid enrolled, as required; and

b. deny claims when information identifying the rendering provider is not submitted.

Finding 4
MDH accepted encounter data from MCOs that excluded necessary data elements and hindered its ability to perform effective oversight, including DPI's use of data analytics to identify and analyze improper claim activity.

Analysis
MDH accepted encounter data from MCOs that excluded necessary data elements and hindered its ability to perform effective oversight, including DPI's use of data analytics to identify and analyze improper claim activity. Specifically, the encounter data submitted by MCOs to MDH through December 31, 2017 did not include the following three critical elements; 1) paid or denied status of claim, 2) claim payment amount, and 3) rendering provider information. According to federal rules issued by CMS and in effect at that time, MCOs were required to include these elements in their encounter data. As shown in Table 2, these excluded elements significantly impacted MDH's use of the encounter data.

Table 2
Impact of Excluded Encounter Data Elements

Excluded Data Element	Impact
Paid or denied status of claim	DPI could not effectively identify paid claims and could not readily focus its investigative and analytic efforts on only paid claims.
Claim payment amount	DPI could not readily determine the materiality of claim activity and focus its analytic efforts on the most significant claims.
Rendering provider information	DPI could not focus its analytic efforts on certain providers or identify unusual patterns in provider claim activity that warranted further investigation.

Since these elements were excluded, DPI required assistance from each MCO to manually research and obtain this information for each claim it investigated.

Beginning January 1, 2018, MDH's MCO contracts required that encounter data submitted to MDH include the claim payment amount and rendering provider information (two of the three previously excluded data elements). However, the contracts did not specifically address the inclusion of the claim's status as paid or denied. Consequently, this data element was still not submitted with the encounter data. In addition, as of January 2019, MDH had not fully implemented changes to MMIS II to enable MDH to use the two additional data elements when

analyzing encounter data. We were advised by MDH information technology personnel that the necessary system changes were not implemented in January 2018 because the changes were not communicated in writing through its work order request process. As of January 2020, we were further advised that these system changes had still not been implemented.

Recommendation 4

We recommend that MDH ensure

a. **encounter data submitted by MCOs includes all federally required data elements, including the paid or denied status of the claim; and**
b. **system changes to MMIS II are implemented timely to enable DPI to use complete encounter data to help identify and analyze improper claim activity.**

Finding 5

MDH did not perform a data match or have an alternative method to determine if MCOs were paying claims related to certain services that MDH had carved out from the MCO contracts.

Analysis

MDH did not perform a data match or have an alternative method to determine if MCOs were paying claims related to certain services that MDH had carved out from the MCO contracts. Carve out services (such as behavioral health, dental, and HIV treatments) are those services that are specifically excluded from coverage by MCOs and instead are covered directly by MDH as fee-for-service claims. If MCOs paid claims related to these carve out services, this could potentially result in capitation rates being set too high.

Based on risk analysis, we performed a data match of fee-for-service behavioral health claims to the encounter data reported by the MCOs during the period from July 2015 through June 2018 to determine if the claims were duplicated. According to MDH's records, fee-for-service behavioral health claims totaled $3.5 billion during this period. Our match was based on a fee-for-service claim having the same date of service, recipient, diagnosis, provider, and claim charge as the reported encounter data from the MCO and disclosed approximately 1.1 million potential duplicate claims totaling $65.4 million.

Due to limitations in the MCO encounter data (such as no indication as to whether the related claims were paid or denied as identified in Finding 4), we were unable to determine from the data itself whether the encounters were actually paid by the MCOs and represented improper payments. Therefore, we selected 20 match

results related to four MCOs and obtained documentation from each MCO to determine if the MCOs actually paid these claims for services that were excluded from their contracts. Based on our review, we determined 8 match results were improperly paid, while the other 12 match results were properly denied or not paid. These results could indicate a significant issue with MCOs paying providers for excluded services. However, since the MCO encounter data lacks certain critical data elements (such as whether each encounter was paid or denied), MDH was unable to determine the extent of this issue.

Finally, although MDH contracts with an independent certified public accounting firm to conduct an annual agreed-upon-procedure review of each MCO's capitation rate setting, their scope did not include testing for such occurrences. Consequently, the annual reviews do not provide assurance that carve out services were excluded from MCO claim payments.

Recommendation 5
We recommend MDH

a. **perform a data match using reliable encounter data or have an alternative method (such as the annual agreed-upon procedure reviews) to ensure that MCOs are not paying claims related to certain services that are carved out from the MCO contracts; and**
b. **take corrective action to address carve out service claims, including the claims mentioned above, that MCOs improperly paid.**

Finding 6
MDH did not ensure MCO providers rendering services to Maryland recipients were enrolled as Medicaid providers, as required by federal regulations that became effective January 1, 2018.

