Audit Report

# Maryland Department of Health
# Medical Care Programs Administration

November 2019

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DEPARTMENT OF LEGISLATIVE SERVICES
MARYLAND GENERAL ASSEMBLY

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DEPARTMENT OF LEGISLATIVE SERVICES
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MARYLAND GENERAL ASSEMBLY

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Legislative Auditor

November 7, 2019

Senator Craig J. Zucker, Senate Chair, Joint Audit and Evaluation Committee
Delegate Shelly L. Hettleman, House Chair, Joint Audit and Evaluation Committee
Members of Joint Audit and Evaluation Committee
Annapolis, Maryland

Ladies and Gentlemen:

We have conducted a fiscal compliance audit of the Maryland Department of Health (MDH) – Medical Care Programs Administration (MCPA) for the period beginning July 1, 2015 and ending July 31, 2018. MCPA administers the Medical Assistance Program (Medicaid), which provides low-income Maryland residents with access to a broad range of health care benefits that are financed by State and federal funds. During fiscal year 2018, MDH spent approximately $11 billion for Medicaid.

During previous audit cycles, we conducted one audit for all aspects of MCPA's activities, whereas, during the current audit cycle we conducted four separate audits of MCPA operations. This audit includes the primary MCPA audit, accounting for approximately $4 billion in expenditures in fiscal year 2018. Separate audits are now conducted of the Managed Care Program, the Behavioral Health Administration's Administrative Service Organization, and the Maryland Pharmacy Program.

Our audit disclosed that MCPA did not adequately monitor vendors that assisted in administering the Medicaid program. For example, MCPA did not sufficiently address errors made by the vendor responsible for determining whether Medicaid recipients required hospitalization. Specifically, the vendor had routinely incorrectly approved hospital services as medically necessary; however, MCPA could only provide limited documentation of follow-up of these errors or required corrective action plans. During the period from April 2016 to October 2018, MCPA determined that 1,889 of 11,435 hospital days reviewed (17 percent) were not medically necessary, including 1,215 days from fiscal year 2018. We estimated the potential cost of the 1,215 unnecessary hospital days identified by the MCPA reviews in fiscal year 2018 to be approximately $4.6 million.

In addition, MCPA did not monitor the vendor responsible for conducting credit balance audits of hospitals to identify possible reimbursements from third-party insurers. For example, we noted that, as of November 2018, the vendor had not conducted the required fiscal year 2018 audits for 29 of 69 hospitals, including 12 that had also not been audited in fiscal year 2017. Furthermore, MCPA did not require or obtain comprehensive, independent security reviews of two vendors that maintained sensitive recipient data.

Our audit also disclosed that MCPA did not sufficiently document its review of investigations of questionable recipient eligibility information performed by the Department of Human Services, Local Health Departments, and MCPA employees. Consequently, there was a lack of assurance that MCPA's oversight of these investigations was sufficiently comprehensive.

We also noted that MCPA did not take certain actions or establish adequate processes over certain services provided, such as those in a hospital, community-based setting, and nursing facility. For example, MCPA had conducted virtually no audits of hospital claims since calendar year 2007. The purpose of these audits included determining whether billed services were provided and were appropriate. According to MCPA records, hospital services totaled approximately $777.5 million during fiscal year 2018. Furthermore, MCPA did not have a process in place to ensure the validity of nursing facility ventilator care claims, which totaled approximately $41.1 million in fiscal year 2018.

Finally, our audit identified that MCPA did not have sufficient controls to restrict access to personally identifiable information (PII) within the Medicaid Management Information System. For example, we noted that 727 employees had access to a screen containing the names and social security numbers of 3.5 million active and inactive Medicaid recipients, and we were advised that the vast majority of these users did not require this access.

Our audit included a review to determine the status of nine findings that were contained in certain preceding audit reports. Specifically, our audit included a review to determine the status of 8 of the 15 findings contained in our preceding audit report on MCPA, dated August 18, 2017, and one finding from our preceding MDH – Office of the Secretary and Other Units audit report, dated August 30, 2017. We determined that MCPA satisfactorily addressed 7 of these 9 findings. The remaining 2 findings are repeated in this report.

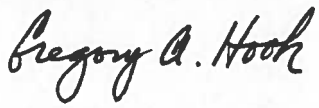
In our preceding audit report, dated August 18, 2017, we reported that MCPA's accountability and compliance level was unsatisfactory in accordance with the rating system we established in conformity with State law. Based on the results

of our current audit, we have concluded that MCPA has made improvements in its fiscal and compliance operations and, accordingly, MCPA's accountability and compliance level is no longer unsatisfactory.

MDH's response to our findings and recommendations, on behalf of MCPA, is included as an appendix to this report. We reviewed the response and noted general agreement to our findings and related recommendations, and we will advise the Joint Audit and Evaluation Committee of any outstanding issues that we cannot resolve with MDH. In accordance with our policy, we have redacted any vendor or products mentioned by MDH in this document.

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

Respectfully submitted,



Gregory A. Hook, CPA
Legislative Auditor

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

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

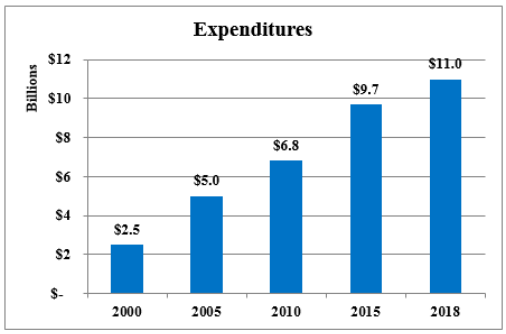
# Background Information

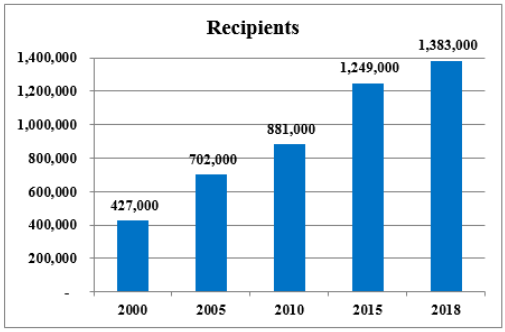
## Agency Responsibilities

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. In its capacity as Maryland's administering agency, MCPA is responsible for enrolling the healthcare providers (such as physicians), establishing program regulations, setting provider payment rates, reviewing and paying provider claims, and obtaining federal reimbursement for eligible costs. MDH has agreements with the Maryland Department of Human Services and the Maryland Health Benefit Exchange delegating to them its responsibility for recipient eligibility determinations.

According to MCPA records as of June 30, 2018, the Medicaid Program served approximately 1.4 million individuals through approximately 59,000 healthcare providers. During fiscal year 2018, MCPA's Medicaid expenditures totaled approximately $11.0 billion, including $6.7 billion in federal fund expenditures.

**Chart 1**
**Medicaid Expenditures and Recipients**
**(Fiscal Years 2000 to 2018)**



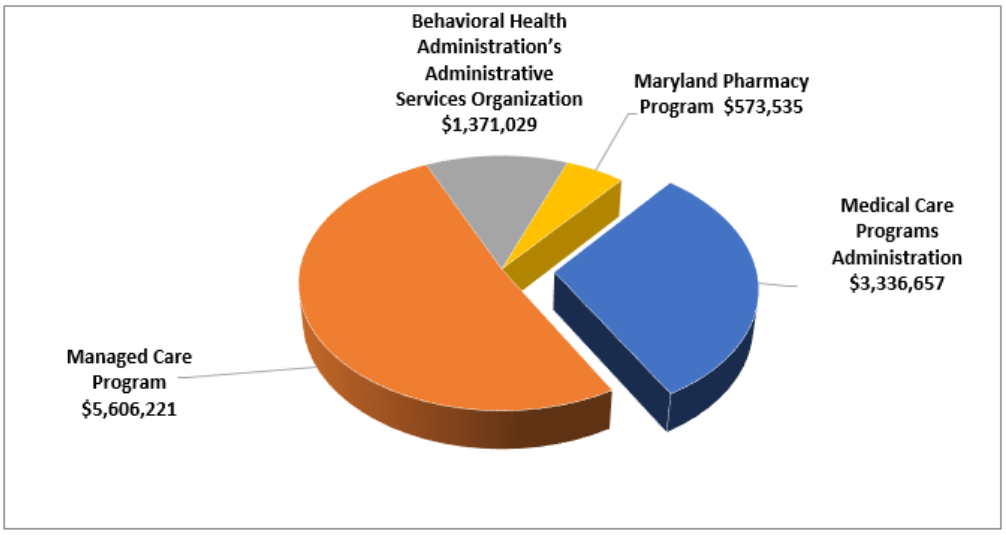

Source: State accounting records, Medicaid Management Information System

Individuals qualifying for cash assistance through the Temporary Cash Assistance program or the federal Supplemental Security Income program automatically qualify for Medicaid benefits. Those eligible for Medicaid through these programs make up most of the Medicaid population and are referred to as

"categorically needy" although there are other individuals who are considered categorically needy due to other circumstances (such as children residing in foster care). The remaining individuals are referred to as "medically needy," meaning they cannot meet the cost of needed medical care, but are generally self-supporting in other respects. Individuals may apply for Medicaid in person, through the mail, or online.

MCPA uses a federally certified computerized system, the Medicaid Management Information System (MMIS II), implemented in 1995, to pay provider claims and to process paid claims for federal reimbursement. According to MCPA records, during fiscal year 2018 MMIS II was used to process transactions totaling approximately $10.9 billion. This Medicaid activity is currently covered under four separate audits as depicted in Chart 2.

**Chart 2**
**MCPA's Fiscal Year 2018 Expenditures Processed via MMIS II by OLA Audit (expressed in thousands)**




Source: State accounting records, MMIS II

In this regard, this MCPA audit excluded the following services that were included in our preceding audit of the Medical Care Programs Administration; these services are now being reviewed under three separate audits:

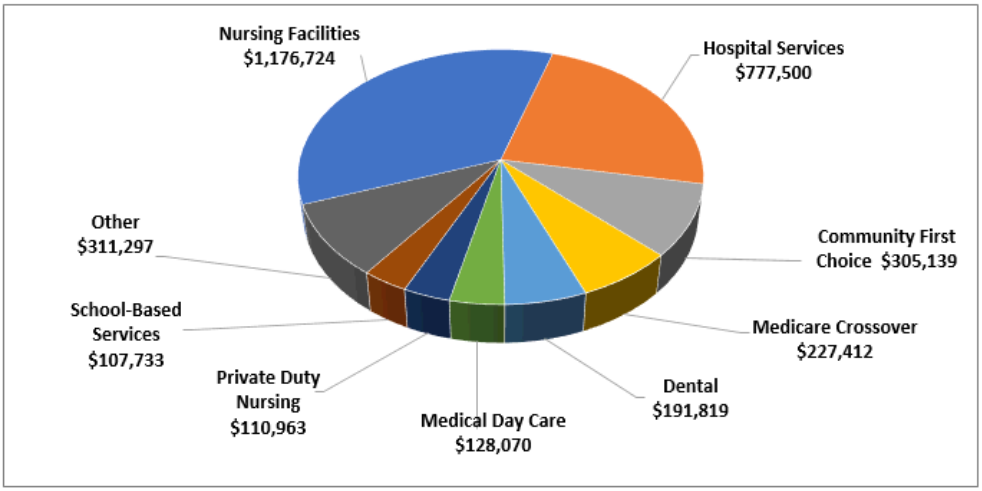
- **Managed Care Program** – MCPA contracts with Managed Care Organizations (MCOs) to provide a wide variety of services to enrolled Medicaid recipients in exchange for specified capitation payments.

- **Behavioral Health Administration's Administrative Services Organization (ASO)** – MCPA contracts with an ASO that is responsible for providing benefit management services to Medicaid recipients enrolled in the Behavioral Health System.

- **Maryland Pharmacy Program** – MCPA provides pharmaceutical benefits to Medicaid recipients.

The scope of this MCPA audit included expenditures for the remaining MCPA activity that, according to the State's records, totaled approximately $4 billion in fiscal year 2018. These expenditures included approximately $3.3 billion processed through MMIS II, depicted in Chart 3, and approximately $695.4 million in expenditures processed outside of MMIS II. Based on our assessments of significance and risk, we reviewed procedures and conducted testing of the service types depicted in Chart 3. Specifically, we reviewed procedures over activities affecting multiple MCPA services, such as MMIS II security and controls, federal fund reimbursements, recipient and provider eligibility, and third-party insurance recoveries. In addition, we reviewed procedures and conducted testing unique to the service types named in Chart 3, such as nursing facilities and hospital services, as well as for expenditures processed outside of MMIS II. Such expenditures included Medicare premiums for Medicaid-eligible recipients, transportation costs, and certain State-funded grants.

**Chart 3**
**Fiscal Year 2018 Expenditures Processed via MMIS II by Service Type**
**(expressed in thousands)**




Source: State accounting records, MMIS II

## Medicaid Enterprise Restructuring Project Settlement

In October 2015, MDH terminated the contract for the Medicaid Enterprise Restructuring Project (MERP). MERP was MDH's chosen replacement for its legacy claims processing system, MMIS II. MMIS II, which was implemented in 1995, is considered by MDH to be outdated technologically, inflexible, and costly to maintain. MMIS II also requires numerous workarounds and has not been fully integrated with the State's various enrollment systems, as originally envisioned.

Although the MERP contract was terminated, litigation ensued between the State and the contractor with both parties making claims for damages. All of the litigation was resolved in a single settlement announced by the Office of the Attorney General on February 9, 2018. The terms of that settlement resulted in the contractor paying the State $81 million. Since much of the cost for implementing MERP was reimbursed by the federal government, the settlement was shared with the federal government, with the State receiving approximately $49.8 million.

With the termination of MERP, MCPA has transitioned to implementing system enhancements to the existing MMIS II as part the MMIS Modular Transformation project. As of July 2019, this project is still in the planning phase (including seeking budgetary approval, gathering system requirements, and procuring project management resources).

## Status of Findings From Preceding Audit Reports

Our audit included a review to determine the status of 8 of the 15 findings contained in our preceding audit report on MCPA, dated August 18, 2017, and one finding relating to federal funds from our preceding MDH – Office of the Secretary and Other Units audit report, dated August 30, 2017. As disclosed in the following table, we determined that MCPA satisfactorily addressed 7 of these 9 findings. The remaining 2 findings are repeated in this report. Our audit did not include a review of 7 findings contained in our preceding MCPA audit report that related to managed care organizations and behavioral health; the status of those findings was addressed in our separate MCPA audits of the Managed Care Program and the Behavioral Health Administration's Administrative Services Organization.

In our preceding audit report, we reported that MCPA's accountability and compliance level was unsatisfactory, in accordance with the rating system we established in conformity with State law. Based on the results of our current audit, we have concluded that MCPA has improved its fiscal and compliance

operations to the point that MCPA's accountability and compliance level is no longer unsatisfactory.