Analysis
As of February 2019, MDH had not identified all MCO providers (such as general practitioners, physicians, specialists, and other providers) who rendered services to Maryland recipients and verified that they were enrolled as Medicaid providers as required by federal regulations that became effective January 1, 2018. Consequently, there was a lack of assurance that MCO providers rendering services to Medicaid recipients were properly screened and meet all Medicaid enrollment requirements, including that the provider was properly licensed and was not debarred or excluded from participating in Medicaid.

Specifically, in November 2017 MDH estimated that there were approximately 10,000 MCO providers rendering services to Maryland Medicaid recipients whose

Medicaid enrollment needed to be verified by the January 1, 2018 deadline. Due to the administrative burden involved with verifying that each of these MCO providers met the enrollment requirements, MDH requested a one-year extension from CMS. In its request for an extension, MDH provided CMS with a timeline of actions it intended to take in order to comply by January 1, 2019. MDH advised us that CMS did not provide a response granting this extension.

Based on our review of MDH records, as of February 2019, MDH was maintaining a list that only tracked the enrollment status of 2,928 of the estimated 10,000 MCO providers. Additionally, the tracking records indicated that only 13 percent of these 2,928 MCO providers had applied to become Medicaid providers, but did not identify how many had been verified. MDH was unable to provide an explanation for why it was not tracking all of the estimated MCO providers or why it was unable to comply by its requested deadline extension.

According to MDH, as of February 2019, the MCOs self-reported that 75 to 85 percent of their providers had been enrolled in Medicaid. However, no detailed support (such as listings of the specific MCO providers who had been enrolled) was provided to MDH by the MCOs to support these reported figures.

Recommendation 6
We recommend MDH take action to ensure MCO providers rendering services to Maryland recipients are identified and enrolled as Medicaid providers, as required by federal regulations.

Finding 7
MDH did not ensure each MCO conducted required investigations of encounter claims activity.

Analysis
MDH did not ensure each MCO conducted required investigations of encounter claims activity. MCOs are required by their MDH contract to conduct investigations of their encounter claims activity and report information on those investigations periodically to DPI. These investigations are critical to ensure MCO payments to providers for encounter claims are proper. Improper claim payments can result in higher medical costs for MCOs and in turn higher capitation rates paid by MDH to the MCOs.

According to a 2017 CMS report, the number of investigations conducted by the MCOs was "extremely low" relative to the size of Maryland's Medicaid managed care program. As shown in Table 3, the number of MCO investigations

performed in fiscal year 2018, in our opinion, was also extremely low relative to the number of Medicaid enrollees and payments. Specifically, the nine MCO's reported that investigations were conducted on at least 409 providers during fiscal year 2018, and one of those MCOs, with $1.455 billion in payments and almost 300,000 enrollees, investigated just 84 providers. Furthermore, two of the nine MCOs did not report sufficient details regarding their investigations. Specifically, one MCO only provided a summary report indicating total number of investigations and recoveries but the report did not include any details of the specific investigations performed. The other MCO did not report any investigations.

MDH's MCO contract terms may have contributed to the low number of investigations of encounter claims activity. Specifically, the contracts did not specify the nature, extent, and frequency of investigations to be performed by the MCOs or how providers should be selected for investigation, did not establish detailed reporting requirements for investigation results, and did not include any penalty provisions or incentives related to investigations. For example, we determined that other states had implemented policies allowing the MCO to share in recoveries of improper claims.

Table 3
Summary of MCO Investigations for Fiscal Year 2018
(payment amount in millions)

MCO	Count of Enrollees	Fiscal Year 2018 Payments	Number of Providers Investigated
MCO 1	299,689	$1,455	84
MCO 2	280,401	1,139	62
MCO 3	218,722	1,120	10
MCO 4	155,862	706	168
MCO 5	90,561	453	32
MCO 6	64,050	280	*
MCO 7	26,379	197	5
MCO 8	44,598	232	48
MCO 9	4,393	14	*
Totals	**1,184,655**	**$5,596**	**409**

*Could not be determined due to lack of reported investigations

Source: MDH records and MDH Enrollment Data published by the Hilltop Institute

Recommendation 7
We recommend that MDH

a. ensure MCOs conduct investigations of encounter claims activity, as required and provide adequate details of each investigation so appropriate follow up can be performed; and

b. modify MCO contracts to specify the nature, extent, and frequency of investigations to be performed and reporting requirements, and include penalties and incentives related to investigations.

Finding 8
A data match performed by MDH to identify incarcerated individuals who were improperly enrolled in MCOs was based on incomplete data and was not used to identify and prevent improper fee-for-service payments related to incarcerated individuals. Our expanded data match identified approximately $9.6 million of potential improper claim payments during fiscal years 2016 to 2018 that had not been identified or investigated by MDH.

Analysis
A weekly data match performed by MDH to identify incarcerated individuals who were improperly enrolled in MCOs was based on incomplete data. Furthermore, the MDH match did not include certain data needed to identify and prevent improper fee-for-service payments related to incarcerated individuals. We obtained incarceration records from the Department of Public Safety and Correctional Services (DPSCS) and performed our own match to MMIS II claims records which identified approximately $9.6 million of potential improper claim payments related to incarcerated individuals during fiscal years 2016 to 2018 that had not been identified or investigated by MDH.

Although MDH performed a weekly match to ensure that incarcerated individuals were not enrolled in MCOs which could result in improper capitation payments, MDH management advised us that it routinely received incomplete data from DPSCS. For example, data pertaining to the incarceration period for certain inmates was either missing or incomplete. MDH also advised us that it previously made attempts to improve the reliability of the data with DPSCS but it had been unable to fully resolve the issues. MDH's match also did not identify certain fee-for-service claims which are disallowed while individuals are incarcerated[2] and MDH had not established other controls to identify and prevent these improper payments.

[2] Medicaid only covers certain fee-for-service claims (such as inpatient hospital care) for incarcerated individuals.

We contacted DPSCS to obtain incarceration data for fiscal years 2016 to 2018 in order to perform our own match with Medicaid claims paid during the same period. We performed various testing to ensure the accuracy and completeness of the incarceration data. Based on these tests, we determined the queries used by DPSCS to generate the incarceration data for MDH needed to be modified in order to obtain more complete and accurate data. For example, we requested that DPSCS modify the query to obtain necessary data to reflect the proper periods of incarceration based on dates of inmate intake, transfer, and release. We determined that the data we finally obtained from DPSCS after this modification were sufficiently reliable for the purposes of our match.

Based on our match, we identified $9.6 million in potential improper Medicaid payments related to more than 3,200 individuals who were incarcerated on the dates the services were provided. These potential improper payments included $7.9 million in MCO capitation payments and $1.7 million in fee-for-service payments that were disallowed since the individual was incarcerated. We determined that these match results were either not previously identified by MDH through its weekly matches or MDH had not taken corrective action to adjust the claims. Our test of the 20 incarcerated individuals from our match with the highest dollar value claims, totaling $912,000, disclosed improper claim payments totaling $867,000 for 19 of these 20 individuals. This included $539,000 in MCO capitation payments for ineligible enrollees and $328,000 in fee-for-service payments for disallowed services. We provided these test results to MDH to determine if they had a reasonable explanation for why these claims were paid. MDH could not justify the claim payments.

Recommendation 8
We recommend that MDH

a. **continue to work in conjunction with DPSCS to obtain complete and accurate incarceration data for its match,**
b. **establish controls based on match results to identify and prevent disallowed fee-for-service payments for incarcerated individuals,**
c. **ensure incarcerated individuals are timely disenrolled from MCOs to prevent improper capitation payments, and**
d. **investigate the potential improper payments we identified and take corrective action (such as recovery of improper payments).**

Finding 9
Claims processing edits were not properly implemented in MMIS II to prevent payments after a credible allegation of fraud against a provider was determined. Additionally, certain existing claims processing edits were not always designed in a manner to analyze critical criteria that could be indicative of either duplicate payments or overpayments.

Analysis
Claims processing edits were not properly implemented in MMIS II to prevent claim payments after a credible allegation of fraud[3] against a provider was determined. Additionally, certain claims processing edits in MMIS II were not always designed in a manner to analyze critical criteria that could be indicative of either duplicate payments or overpayments.

Claims Payment Edits Were Not Properly Implemented
MDH's MMIS II claims processing edits were not properly implemented to prevent payments to providers who were suspended after MDH's OIG determined there was a credible allegation of fraud against the providers. Specifically, claims processing edits only prevented payments with a date of service after the determination of a credible allegation of fraud rather than preventing the payment of all claims submitted after the determination, as permitted by federal regulations.

Our review of claims paid to suspended providers between January 1, 2016 and June 30, 2018 identified 12,904 claims totaling $1.2 million that were improperly paid, based on federal regulations, to 16 different providers after MDH's OIG determined there were credible allegations of fraud against these providers. These payments were made from 3 to 285 days after the suspension date and included 2,271 payments totaling $172,000 that were made 30 days or more after the date of suspension. All of these claims had dates of service prior to the determination of the credible allegation of fraud but were paid after the provider's suspension date.

Federal regulations require state Medicaid agencies to suspend all Medicaid payments to a provider after the agency determines that there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payments only in part.

[3] Based on federal regulations, a credible allegation of fraud can be an allegation from any source (such as investigations, fraud hotline complaints, data mining, and patterns identified in provider audits) that has been verified by a state and determined to be reliable.

Claims Payment Edits Were Not Properly Designed to Identify Duplicate Payments and Overpayments

Although MDH had implemented various MMIS II system edits to analyze claims data for the purpose of preventing and detecting improper claim payments, our review identified two scenarios in which duplicate payments and overpayments would not be detected by these existing system edits. The first scenario relates to situations where claims were submitted by two different rendering providers for the same service. In these situations, claim payment processing edits were not in place to trigger a denial or suspension of the claim payment when critical elements matched that were indicative of a potential duplicate payment or overpayment. The second scenario relates to claims involving both Medicaid and Medicare reimbursements (known as Medicare crossover claims). In these situations, MDH did not always apply system edits to detect potential duplicate claims.