**Table 1**
**Status of Preceding Findings**

| Preceding Finding | Finding Description | Implementation Status |
|---|---|---|
| Finding 2 | The current memoranda of understanding with the Department of Human Services and the Maryland Health Benefits Exchange are not sufficient to ensure that eligibility determinations are timely and proper. | Not repeated |
| Finding 3 | MCPA did not take timely follow-up action on questionable enrollee information it identified and did not ensure that critical eligibility information was properly recorded on the Medicaid Management Information System (MMIS II). | Not repeated |
| Finding 4 | MCPA did not take timely action to ensure recipients age 65 or older had applied for Medicare as required by State regulations. | Not repeated |
| Finding 5 | MCPA did not ensure that all reports of potential third-party health insurance for Medicaid recipients were received and properly investigated in a timely manner. | Not repeated |
| Finding 7 | MCPA has not conducted required audits of hospital claims processed since calendar year 2007. | **Repeated** (Current Finding 6) |
| Finding 8 | MCPA did not adequately monitor the vendors responsible for conducting credit balance audits and utilization reviews of long-term care facilities and/or hospitals. | **Repeated** (Current Finding 2) |
| Finding 12 | MCPA did not ensure that the former dental benefits administrator was properly administering the dental benefits program and was conducting required provider audits, and did not ensure bank accounts were reconciled, and sensitive data were secured. | Not repeated |
| Finding 13 | Sensitive PII within the Electronic Data Interchange Transaction Processing System (EDITPS) database was stored and transmitted without adequate safeguards and MCPA did not remediate 20 of the 21 security vulnerabilities identified in a consultant's report on EDITPS. | Not repeated |
| MDH – Office of the Secretary and Other Units Finding 6 | Supervisory oversight of federal fund reimbursement requests was not always effective. | Not repeated |

# Findings and Recommendations

## Vendor Oversight

**Background**

The Medical Care Programs Administration (MCPA) uses numerous vendors to assist in its administration of the Medicaid program and in verifying billings by providers, including hospitals and long-term care providers such as nursing facilities. MCPA also uses vendors to conduct audits of hospital claims to identify overpayments (such as from duplicate bills and unauthorized charges) and to conduct patient credit balance audits to identify amounts due to the State for claims paid to hospitals and nursing facilities by both the State and third parties (such as insurance companies). In addition, MCPA uses vendors to review nursing facility cost settlements to identify underpayments or overpayments, and to conduct utilization reviews (including continued stay and medical eligibility reviews) of Medicaid recipients receiving services from hospitals and nursing facilities.

**Finding 1**
**MCPA did not sufficiently address errors noted in medical necessity determinations made by its utilization control agent vendor and did not ensure the vendor conducted timely continued stay reviews of nursing facilities.**

**Analysis**

MCPA did not sufficiently address errors noted in medical necessity determinations made by its utilization control agent (UCA) vendor and did not ensure the UCA conducted timely continued stay reviews of nursing facilities. MCPA contracted with the UCA for the period from February 1, 2016 to January 31, 2020 (including executed renewal options and modifications) for an amount not-to-exceed approximately $34.8 million. According to the State's records, the contractor had been paid approximately $15.1 million as of October 2018.

Hospital Medical Necessity Determinations

Although MCPA identified errors in the UCA's medical necessity determinations, it did not take timely action to ensure the UCA implemented comprehensive actions to correct the errors. The UCA was to review and approve the number of days necessary for inpatient acute care hospital services. According to MCPA records, the UCA was paid approximately $5.3 million for performing 68,919 reviews during the period from April 2016 to October 2018.

During the period from June 2016 through October 2018, MCPA conducted 1,040 reviews which examined 11,435 patient hospital days that the UCA deemed medically necessary. MCPA determined that 1,889 of the days (17 percent) were not medically necessary, including 1,215 days from fiscal year 2018. Using the fiscal year 2018 average hospital day charge of $3,787 obtained from the Health Services Cost Review Commission, we estimated that the potential cost of the 1,215 unnecessary hospital days identified by the MCPA reviews in fiscal year 2018 totaled approximately $4.6 million.

MCPA management advised us that it had ongoing conversations with the UCA regarding these errors, but could only provide us with limited documentation to support these conversations. Also, MCPA provided no documentation to support that the UCA had submitted a formal corrective action plan. In January 2018, MCPA did send a letter to the UCA that identified several types of problems that had been noted consistently during the reviews. The letter indicated that MCPA had not previously provided specific data on the overall findings and did not request a formal corrective action plan to address these problems.

In response, the UCA submitted a list of action items that had been implemented to address the errors. However, the letter did not detail why the errors were occurring, the period to implement corrections, or the party responsible for the corrections. Each of these elements are required by the contract to be included in a corrective action plan.

The failure to implement a timely and comprehensive corrective action plan is significant because the rate of errors identified by MCPA reviews increased from 11 percent in calendar year 2017 to 22 percent in calendar year 2018 (as of October 2018). According to MCPA management, in fiscal year 2019, the UCA decreased the rate of errors.

Nursing Facilities

MCPA did not have procedures to monitor the UCA's continuing stay reviews (CSRs) of nursing facilities to ensure the reviews were performed timely. Our analysis of 10,666 recipients residing in nursing facilities as of September 2018 with paid claims and who had been assigned to a nursing facility for at least four months prior to June 2018, disclosed that 2,328 recipients (22 percent) had not received a CSR during the period from June 2017 to June 2018. The contract required the UCA to perform CSRs for 95 percent of the recipients quarterly during the first year in the nursing facility and annually thereafter. Since MCPA did not monitor the UCA, it was not aware of the missing CSRs and did not assess liquidated damages as provided for in the contract. According to MCPA's

records, the UCA was paid approximately $1.8 million for performing 24,728 CSRs in fiscal year 2018.

**Recommendation 1**
**We recommend that MCPA**

**a. ensure that comprehensive corrective action is taken timely when deficiencies in the UCA vendor's medical necessity reviews are identified, and**

**b. monitor the UCA vendor to ensure CSRs are performed timely and assess liquidated damages as permitted by the contract.**

**Finding 2**
**MCPA did not monitor the vendor responsible for conducting credit balance audits of hospitals and nursing facilities to ensure the audits were conducted timely and properly, and the contract did not include provisions to assess liquidated damages for noncompliance with contract requirements.**

**Analysis**
MCPA did not ensure the vendor conducted timely and comprehensive credit balance audits of hospitals and nursing facilities, and the related contract did not provide for corrective action to be taken against the vendor, such as the assessment of liquidated damages for noncompliance with contract provisions. MCPA contracted with the vendor for the period from July 1, 2013 to June 30, 2020 (including executed renewal options and modifications) for an amount not-to-exceed approximately $22.4 million for various services, including credit balance audits. According to State records, the vendor was paid approximately $12.0 million as of August 2018, of which $302,000 was paid in fiscal year 2018 for the credit balance audits performed. Fiscal year 2018 recoveries relating to hospital and nursing facility credit balance audits totaled $1.8 million and $800,000, respectively.

- MCPA did not monitor the vendor to ensure the credit balance audits were performed in a timely manner. At our request, the vendor provided a summary of the audits performed for fiscal years 2017 and 2018, and we noted that, as of November 2018, the vendor had not conducted the required fiscal year 2018 audits for 29 of the 69 hospitals, including 12 hospitals that also had not been audited in fiscal year 2017. In addition, 41 of the 215 nursing facilities had not been audited in either fiscal year 2017 or 2018. The May 2013 contract with the vendor provided for annual audits of hospitals, but did not specify the frequency of the nursing facility audits. MPCA management advised us that it expected the vendor to conduct nursing facility

audits at least biennially. A similar condition was noted in our preceding audit report.

- MCPA did not review the vendor's procedures for conducting the credit balance audits to ensure that they were sufficient to identify overpayments. Although the vendor provided a methodology for identifying overpayments in its proposal for the current contract, MCPA did not ensure that the vendor's current methodology was consistent with the accepted proposal. A similar condition was noted in our preceding audit report.

- The contract did not provide for liquidated damages, penalties, or other actions for the vendor's failure to comply with the contract. In this regard, MCPA management advised us that it was generally aware that the vendor was not conducting audits in accordance with the time frames specified in the contract, but it was unable to require corrective action because of the lack of necessary contract language.

**Recommendation 2**
**We recommend that MCPA**

**a. monitor the vendor to ensure credit balance audits are performed for all facilities in a timely manner and are sufficiently comprehensive (repeat), and**

**b. ensure future contracts include provisions for appropriate corrective action when the vendor fails to meet contractual requirements.**

**Finding 3**
**MCPA did not require nor obtain comprehensive, independent reviews of the automated systems used by two vendors to ensure sensitive data, including personally identifiable information and protected health information, were properly safeguarded.**

**Analysis**
MCPA did not require nor obtain comprehensive, independent reviews of the automated systems used by two vendors to ensure sensitive data were properly safeguarded. Both of these vendors maintained automated systems which contained personally identifiable information (PII) and protected health information (PHI) for all Maryland Medicaid recipients. For example, one of these vendors was responsible for assisting MCPA with identifying legally liable third parties for Medicaid recipients' medical expenses.

The American Institute of Certified Public Accountants guidance for service organizations (such as these vendors) includes an independent review of controls for which the resultant independent auditor's report is referred to as a System and Organization Controls (SOC) report. The vendors' contracts did not require and MCPA did not obtain any SOC reports. There are several types of SOC reports, with varying scopes and levels of review and auditor testing. One type of report, referred to as a SOC 2 Type 2 report, includes the results of the auditor's review of controls placed in operation and tests of operating effectiveness for the period under review and could include an evaluation of system security, availability, processing integrity, confidentiality, and/or privacy.

In response to our inquiries, MCPA advised that, while the vendors did not obtain SOC 2 Type 2 reports, they had obtained other security reviews. For example, the vendor responsible for identifying liable third parties obtained three SOC 1 Type 2 reports covering the period from March 2015 to February 2018. Although these reports identified certain control issues (such as inadequate data backups and system access) they are generally intended to focus on controls relevant to financial reporting and would not provide MCPA sufficient assurances regarding the security of MCPA data. Furthermore, there was no documentation that MCPA had reviewed these reports nor ensured that the related deficiencies had been corrected.

**Recommendation 3**
**We recommend that MCPA require the vendors to obtain periodic SOC 2 Type 2 reviews, obtain and review the resulting reports, and ensure any related deficiencies are corrected.**

## Recipient Enrollment

**Finding 4**
**MCPA did not sufficiently document its review of investigations of questionable recipient eligibility and did not take adequate follow-up action when errors were identified in changes to critical eligibility information.**

**Analysis**
MCPA did not sufficiently document its review of investigations of questionable recipient eligibility to ensure proper corrective action was taken and did not take sufficient follow-up action when errors were identified in changes to critical eligibility information.

- MCPA did not sufficiently document its review of investigations of questionable recipient eligibility performed by the Department of Human Services (DHS), Local Health Departments (LHDs), and MCPA employees to ensure appropriate corrective action was taken. MCPA has several automated and manual processes to identify instances of questionable eligibility information or activity, such as missing social security numbers, recipients who are deceased, and recipients receiving federal benefits in another State. Instances of questionable eligibility information or activity identified are investigated and resolved by DHS, LHDs, and MCPA employees, and these efforts are subject to independent oversight review by MCPA.

  Our test of 41 investigations reviewed by MCPA during the period from March through August 2018 disclosed that MCPA did not document the specific supporting documentation that had been reviewed for any of the DHS or LHD investigations to ensure the proper corrective action was taken, such as recovery of improper payments. MCPA management advised us that it had access to and reviewed source documentation when available; however, this was not supported by our aforementioned test of the investigations and was not required in MCPA's standard operating procedures. Consequently, there was a lack of assurance that MCPA's oversight of investigations of questionable recipient eligibility was sufficiently comprehensive.

  Our testing did not disclose any improper corrective actions taken by DHS or LHDs. However, the need for review of supporting documentation is evidenced by our March 2019 audit report of DHS' Family Investment Administration (FIA) which noted that FIA did not take appropriate corrective action for 29 of 31 system alerts we tested, including alerts of a recipient receiving benefits in another state.

- MCPA did not take adequate follow-up action when MCPA employees did not make the correct changes to a recipient's critical eligibility information, such as date of birth, social security number, and address. MCPA is notified via automated and manual reporting processes when recipient information in the Medicaid Management Information System (MMIS II) differs from DHS' CARES and the Maryland Health Benefit Exchange's (MHBE) Maryland Health Connection (MHC) and what the proper information should be. MCPA employees manually process the changes to recipient information in MMIS II. These changes were subject to supervisory review, which often identified errors in these changes made in MMIS II.

  For example, MCPA's supervisory review of 866 changes made to eligibility information by 30 MCPA employees during the period between January and

June 2018 identified 107 changes made by 26 employees that were not consistent with supporting documentation and that required correction. For 7 of these 26 employees, between 20 and 33 percent of their changes were found to contain errors. Other than correcting the specific errors noted, MCPA did not expand its review to identify the scope of the errors related to these 7 employees and did not ensure that the issues were addressed with these employees, such as through additional training or disciplinary action.

**Recommendation 4**
**We recommend that MCPA**

a. **sufficiently document its reviews of investigations of questionable recipient eligibility to support that proper corrective action was taken; and**
b. **expand testing, provide additional training, and take appropriate disciplinary action when persistently occurring errors are identified in changes made by MCPA employees to critical eligibility information.**

## Third-Party Liability

**Finding 5**
**MCPA did not ensure that all referrals of potential third-party health insurance information were timely and properly investigated.**

**Analysis**
MCPA did not ensure that all referrals of potential third-party health insurance information were timely and properly investigated, as required. Federal regulations provide that Medicaid shall be the payer of last resort and that it shall only be used to pay costs not covered by others, such as third-party insurers. To identify other liable parties, MCPA receives automated and manual referrals from several sources, including DHS, MHBE, and Managed Care Organizations (MCOs). According to agency records, MCPA received approximately 235,400 referrals of possible liable third parties during fiscal year 2018 (including 76,000 from DHS, 54,200 from MHBE, and 46,100 from MCOs), and recovered approximately $77.0 million from Medicaid providers.

- As of September 2018, MCPA had not yet investigated any of the 64,700 referrals received from MCOs between May 2017 and July 2018. Federal regulations require MCPA to follow up on the potential third-party insurance information obtained within 60 days. MCPA personnel advised us that this backlog occurred because MCO referrals, which were manually processed,

were more time-intensive to investigate than referrals from other sources (DHS and MHBE) for which the process was partially automated.

- MCPA did not adequately document supervisory reviews of referral investigations to ensure appropriate conclusions were reached and insurance status was properly recorded in MMIS II. Specifically, supervisors did not review any of the investigations of MCO referrals (received prior to May 2017) performed during the audit period. Furthermore, supervisors did not document the results of their reviews of DHS and MHBE investigations and how many were reviewed. Our testing of 20 referrals from DHS and MHBE that were received during the period from March through July 2018 disclosed that, for 3 referrals, MCPA personnel did not accurately record new insurance information, including the insurance term end date, into MMIS II. In addition, for 2 other referrals, MCPA did not have sufficient documentation to support the referrals had been properly investigated.

**Recommendation 5**
**We recommend that MCPA**

**a. ensure all MCO insurance referrals are investigated in a timely manner and develop a plan for eliminating the aforementioned backlog; and**

**b. ensure that supervisory reviews of referral investigations are conducted and documented, including MCO referrals, that appropriate conclusions are reached, and that insurance status is properly recorded in MMIS II.**

## Hospital Services

**Finding 6**
**MCPA had conducted virtually no audits of hospital claim payments since calendar year 2007.**

**Analysis**
MCPA had conducted virtually no audits of hospital claim payments since calendar year 2007. The failure to audit hospital claims timely could result in MCPA paying for hospital services that were never provided or were not medically necessary, or for excessive costs due to unbundling of services. According to MCPA records, hospital services totaled approximately $777.5 million during fiscal year 2018.

As noted in our preceding audit report, MCPA terminated its contract for these audits in February 2012 because the vendor failed to conduct the required number of audits. Prior to the vendor's termination, the most recent claims audited by the

vendor covered services paid during calendar years 2004 through 2007. MCPA contracted with another vendor in August 2015, but the vendor only conducted one audit before being terminated for performance issues approximately one year later. Finally, while the MDH Office of the Inspector General conducted hospital claims audits during the audit period, only 2 of approximately 70 State hospitals were audited and only for calendar year 2010 claims.

In June 2019, MCPA procured a vendor to perform these audits. However, the scope of the contract excluded claim payments made during the period from January 2008 through June 2015.

The Patient Protection and Affordable Care Act, enacted in 2010, required states to implement these recovery audits through a contractor. Although MCPA requested and received an exemption from conducting the audits from the federal Centers for Medicare and Medicaid Services for the period from July 1, 2017 through July 1, 2019, the audits are still important to ensure hospital services that were provided were necessary and not excessive. In this regard, MCPA has historically found these audits to be beneficial as the aforementioned previously conducted audits performed for claim payments made in calendar years 2005 and 2006 identified overpayments totaling approximately $10.7 million. The lack of hospital claims audits has been commented upon in our two preceding audit reports. We were advised by MCPA that it believes that it may not be able to audit hospital claims from prior to 2013 because MMIS does not maintain recipient data beyond five years.