Our analysis of claims data for fiscal year 2016 through 2018 disclosed 62,000 claims totaling approximately $3.0 million that related to the above noted scenarios and could be indicative of potential duplicate payments or overpayments. These claims were submitted by 1,867 providers, including 15 providers that accounted for $1.1 million of the $3.0 million claims. We performed a targeted test of 30 claims, totaling $46,900, related to these 15 providers to determine if these claims did, in fact, represent duplicate payments or overpayments. After presenting our test results to MDH for further review and research, we concluded there were issues with 27 of these claims totaling $45,300, as summarized in Table 4.

Table 4
Summary of Potential Overpayments or Duplicate Payments Tested

Claim Payments Tested	Summary of Further Review	Overpayments or Duplicate Payments Identified
$21,650	Claims were correctly submitted by two different rendering providers (dual surgeons for the same procedure) but the payment amount was not properly adjusted to only pay the claim at 62.5 percent to each provider, in accordance with CMS guidance. Instead, each provider was paid 100 percent of the claim. This resulted in overpayments of $8,100 related to the claims selected for testing and $16,200 in total overpayments for these dual surgeons. While MDH had identified this programming error in January 2019, MDH did not take action to recover the overpayments for these claims and other similar claims that had also been overpaid (even though it was still within the allowable timeframe to do so). Overpayments related to these other claims totaled $134,250.	$150,450
9,950	Claims may have been incorrectly submitted by two different rendering providers and are probable duplicate payments. MDH did not have documentation on file to determine whether these claims were proper and not duplicates. MDH advised us the claims may have been improperly billed without the appropriate coding but further review would be necessary by contacting the providers.	9,950
12,200	Claims were submitted by the provider to both Medicare and Medicaid but should have only been paid by Medicare. As confirmed through review of source billing documentation or confirmation from MDH, both claims were paid without detection.	12,200
1,500	Claims were submitted by the provider to both Medicare and Medicaid. Claims were correctly paid by Medicare but were incorrectly paid by Medicaid. Although, MDH subsequently detected and recovered these duplicate claim payments through other means, MDH did not attempt to modify its system edits to prevent these types of duplicate payments in the future.	1,500
$45,300		**$174,100**

Recommendation 9

We recommend that MDH

a. establish claims processing edits to prevent all payments to providers who have a credible allegation of fraud against them,

b. evaluate and enhance claims processing edits to trigger a denial or suspension when critical data elements match that are indicative of potential duplicate payments or overpayments related to claims

submitted by two rendering providers or claims involving both Medicaid and Medicare reimbursements, and

c. follow up on the aforementioned claims paid after a credible allegation of fraud was determined and the potential duplicate payments and overpayments identified and take corrective action (such as pursuing recovery or processing adjustments to offset future claim payment amounts).

APPENDIX

Maryland
DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

May 28, 2020

Mr. Gregory A. Hook, CPA
Legislative Auditor
Office of Legislative Audits
State Office Building, Room 1202
301 West Preston Street
Baltimore, MD 21201

Dear Mr. Hook:

Enclosed, please find the responses to the draft performance audit report on the Maryland Department of Health - Effort to Identify and Analyze Improper Medicaid Payments for the period beginning July 1, 2015 and ending June 30, 2018.

If you have any questions, please contact Frederick D. Doggett at 410-767-0885 or email at frederick.doggett@maryland.gov.

Sincerely,

Robert R. Neall, Secretary
Maryland Department of Health

Enclosure

cc: Dennis R. Schrader, Deputy Secretary for Health Care Financing, MDH
Frederick D. Doggett, Inspector General, MDH
Dionne R. Washington, Chief of Staff, Health Care Financing, MDH

Maryland Department of Health
Efforts to Identify and Analyze Improper Medicaid Payments

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Finding 1
MDH's process to identify and analyze improper Medicaid payments through its DPI was not comprehensive and did not incorporate certain best practices.

We recommend that MDH take steps to effectively identify and analyze improper Medicaid payments through its program integrity operations by

a. implementing a robust system of data analytics based on a risk-based approach that incorporates cross-matching, geo-mapping, and trend analysis to proactively highlight irregularities in Medicaid payment activity;
b. performing comprehensive analytics of MCO encounter data as part of its oversight of MCO activities;
c. taking advantage of data matching services available through the United States Treasury's DNP Center; and
d. performing a periodic documented risk assessment and implementing a formal process to measure and report reliable quantifiable benefits of its program integrity operations.