**Recommendation 6**

**We recommend that MCPA**

**a. take the necessary steps to ensure that hospital claims are audited in a timely manner (repeat); and**

**b. develop a plan to address the propriety of unaudited hospital claims from prior periods, including those noted above.**

## Community First Choice

**Finding 7**
**MCPA had not established appropriate oversight to ensure that all Community First Choice program recipients received daily living assistance services in accordance with their plans of service.**

**Analysis**
MCPA had not established appropriate oversight to ensure that Community First Choice (CFC) program recipients received daily living assistance consistent with their plans of service. CFC is a community-based Medicaid waiver program implemented by MCPA in January 2014 in which elderly or disabled individuals who would otherwise live in a nursing facility are able to live in their own homes. CFC recipients receive assistance with daily living activities from personal assistant providers, under agreements with MCPA, in accordance with a plan of service. LHDs are responsible for evaluating the quality of personal assistance services provided to the CFC recipients with use of nurse monitors. According to State records, during fiscal year 2018, MCPA paid CFC providers approximately $305.1 million, of which $257.8 million and $6.2 million were for personal assistant and nurse monitoring providers (through the LHDs), respectively.

Our review disclosed that MCPA had not established a process to ensure that nurse monitors were properly evaluating the quality of personal assistance services provided. According to MCPA records, 12,587 recipients received personal assistance services in fiscal year 2018. Our analysis of CFC expenditure data in MMIS II disclosed that 2,019 (or 16 percent) of these recipients did not, however, receive nurse monitoring services during this period to evaluate the quality of personal assistance services. We noted that the nurse monitoring services for approximately 65 percent of these 2,019 recipients were to be provided by one LHD. In addition, MCPA did not review the sufficiency of the nurse monitoring that was performed for the other 10,568 recipients, and our review disclosed that the nurse monitoring services were not consistently performed for these recipients. For example, we identified instances in which nurse monitoring was performed, but did not appear to meet the number of hours called for in the recipients' plans of service. MCPA management advised us that it was aware that nurse monitoring was not being performed and that the lack of monitoring was primarily the result of LHD staffing issues.

**Recommendation 7**
**We recommend that MCPA establish a process to ensure that all CFC recipients are monitored by nurses and that the related monitoring is**

**sufficient to ensure personal assistance services are received in accordance with the plans of service.**

## Medical Day Care

**Finding 8**
**MCPA did not audit all Medical Day Care program providers as required by its policy, and the related audit policy and procedures were not sufficiently comprehensive.**

**Analysis**
MCPA did not audit all Medical Day Care (MDC) program providers as required by its policy, and the related audit policy and procedures were not sufficiently comprehensive. MDC is a community-based group program that offers eligible recipients health, social, and personal support in a day-care setting in accordance with their individualized plans of care as an alternative to institutional care. During fiscal year 2018, MCPA paid 127 MDC providers approximately $128.1 million for these services. MCPA's policy requires that each provider be audited by MCPA staff at least biennially to ensure claims were properly supported and to assess the quality and appropriateness of the services rendered.

MDC Provider Audits
MCPA did not audit all MDC providers in accordance with its policy. Specifically, MCPA audited only 66 of 177 providers, during the six-year period from fiscal year 2013 through 2018, of which 64 providers were audited only once during this period. The failure to conduct all the required audits is significant because these audits, when performed, routinely identified deficiencies.

Our review of the 20 audits conducted during fiscal years 2017 and 2018 noted that 12 audits collectively identified approximately $239,000 in unsupported claims. Generally, MCPA attempts to recover unsupported claims by billing the provider, entering into a payment plan, or withholding future payments from the provider. In addition, all 20 audits detected certain program compliance issues. For example, the audits noted instances in which discharge summaries were not appropriately documented to reflect recipient discharge goals and follow-up protocols. The audit reports also noted instances in which allegations of reportable instances affecting the health or welfare of recipients had not been reported to the appropriate authorities. Furthermore, since MCPA only requires providers to retain documentation for six years, certain records may no longer be

available for audit. MCPA management advised us that these audits were not performed because of limited staff resources.

MDC Provider Audit Policy

MCPA's MDC audit policy and procedures were not sufficiently comprehensive.

- More than one year's worth of claim activity was not required to be audited. Our review of the aforementioned 20 audits disclosed that they only covered one year of claims activity regardless of when the last audit was completed.

- Explanations of the factors used in determining the number of claims tested were not required to be documented. For the aforementioned 20 audits, the number of claims tested ranged from 1 to 25 percent of claims processed for the year, and there were no documented explanations of test item selections.

- The expansion of testing when deficiencies were noted was not addressed by the policy. For 3 of the 20 audits we reviewed, more than half of the claims tested were unsupported, and MCPA did not expand its testing to determine the extent of the problem.

**Recommendation 8**

**We recommend that MCPA**

**a. audit each MDC provider at least biennially, in accordance with its policy, and recover any unsupported claims identified;**

**b. ensure that all claims since the previous audit are subject to testing; and**

**c. enhance its MDC audit policy to establish audit scope requirements and testing methodology, including a requirement to expand audit testing when significant deficiencies are identified.**

## Nursing Facility Services Program

**Finding 9**

**MCPA did not have an established process to ensure ventilator care claims submitted by nursing facilities were valid, as required by State regulations.**

**Analysis**

MCPA did not did not have a process in place to ensure nursing facility ventilator care claims, which totaled approximately $41.1 million in fiscal year 2018, were valid. According to agency records, as of July 1, 2018, 14 nursing facilities were authorized to provide ventilator care services at an average daily reimbursement rate of $756. However, MCPA did not validate any of the claims submitted by

these facilities during the audit period. State regulations require MCPA to periodically validate that days paid for ventilator care recipients are supported by medical records and to recoup payments for days that are not supported. At our request during the audit, MCPA obtained and reviewed 10 ventilator claims from two providers totaling $244,040, and MCPA concluded the claims were properly supported by reviewing the related medical records.

**Recommendation 9**
**We recommend that MCPA establish procedures to periodically validate ventilator care claims submitted by nursing facilities, as required by State regulations, and recoup any claim payments that were not supported.**

## Claims Processing

**Finding 10**
**Claims that were suspended by automated edits within MMIS II and subsequently reviewed and paid were not subject to sufficient supervisory review and approval.**

**Analysis**
Claims that were suspended by automated edits within MMIS II and subsequently reviewed and paid were not subject to sufficient supervisory review and approval. MMIS II contains numerous automated edits that suspend claims (from payment) that do not meet established criteria (for example, a hospital claim that does not have the required preauthorization code). All claims that are suspended by an edit must be manually reviewed by an MCPA employee. If the claim is ultimately determined to be proper, the MCPA employee will "force" the claim past the edit to process the payment. During fiscal year 2018, MCPA forced payment for 89,744 claims totaling approximately $151.6 million.

Although MCPA generated output reports of these forced paid claims for supervisory review and approval, the supervisor performing the review of forced claims paid was not independent because the supervisor also had access capability to manually enter these claims and force them to be paid. Furthermore, the supervisor only selected and reviewed three percent of the forced claims processed. Based on our test of 20 significant claims forced for payment that were not subject to review, we believe this level of review is insufficient.

Specifically, our review of 20 forced claims paid during the period from October 2015 to June 2018, totaling approximately $4.3 million, disclosed that 13 claims totaling approximately $338,000 were processed by an employee who was not

authorized to process these types of forced claims (hospital claims). Furthermore, 2 of these 13 claims should not have been paid because the claims had not been approved as medically necessary. According to MCPA records, during fiscal years 2016 to 2018 this employee forced 4,564 claims for payment totaling $31.8 million although the employee was not authorized to process these types of claims.

**Recommendation 10**
**We recommend that MCPA**

**a. ensure all forced claims are subject to documented supervisory review by an employee independent of the claims processing, and**
**b. review the aforementioned claims processed by the aforementioned employee and recover any amounts improperly paid.**

## Information Systems Security and Control

**Finding 11**
**MCPA did not have sufficient procedures and controls to restrict access to MMIS II. For example, 727 MMIS II active users could view the names and social security numbers of 3.5 million active and inactive Medicaid recipients.**

**Analysis**
MCPA did not have sufficient procedures and controls to restrict access to MMIS II. According to MCPA records, as of August 2018, there were 814 active users in MMIS II for which fiscal year 2018 transactions totaled $10.9 billion.

- Although MCPA had a process to request monthly confirmations of users' general MMIS II access, MCPA did not perform a periodic review to ensure employee access to personally identifiable information (PII) stored in MMIS II for Medicaid recipients was properly restricted. As a result, numerous MCPA employees had unnecessary access to view PII in MMIS II. For example, 727 MMIS II active users had access to a screen containing the names and social security numbers of 3.5 million active and inactive Medicaid recipients. We were advised by MCPA management that the vast majority of these users did not require access to this information; however, MCPA had not taken any action to address this because it would require MMIS II to be reprogrammed.

- MCPA did not follow up with units that did not respond to monthly confirmations as to the propriety of user access. MCPA sent monthly reports of MMIS II users to the security officers in each of MCPA's 64 units. Each

security officer was required to respond and confirm the propriety of the user access or to note any changes that were needed. Our review of the monthly reports from May through December 2018 disclosed that about half of the units did not respond each month and MCPA did not take any follow-up action to determine if the access was proper. For example, only 27 of 64 units (42 percent) responded to the September 2018 monthly confirmation request.

- Password controls were not in accordance with the State of Maryland *Information Technology Security Manual*. Specifically, user passwords in MMIS II were only four characters long and did not expire.

The State of Maryland *Information Technology Security Manual* requires agencies to enforce access controls that provide separation of duties, and to monitor the controls over their information system, including periodic reviews of user accounts and access for propriety. The *Manual* also requires passwords to be a minimum of 12 characters and changed at least every 90 days.

**Recommendation 11**
**We recommend that MCPA**

**a. perform periodic reviews to ensure that PII is properly restricted to authorized employees and remove unnecessary employee access to PII, including those noted above;**
**b. follow up with units that do not respond to the monthly user access reports; and**
**c. establish user password controls that comply with the aforementioned State of Maryland *Information Technology Security Manual*.**

# Audit Scope, Objectives, and Methodology

We have conducted a fiscal compliance audit of the Medical Care Programs Administration (MCPA) of the Maryland Department of Health (MDH) for the period beginning July 1, 2015 and ending July 31, 2018. 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 State Government Article, Section 2-1221 of the Annotated Code of Maryland, the objectives of this audit were to examine MCPA's financial transactions, records and internal controls, and to evaluate its compliance with applicable State laws, rules, and regulations.

This audit excluded the procedures and controls over the Managed Care Program, Behavioral Health Administration's Administrative Services Organization, and the Maryland Pharmacy Program that were included in our preceding audit of the MCPA. These activities are now being reviewed under three separate audits (as further explained in the cover letter of this report).

In planning and conducting our audit, we focused on the major financial-related areas of operations based on assessments of significance and risk. The areas addressed by the audit included Medicaid Management Information System (MMIS II) security and controls, federal fund reimbursements, recipient and provider eligibility, third party insurance recoveries, nursing facilities, hospital services, community first choice, medical day care, private duty nursing, school based services, Medicare crossover claims, and dental billings. We also determined the status of 8 of 15 findings contained in our preceding audit report on MCPA and one finding in our preceding audit report on the MDH – Office of the Secretary and Other Units. We determined the status of the remaining 7 findings during our separate MCPA audits of managed care organizations and the Behavioral Health Administration's Administrative Service Organization.

Our audit did not include certain support services provided to MCPA by MDH. These support services (such as payroll, purchasing, maintenance of accounting records, and related fiscal functions) are included within the scope of our audit of the MDH – Office of the Secretary and Other Units. Our audit also did not include an evaluation of internal controls over compliance with federal laws and regulations for federal financial assistance programs and an assessment of

MCPA's compliance with those laws and regulations because the State of Maryland engages an independent accounting firm to annually audit such programs administered by State agencies, including MCPA.

To accomplish our audit objectives, our audit procedures included inquiries of appropriate personnel, inspections of documents and records, observations of MCPA's operations, and tests of transactions. Generally, transactions were selected for testing based on auditor judgment, which primarily considers risk. Unless otherwise specifically indicated, neither statistical nor non-statistical audit sampling was used to select the transactions tested. Therefore, the results of the tests cannot be used to project those results to the entire population from which the test items were selected.

We also performed various data extracts of pertinent information from the State's Financial Management Information System (such as revenue and expenditure data). The extracts are performed as part of ongoing internal processes established by the Office of Legislative Audits and were subject to various tests to determine data reliability. We determined that the data extracted from this source were sufficiently reliable for the purposes the data were used during the audit. We also extracted data from MMIS II for the purpose of selecting test items and assessing user access. We performed various tests of the relevant data and determined that the data were sufficiently reliable for the purposes the data were used during the audit. Finally, we performed other auditing procedures that we considered necessary to achieve our audit objectives. The reliability of data used in this report for background or informational purposes was not assessed.

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

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

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

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

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

**APPENDIX**

Maryland
DEPARTMENT OF HEALTH

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

November 1, 2019

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 are the responses to the draft audit report from your Maryland Medical Care Programs Primary Audit for the period beginning July 1, 2015 and ending July 31, 2018.

There are a few Analysis comments in Finding #6 and Finding #7 for your consideration.

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

Sincerely,

Robert R. Neall, Secretary
Maryland Department of Health

cc: Frederick D. Doggett, Inspector General, MDH
Jennifer Forsythe, Assistant Inspector General, Program Integrity, MDH
Sha S. Brown, Assistant Inspector General, Audits and Compliance, MDH
Dennis R. Schrader, Deputy Secretary for Health Care Financing, MDH
Carlean Rhames-Jowers, Audit Liaison – Medicaid, MDH

**Maryland Department of Health**
**Medical Care Programs Administration**

**Agency Response Form**

## Vendor Oversight

**Finding 1**
**MCPA did not sufficiently address errors noted in medical necessity determinations made by its utilization control agent vendor and did not ensure the vendor conducted timely continued stay reviews of nursing facilities.**

**We recommend that MCPA**

**a. ensure that comprehensive corrective action is taken timely when deficiencies in the UCA vendor's medical necessity reviews are identified, and;**

**b. monitor the UCA vendor to ensure CSRs are performed timely and assess liquidated damages as permitted by the contract.**

| Agency Response | | | |
|---|---|---|---|
| **Analysis** | | | |
| **Please provide additional comments as deemed necessary.** | | | |
| **Recommendation 1a** | Agree | **Estimated Completion Date:** | 8/31/2019 |
| **Please provide details of corrective action or explain disagreement.** | MCPA sent the utilization control agent a Corrective Action Plan (CAP) on January 6, 2017 and two letters of concern on November 9, 2017 and January 5, 2018. The CAP and letters of concern addressed the differences in medical necessity review decisions raised by the auditors during "2016" and "2017" review years. Even though the Department discussed these differences at bi-weekly meetings and through emails with the vendor, there were no formal minutes or documentation to reflect these discussions. Moving forward, MCPA will ensure sufficient written documentation is completed when CAPs or letters of concern are issued to the vendor. | | |
| **Recommendation 1b** | Agree | **Estimated Completion Date:** | 12/31/2019 |
| **Please provide details of corrective action or explain disagreement.** | MCPA agrees with this finding. The accuracy of the nursing facility population census with a corresponding precise CSR schedule is an area needing a more robust monitoring process that would likely extend beyond the actions of the UCA alone and would require greater MCPA oversight. MCPA will do 3 things: 1) Convene the Long Term Care team at the Department to develop improved approaches for assuring | | |