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.			
Recommendation 1a	Agree	**Estimated Completion Date:**	12/31/2020
Please provide details of corrective action or explain disagreement.	In October 2019, the DPI placed a solicitation in the Maryland Marketplace for a new SURS contractor. The scope of work, as defined in the solicitation, has been expanded from the previous contract to focus more on a risk-based approach and incorporate the additional data analytic tools identified in this recommendation. A new contract should be in place by the end of calendar year 2020.		
Recommendation 1b	Agree	**Estimated Completion Date:**	12/31/2020
Please provide details of corrective action or explain disagreement.	Data runs performed using SURS incorporate both FFS and MCO claims data. As such, data being analyzed by the DPI includes both FFS and MCO claims. The DPI expects to be able to run more comprehensive data analytics on MCO data once the new SURS contract is in place.		
Recommendation 1c	Agree	**Estimated Completion Date:**	12/31/2020
Please provide details of corrective action or explain disagreement.	Our understanding of the U.S. Treasury's "Do Not Pay" Center is that it would require a data-sharing agreement between MDH and the Federal government that does not currently exist. The DPI will explore this option. In the meantime, the DPI notes that the Do Not Pay database		

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	draws information from various federal databases that are currently used by DPI, including the List of Excluded Individuals and Entities; the Social Security Death Index; and Vital Statistics.		
Recommendation 1d	Agree	**Estimated Completion Date:**	12/31/2020
Please provide details of corrective action or explain disagreement.	DPI is in the process of revising all of its policies and procedures. As part of this effort, we will include formal processes for risk assessment, as well as measuring and reporting quantifiable benefits of DPI operations.		

Finding 2
MDH did not ensure that prescribing physicians and referring providers were enrolled in Medicaid, as required by federal regulations. During the period July 1, 2015 to June 30, 2018, MDH approved prescription and laboratory claims totaling approximately $175 million submitted by prescribing physicians and referring providers whose enrollment in Medicaid was not validated.

We recommend that MDH

a. ensure that prescribing physicians and referring providers are enrolled in Medicaid, as required by federal regulations prior to paying related claims;

b. ensure required enrollment information identifying the prescribing physicians and referring providers is provided to DPI to perform comprehensive data analysis of claim activity; and

c. continue to pursue guidance from CMS or consider contacting other states for guidance to assist in meeting enrollment requirements for prescribing physicians and referring providers.

Agency Response	
Analysis	**Factually Accurate**
Please provide additional comments as deemed necessary.	MDH has been in partial compliance with the prescriber enrollment provision for 18-24 months. We send the Pharmacy Point-of-Sale (POS) vendor a file to edit against that includes: 1) sanctioned provider information; 2)"bogus" NPIs from a point-in-time data pull; and 3) hundreds of providers who "ignored" outreach for a few years and never enrolled. What MDH has not been able to implement is a change where the POS vendor would edit pharmacy encounters against a daily FFS Provider file of individual prescribers. Second paragraph, bottom of page 11 states, "identifying prescribing

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	physician on pharmacy claims can help detect if opioids and other high-risk prescription medications are being prescribed by certain physicians in a questionable manner." MDH does capture the prescriber NPI on pharmacy claims. We just do not edit on the NPI currently. The prescriber data is put into the "referring provider" field for Pharmacy claims. The DPI could use this data presently to do the analysis described.		
Recommendation 2a	Agree	**Estimated Completion Date:**	4/30/2021
Please provide details of corrective action or explain disagreement.	MDH is implementing the Prescriber Enrollment edits for the FFS Program with the launch of the new Pharmacy POS system, which is expected to go-live Winter 2021. MDH is also actively working toward implementation of referring provider enrollment for Spring 2021. MDH Provider Services and Systems team is developing an online "Provider Look-up" tool to help labs identify whether referring physicians are enrolled prior to billing. The tool is in development and being tested presently and MDH expects to launch in Summer/Fall 2020.		
Recommendation 2b	Agree	**Estimated Completion Date:**	1/1/2020
Please provide details of corrective action or explain disagreement.	As the prescribing and referring physicians are enrolled, DPI shall have access to the required enrollment identifying information. Prescriber data is presently available in the "referring" field for Pharmacy claims.		
Recommendation 2c	Agree	**Estimated Completion Date:**	1/1/2020
Please provide details of corrective action or explain disagreement.	MDH did seek CMS guidance as early as Summer 2018, related to enrolling prescribing and referring physicians and did eventually receive guidance since discussions with the auditors. MDH moved ahead with implementing an enrollment path for ORP providers that does not include a provider agreement. CMS indicated in their response over a year later in June 2019 that MDH may develop a provider agreement for ORP providers that is separate from the agreement executed by providers who render Medicaid-billable services. MDH shall work with its legal team and provider enrollment system vendor to develop and implement an ORP provider agreement. MDH regularly participates on All-State calls on Provider Enrollment Compliance and also attends the Medicaid Integrity Institute (MII) work sessions in South Carolina as offered.		

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Finding 3
MDH did not ensure that rendering providers for certain group practices were enrolled in Medicaid, as required by State regulations.

We recommend that MDH
a. ensure rendering providers are Medicaid enrolled, as required; and
b. deny claims when information identifying the rendering provider is not submitted.

Agency Response	
Analysis	**Factually Inaccurate**
Please provide additional comments as deemed necessary.	During the audit period of July 1, 2015 through June 30, 2018, the Provider Type 28 EPSDT Therapy Group Providers were not required to enroll their individual rendering providers. Medicaid incorporated by reference the EPSDT Manual within 10.09.23.01-1 effective January 1, 2017. Page 9 of the IBR EPSDT Manual states, "renderers in a therapy group provider type practice (Provider Type 28) are not required to be assigned an individual rendering Maryland Medical Assistance provider number." Further, page 12 states, "At this time, only therapy group (provider type 28) providers can bill without including a rendering provider number on the claim." Please note that the EPSDT manual incorporated by reference in 2017 implemented policies that had been in effect throughout the audit period noted above. To support this finding, OLA cited versions of the EPSDT Manual dated July 1, 2018, and January 1, 2019. Both of these versions were published and adopted (incorporated by reference) after the end of the audit period (June 30, 2018), and therefore are not applicable to the scope of the audit. MDH updated the Manual based on guidance from CMS indicating that individual rendering providers must enroll with state Medicaid programs; CMS subsequently announced, however, that the enrollment of rendering providers is not a federal requirement. The licenses of rendering providers are verified in accordance with the IBR manual in effect during the audit period and incorporated into the regulations in 2017. Page 9 states, "a listing of therapists and license numbers of participating members of the practice must be attached to the

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	therapy group application for in-state applicants. Out-of-state applicants must submit a copy of all licenses and/or certificates of the therapists participating in the practice." This verification occurred during initial enrollment and revalidation of the Group.

Auditor's Comment: In its response, the Maryland Department of Health (MDH) agreed with all of the recommendations but indicated that they believed the analysis was not factually accurate. MDH contends that during the audit period early and periodic screening, diagnosis, and treatment (EPSDT) therapy group providers were not required to enroll their rendering providers nor identify rendering providers on claims. However, MDH does not acknowledge that prior to the incorporation of the January 2017 *EPSDT Manual* in the Code of Maryland Regulations (COMAR), COMAR incorporated the *Physicians' Services Provider Fee Manual*. This *Manual*, effective January 2014, itself references Maryland Medicaid's billing instructions, which are directly applicable to EPSDT providers and clearly indicate requirements for rendering providers, including physical therapists, occupational therapists, and speech-language pathologists, to be enrolled and be assigned a provider number for billing purposes. In addition, in August 2017, eight months after the *EPSDT Manual* became effective, MDH sent a written notification to all therapy group providers clarifying that their rendering providers are required to be enrolled and identified on each claim. Finally, a July 2018 update to the *EPSDT Manual* made it consistent with both the aforementioned billing instructions and the August 2017 written notification, by re-affirming MDH's position of the rendering provider enrollment and billing requirements for therapy group practices. Consequently, we believe our analysis is accurate, valid, and supported.

Recommendation 3a	Agree	**Estimated Completion Date:**	12/31/2020
Please provide details of corrective action or explain disagreement.	While Maryland Medicaid did not require that individual rendering providers be enrolled during the audit period, Medicaid chose to begin enrolling these providers in late 2017 when we were under the impression that it was a Federal requirement. Maryland began the process of enrolling new Provider Type 28 EPSDT Therapy Providers as Type of Practice 35-Groups following the audit period in 2018. New providers enrolling from this point forward were set-up initially as Type of Practice 35-Groups. Medicaid has been enrolling individual rendering providers for these groups with Type of Practice 35 - Group since that time. Medicaid is in the process of changing the legacy Type of Practice 99s to Type of Practice 35s, but many of the individual rendering providers are already enrolled.		

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	Due to the COVID-19 state of emergency, MDH's plan to issue a transmittal requiring all historical, or legacy, Provider Type 28 EPSDT Therapy Groups begin submitting individual rendering providers has been postponed by a few months. MDH intends to send this transmittal by late Summer/Fall 2020.		
Recommendation 3b	Agree	**Estimated Completion Date:**	12/31/20
Please provide details of corrective action or explain disagreement.	MDH is currently denying claims for all Provider Type 28s with a Type of Practice 35 - Group. Maryland began the process of enrolling new Provider Type 28 EPSDT Therapy Providers as Type of Practice 35-Groups in 2018. Any new group providers were automatically subject to claims denials if their individual rendering providers were not enrolled. Between October 1, 2020 and December 31, 2020, MDH intends to change the remaining historical, or legacy, Provider Type 28 EPSDT Therapy Groups with Type of Practice 99 to Type of Practice 35s. Once these providers change to Type of Practice 35, MDH will deny claims where the individual rendering provider information is not submitted or not actively enrolled.		