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|---|---|
| | CSRs get completed by the UCA, 2) work with the current UCA to implement a more comprehensive and active approach to collecting the participant census and completing their CSRs, 3) write more targeted and active approaches to CSRs into the RFP for the next UCA. |

**Maryland Department of Health**
**Medical Care Programs Administration**

## Agency Response Form

**Finding 2**
**MCPA did not monitor the vendor responsible for conducting credit balance audits of hospitals and nursing facilities to ensure the audits were conducted timely and properly, and the contract did not include provisions to assess liquidated damages for noncompliance with contract requirements.**

**We recommend that MCPA**

**a. monitor the vendor to ensure credit balance audits are performed for all facilities in a timely manner and are sufficiently comprehensive (repeat), and**

**b. ensure future contracts include provisions for appropriate corrective action when the vendor fails to meet contractual requirements.**

| Agency Response | | | |
|---|---|---|---|
| **Analysis** | | | |
| **Please provide additional comments as deemed necessary.** | | | |
| **Recommendation 2a** | Agree | **Estimated Completion Date:** | 12/31/2020 |
| **Please provide details of corrective action or explain disagreement.** | The DRAFS department has implemented additional checks and balances which ensures that all audits are being performed in a timely manner by the contractor. The Department has accepted two (2) ways of auditing. The first methodology is that the contractor is required to send notice to each of the facilities noting the upcoming audit. The second process requires a letter to be individually sent which requests the specific dates which are under audit.<br>These processes allow the facility adequate time to prepare the necessary paperwork they are obligated to submit for review. Established procedures dictate that the letter is first sent to our department for mandatory review and approval.<br>Moreover, the practice includes a calendar in which the facility names are added and the date(s) are scheduled to be audited. The information retrieved from the letters is sent for signature and cross referenced to a spreadsheet. Our accountant then independently reaches out to the facility to see if the audit has been performed. The spreadsheet keeps track of all contact with each of the separate facilities. If the facility makes us aware that the audit had not taken place, the Department then | | |

## Agency Response Form

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| | contacts the contractor to identify and examine the status of the audit. | | |
| **Recommendation 2b** | Agree | **Estimated Completion Date:** | 12/31/2020 |
| **Please provide details of corrective action or explain disagreement.** | The new Third Party Liability contract has requirements within the SLA section which states that the department must be notified of all hospital and Long Term Care Facility audits per year. The contractor shall conduct annual onsite audits of 100% of hospitals and Long Term Care Facilities and report findings to the Contract Monitor within 30days of completion of the audits. There is also an assessment for all audits that are not performed. Hospitals assessments are in the amount of $6,500 per hospital and $7,850 for each LTC Facility not audited on an annual basis. | | |

**Maryland Department of Health**
**Medical Care Programs Administration**

## Agency Response Form

**Finding 3**
**MCPA did not require nor obtain comprehensive, independent reviews of the automated systems used by two vendors to ensure sensitive data, including personally identifiable information and protected health information, were properly safeguarded.**

**We recommend that MCPA require the vendors to obtain periodic SOC 2 Type 2 reviews, obtain and review the resulting reports, and ensure any related deficiencies are corrected.**

| Agency Response | | | |
|---|---|---|---|
| **Analysis** | | | |
| **Please provide additional comments as deemed necessary.** | | | |
| **Recommendation 3** | Agree | **Estimated Completion Date:** | 7/01/2019 |
| **Please provide details of corrective action or explain disagreement.** | The Department's contract monitors on both contracts have reviewed and took the appropriate steps to ensure all deficiencies were addressed as of March 2019. Going forward monitors will ensure compliance review and documentation of all actions.<br><br>The vendor's contract will continue to receive the SOC 2 Type 2 report and review any deficiencies as well as document and track each finding. Separate findings in the other vendor's IA's have been addressed by the contract monitor and also documented.<br><br>MCPA feels they have met their obligation to obtain a comprehensive, independent review of the automated systems used by both vendors to ensure sensitive data, including personally identifiable information and protected health information, were properly safeguarded by adhering to the established protocol on both contracts after March 2019.<br><br>One vendor's system is scheduled to be migrated to MDThink by the end of 2019. The MOU between MDH and MDThink mandates MARS-E 2.0 compliance, as required by CMS, as well as FedRAMP Moderate certification and shall require a compliant System Security Plan. The MARS-E 2.0 and FedRAMP compliance will be validated by an annual independent System Security Assessment. | | |

**Maryland Department of Health**
**Medical Care Programs Administration**

**Agency Response Form**

## Recipient Enrollment

**Finding 4**
**MCPA did not sufficiently document its review of investigations of questionable recipient eligibility and did not take adequate follow-up action when errors were identified in changes to critical eligibility information.**

**We recommend that MCPA**

**a. sufficiently document its reviews of investigations of questionable recipient eligibility to support that proper corrective action was taken; and**

**b. expand testing, provide additional training, and take appropriate disciplinary action when persistently occurring errors are identified in changes made by MCPA employees to critical eligibility information.**

| Agency Response | | | |
|---|---|---|---|
| **Analysis** | | | |
| **Please provide additional comments as deemed necessary.** | | | |
| **Recommendation 4a** | Agree | **Estimated Completion Date:** | 8/20/2019 |
| **Please provide details of corrective action or explain disagreement.** | After meeting with OLA auditors in August 2019 to clarify the nature of the finding, MCPA immediately augmented its existing SOPs to include the steps its analysts take to review case actions that are completed by DHS, LDSS, LHD and MDH staff.<br>In addition, in May 2019, MCPA launched an inhouse database that formalizes program integrity reviews, tracks findings and stores universes and samples for all program integrity activities. PIRAMID (Program Integrity and Management Information Database) is a secured SQL database that uses Visual Studio's SQL Server Integration Services to import and prepare universes of data in order to create random samples, present pathed review protocols, and collect information about the review itself (including findings, trend analysis and feedback reports for MCPA leadership and the staff in the DHS, LDSS, LHD and MDH offices).<br>Planned improvements in eligibility system automation - specifically, the replacement of CARES with the Eligibility & Enrollment system (E&E) under MD THINK in 2020 - will reduce overall numbers of cases that require significant front-line staff time to resolve for missing Social Security Numbers, out-of-state alerts and death matches. E&E will also | | |

## Agency Response Form

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|---|---|---|---|
| | be able to provide universes easily through Qlik software for program integrity reviews that will be easier to ingest into PIRAMID. | | |
| **Recommendation 4b** | Agree | **Estimated Completion Date:** | 12/31/2019 |
| **Please provide details of corrective action or explain disagreement.** | In its Discussion Notes, OLA concluded that "Other than correcting the specific errors noted, MCPA did not expand its review to identify the scope of the errors related to these 7 employees and did not ensure that the issues were addressed with these employees, such as through additional training or disciplinary action."<br>MCPA will augment its supervisory reviews in the Division of Recipient Eligibility Programs (DREP) in order to target the staff who have made more mistakes, as identified during supervisory review.<br>MCPA will continue with its existing random sampling process for all transactions and the corrections of the errors found during supervisory review. Then, once the supervisory review results are analyzed, for staff who have an error rate of more than 5 percent, MCPA will devise a secondary sample that is stratified for those staff only.<br>MCPA has met with the DREP staff and has provided additional training by the supervisor and/or management within the DREP units after the finding was communicated. When needed, MCPA will take disciplinary action (PEP and PIP if needed) against individual DREP staff, beginning with the December 2019 PEP reviews. | | |

**Maryland Department of Health**
**Medical Care Programs Administration**

**Agency Response Form**

## Third-Party Liability

| **Finding 5**<br>**MCPA did not ensure that all referrals of potential third-party health insurance information were timely and properly investigated.** |
|---|

**We recommend that MCPA**

**a. ensure all MCO insurance referrals are investigated in a timely manner and develop a plan for eliminating the aforementioned backlog; and**