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Finding 4

MDH accepted encounter data from MCOs that excluded necessary data elements and hindered its ability to perform effective oversight, including DPI's use of data analytics to identify and analyze improper claim activity.

We recommend that MDH ensure

a. encounter data submitted by MCOs includes all federally required data elements, including the paid or denied status of the claim; and

b. system changes to MMIS II are implemented timely to enable DPI to use complete encounter data to help identify and analyze improper claim activity.

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.			
Recommendation 4a	Agree	**Estimated Completion Date:**	3/31/2020
Please provide details of corrective action or explain disagreement.	MDH concurs that these three data elements are beneficial to the Department and allows better use of encounter data for analytics. However, since March 2020, all of these data elements (paid and denied status, claim payment amount, rendering provider information) are now required as part of our encounter data and have been included in subsequent encounter data sets.		
Recommendation 4b	Agree	**Estimated Completion Date:**	7/31/2020
Please provide details of corrective action or explain disagreement.	MDH shall work to draft a change request to modify the MMIS and ensure timely implementation. MDH shall also coordinate communication with MCOs to ensure all parties involved align business rules, update encounter data submission guidelines, and set up processes with the Medicaid business units to detect and identify improper claims activity within encounter data.		

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Finding 5
MDH did not perform a data match or have an alternative method to determine if MCOs were paying claims related to certain services that MDH had carved out from the MCO contracts.

We recommend MDH

a. perform a data match using reliable encounter data or have an alternative method (such as the annual agreed-upon procedure reviews) to ensure that MCOs are not paying claims related to certain services that are carved out from the MCO contracts; and

b. take corrective action to address carve out service claims, including the claims mentioned above, that MCOs improperly paid.

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.			
Recommendation 5a	Agree	**Estimated Completion Date:**	[1]6/30/2021
Please provide details of corrective action or explain disagreement.	MDH concurs with the recommendation to perform a data match using reliable encounter data to ensure MCOs are not paying claims related to certain services that are carved out of the MCO capitation rates. MDH will work with the MCOs to develop an annual process (or more frequently) to perform a paid claims review related to carve-out (excluded) services.		
Recommendation 5b	Agree	**Estimated Completion Date:**	[2]6/30/2021
Please provide details of corrective action or explain disagreement.	The plan is to review these claims annually, and, if there are carve-out claims that have been paid by both the MCOs or by the ASO, those will be sent back to the MCO or ASO for correction.		

[1] This date is subject to change depending on the COVID-19 crisis
[2] This date is subject to change depending on the COVID-19 crisis

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Finding 6
MDH did not ensure MCO providers rendering services to Maryland recipients were enrolled as Medicaid providers, as required by federal regulations that became effective January 1, 2018.

We recommend MDH take action to ensure MCO providers rendering services to Maryland recipients are identified and enrolled as Medicaid providers, as required by federal regulations.

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.			
Recommendation 6	Agree	**Estimated Completion Date:**	1/1/2020
Please provide details of corrective action or explain disagreement.	Encounter Subsystem edits have gone live since the time of the audit. As of January 1, 2020, the MMIS Encounter Data Subsystem edits all encounters for MCO par providers against the FFS Provider Subsystem for dates of service on or after 1/1/20, submitted on or after 1/1/20. These edits ensure that all MCO providers that are rendering services, but not currently enrolled are identified and subsequently enrolled as Medicaid providers. CMS has also provided for exceptions to the FFS screening/enrollment requirements for "non-par" (not in the MCO network) MCOs providers, such as hospitals/hospitalists providing emergency one-time services when a participant is traveling out-of-state. MDH built this CMS exception into the Encounter Data edits that went live on 1/1/20.		

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Finding 7
MDH did not ensure each MCO conducted required investigations of encounter claims activity.

We recommend that MDH

a. **ensure MCOs conduct investigations of encounter claims activity, as required and provide adequate details of each investigation so appropriate follow up can be performed; and**
b. **modify MCO contracts to specify the nature, extent, and frequency of investigations to be performed and reporting requirements, and include penalties and incentives related to investigations.**

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.			
Recommendation 7a	Agree	**Estimated Completion Date:**	12/31/2020
Please provide details of corrective action or explain disagreement.	DPI has identified significant inconsistencies in MCOs reports on investigations. In cooperation with MCOs, DPI is developing and implementing an MCO reporting dashboard that will require more detailed reporting. All fields on the dashboard will be consistent, better enabling DPI to efficiently track and monitor the number and status of investigations being performed by each MCO. The dashboard will enable DPI to follow up on individual investigations as needed.		
Recommendation 7b	Agree	**Estimated Completion Date:**	12/31/2020
Please provide details of corrective action or explain disagreement.	DPI will work with Medicaid to ensure that the MCO contracts mirror the investigation requirements procedures now being revised, including use of the new reporting dashboard. DPI will also work with Medicaid to identify appropriate contractual incentives and penalties.		

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Finding 8
A data match performed by MDH to identify incarcerated individuals who were improperly enrolled in MCOs was based on incomplete data and was not used to identify and prevent improper fee-for-service payments related to incarcerated individuals. Our expanded data match identified approximately $9.6 million of potential improper claim payments during fiscal years 2016 to 2018 that had not been identified or investigated by MDH.

We recommend that MDH

a. continue to work in conjunction with DPSCS to obtain complete and accurate incarceration data for its match,
b. establish controls based on match results to identify and prevent disallowed fee-for-service payments for incarcerated individuals,
c. ensure incarcerated individuals are timely disenrolled from MCOs to prevent improper capitation payments, and
d. investigate the potential improper payments we identified and take corrective action (such as recovery of improper payments).

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.			
Recommendation 8a	Agree	**Completion Date:**	1/28/2020
Please provide details of corrective action or explain disagreement.	MCPA agrees with the recommendation and shall continue to work in conjunction with DPSCS to obtain complete and accurate incarceration data for its match and shall work to identify other sources of accurate data to enhance the identification of incarcerated individuals.		
Recommendation 8b	Agree	**Completion Date:**	3/31/2020
Please provide details of corrective action or explain disagreement.	MDH uses match criteria (SSN, First name, Last Name, DOB) to identify incarcerated individuals that may be enrolled with an MCO. By utilizing this process to accurately disenroll incarcerated individuals, MCPA has prevented improper capitation payments for thousands of inmates. In addition to the automated disenrollment process, MDH regularly receives referrals from MCOs or other stakeholders about incarcerated individuals. The process to verify the individual's incarcerated status and		

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	manually disenroll the individual from the MCO is outlined in the SOP shared with OLA. MCPA is developing new ways to improve the current incarcerated MCO disenrollment process. One such way is the development of a report to include near matches from the Weekly DPSCS/MDH eligibility matching process. The weekly report would be reviewed by MDH and if the individual can be accurately matched, then the MCO disenrollment would occur manually. The report shall be available in March 2020.		
Recommendation 8c	Agree	**Completion Date:**	1/28/2020
Please provide details of corrective action or explain disagreement.	When MDH is notified through an automated process or manually validates an individual's incarceration status, the necessary steps to ensure individuals are disenrolled timely are taken. Pursuant to COMAR 10.67.02.06.E(2)(d), the enrollee's disenrollment shall take effect from the first day of the month following the month in which the Department verifies the individual is an inmate. MDH shall ensure this process continues to be followed to avoid erroneous capitated payments.		
Recommendation 8d	Agree	**Estimated Completion Date:**	7/1/2020
Please provide details of corrective action or explain disagreement.	MCPA shall research the potential improper payments identified and take corrective action such as, recovery of improper payments as appropriate.		

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Finding 9
Claims processing edits were not properly implemented in MMIS II to prevent payments after a credible allegation of fraud against a provider was determined. Additionally, certain existing claims processing edits were not always designed in a manner to analyze critical criteria that could be indicative of either duplicate payments or overpayments.

We recommend that MDH

a. establish claims processing edits to prevent all payments to providers who have a credible allegation of fraud against them,

b. evaluate and enhance claims processing edits to trigger a denial or suspension when critical data elements match that are indicative of potential duplicate payments or overpayments related to claims submitted by two rendering providers or claims involving both Medicaid and Medicare reimbursements, and

c. follow up on the aforementioned claims paid after a credible allegation of fraud was determined and the potential duplicate payments and overpayments identified and take corrective action (such as pursuing recovery or processing adjustments to offset future claim payment amounts).

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.			
Recommendation 9a	Agree	**Estimated Completion Date:**	9/30/2020
Please provide details of corrective action or explain disagreement.	MDH agrees that there was a problem with Payment Withhold data not going to its ASOs. The Division of Medicaid Information Systems (DMIS) has recently developed a supplemental daily provider file for the ASOs, which includes payment withhold data. DMIS is ready for testing with the new Behavioral Health ASO. Medical Benefits Management - Division of Dental, Clinics and Labs needs to work on updating the provider file for the Dental ASO as well, and MDH will continue to move this effort forward. In addition, MDH will establish claims processing edits within the MMIS system to prevent all payments to providers who have credible allegations of fraud against them.		
Recommendation 9b	Agree	**Estimated Completion Date:**	12/31/2020

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Please provide details of corrective action or explain disagreement.	MDH will perform a careful analysis of the identified potential duplicate claim categories as well as the related MDH policies. A risk analysis will be performed to compare prevalence, false positives and true duplicates. Where appropriate MDH will enhance the duplicate system edits to deny the dupes and/or flag potential duplicate claims for retrospective review, followed by appropriate retraction or offset.		
Recommendation 9c	Agree	**Estimated Completion Date:**	12/31/2020
Please provide details of corrective action or explain disagreement.	MDH will develop a process to identify duplicate claims and overpayments and follow up erroneously paid claims or fraudulent activity as identified through this audit or subsequent analysis.		

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