**b. ensure that supervisory reviews of referral investigations are conducted and documented, including MCO referrals, that appropriate conclusions are reached, and that insurance status is properly recorded in MMIS II.**

| **Agency Response** | | | |
|---|---|---|---|
| **Analysis** | | | |
| **Please provide additional comments as deemed necessary.** | | | |
| **Recommendation 5a** | Agree | **Estimated Completion Date:** | 12/31/2020 |
| **Please provide details of corrective action or explain disagreement.** | The DRAFS department is putting forth every effort to hire additional augmented staff in order to specifically concentrate on eliminating the MCO backlog. It is our objective to add more oversight and protection of the Department by changing to the 270/271 format.<br>This standard will produce Verification of Insurance Eligibility in a much more efficient manner. Additionally, it will also allow the MCO's to submit their data through a secure portal using specific file specifications. Having this advantage will allow our staff to process a request and obtain the desired outcome with greater accuracy and speed. The elimination of the backlog and the ability to produce a much more manageable workflow will be an additional added benefit. | | |
| **Recommendation 5b** | Agree | **Estimated Completion Date:** | 12/01/2020 |
| **Please provide details of corrective action or explain disagreement.** | The insurance recoveries supervisors complete monthly audits on each MCO reports that are generated for the unit. The monthly audit results are shared with the employees for review and corrections. We have also modified the process of loading them into MMIS II to expedite the inputting of the updated data. | | |

**Maryland Department of Health**
**Medical Care Programs Administration**

**Agency Response Form**

## Hospital Services

**Finding 6**
**MCPA had conducted virtually no audits of hospital claim payments since calendar year 2007.**

**We recommend that MCPA**

a. **take the necessary steps to ensure that hospital claims are audited in a timely manner (repeat); and**
b. **develop a plan to address the propriety of unaudited hospital claims from prior periods, including those noted above.**

| **Agency Response** | |
|---|---|
| **Analysis** | |
| **Please provide additional comments as deemed necessary.** | MCPA did not conduct an appropriate number of hospital claim payments since calendar year 2007.<br><br>MCPA failed to conduct an appropriate number of hospital claim payments since calendar year 2007. The failure to audit hospital claims timely could result in MCPA paying for hospital services that were never provided or were not medically necessary, or for excessive costs due to unbundling of services. According to MCPA records, hospital services totaled approximately $777.5 million during fiscal year 2018. |

**Auditor's Comment**: While agreeing with the recommendation, MCPA proposed alternative language related to the number of hospital audits that were conducted. Based on the very limited number of audits completed, we continue to believe our characterization of the number of audits is accurate.

| | | | |
|---|---|---|---|
| **Recommendation 6a** | Agree | **Estimated Completion Date:** | 6/01/2019 |
| **Please provide details of corrective action or explain disagreement.** | As of June 1, 2019, The MCPA successfully obtained a Medicaid Hospital Claims Audit Contractor. Pursuant to the contract, the Medicaid Hospital Claims Audit Contractor will be conducting audits from 2017 forward. | | |
| **Recommendation 6b** | Agree | **Estimated Completion Date:** | 6/01/2019 |
| **Please provide details of corrective action or explain disagreement.** | The MCPA has implemented a work plan to audit hospitals claims with dates of service from 2016 through 2018. During calendar year 2019, the MCPA has commenced an audit of 31 hospitals in accordance with that work plan. The MCPA will expand the work plan to conduct audits of hospital claims with dates of service from 2013 until 2015. The MCPA | | |

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| | is unable to audit hospital claims from prior to 2013 due to the fact that MMIS does not maintain recipient data beyond 5 years. |

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## Community First Choice

| **Finding 7**<br>**MCPA had not established appropriate oversight to ensure that all Community First Choice program recipients received daily living assistance services in accordance with their plans of service.** |
|---|

**We recommend that MCPA establish a process to ensure that all CFC recipients are monitored by nurses and that the related monitoring is sufficient to ensure personal assistance services are received in accordance with the plans of service.**

| **Agency Response** | |
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| **Analysis** | |
| **Please provide additional comments as deemed necessary.** | MCPA had not established appropriate oversight to ensure that all Community First Choice program recipients received required nurse monitoring services.<br><br>Re Finding 7, Section 1.3 of the agreement that is referenced is no longer relevant to the scope of work for the nurse monitor. Ensuring the provision of personal assistance services *was* a responsibility of the nurse monitor, but no longer is as a result of the Department's transition to an agency-only model. This is why MCPA distinguished the nurse monitor's role as evaluating the quality of personal assistance services provided, not ensuring services are received. |

**Auditor's Comment**: We subsequently revised our report to reflect the information provided in MCPA's above response. The revisions were communicated to MCPA. The finding regarding the oversight of services provided under the Community First Choice program is still valid, and MCPA's response as related to the implementation of the recommendation is adequate.

| **Recommendation 7** | Agree | **Estimated Completion Date:** | 12/31/2019 |
|---|---|---|---|
| **Please provide details of corrective action or explain disagreement.** | Ensuring the receipt of personal assistance services (PAS) is primarily the job of the participant's Supports Planner (i.e. case manager, not the Nurse Monitor (NM). The NM evaluates whether the PAS being provided are sufficient to meet the needs of the participant and are being delivered in a manner consistent with the Code of Maryland Regulations (COMAR). To address this finding, MCPA created a report detailing the number of participants, per jurisdiction, who had not received at least | | |

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| | one visit by a NM in calendar year 2018 and provided additional technical assistance to the jurisdiction to which most of these participants belonged. This report will be ran at least annually to ensure MCPA is evaluating the extent to which all participants receiving PAS are also receiving NM. MCPA has also begun working on an agreement, which mirrors the provider solicitation for Supports Planning Agencies, to ensure that all local health departments (LHD) are responsible for evaluating the quality of personal assistance services provided to CFC recipients. At this time, MCPA expects to have a final version of the agreement by the end of calendar year 2019. |

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## Medical Day Care

**Finding 8**
**MCPA did not audit all Medical Day Care program providers as required by its policy, and the related audit policy and procedures were not sufficiently comprehensive.**

**We recommend that MCPA**

**a. audit each MDC provider at least biennially, in accordance with its policy, and recover any unsupported claims identified;**
**b. ensure that all claims since the previous audit are subject to testing; and**
**c. enhance its MDC audit policy to establish audit scope requirements and testing methodology, including a requirement to expand audit testing when significant deficiencies are identified.**

| Agency Response | | | |
|---|---|---|---|
| **Analysis** | | | |
| **Please provide additional comments as deemed necessary.** | | | |
| **Recommendation 8a** | Agree | **Estimated Completion Date:** | 6/30/2020 |
| **Please provide details of corrective action or explain disagreement.** | The (MCPA) program has reprioritized its auditing schedule to include a minimum of 50% of enrolled providers each year. We plan to request PINs to address the findings and meet the estimated completion date of June 30, 2020. | | |
| **Recommendation 8b** | Agree | **Estimated Completion Date:** | 6/30/2020 |
| **Please provide details of corrective action or explain disagreement.** | The (MCPA) program's policy in standard operating procedure will be updated to reflect the factors used in determining the number of claims to be tested. | | |
| **Recommendation 8c** | Agree | **Estimated Completion Date:** | 6/30/2020 |
| **Please provide details of corrective action or explain disagreement.** | The (MCPA) program's policy in standard operating procedure will be updated to reflect the factors used in determining the number of claims to be tested. | | |

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## Nursing Facility Services Program

**Finding 9**
**MCPA did not have an established process to ensure ventilator care claims submitted by nursing facilities were valid, as required by State regulations.**

**We recommend that MCPA establish procedures to periodically validate ventilator care claims submitted by nursing facilities, as required by State regulations, and recoup any claim payments that were not supported.**

| Agency Response | | | |
|---|---|---|---|
| **Analysis** | | | |
| **Please provide additional comments as deemed necessary.** | | | |
| **Recommendation 9** | Agree | **Estimated Completion Date:** | 2/01/2021 |
| **Please provide details of corrective action or explain disagreement.** | When the UCA does their MDS validation outlined in 10.09.10.24.A, the results are used in determining the facility's overall reimbursement rate. There is not currently however an explicit fee-for-service add-on for ventilator care validation in the UCA's contract and a corresponding mechanism to identify recoupment of these payments as described in 10.09.10.24.B and identified by this finding. The requirement has been written into the next RFP for the UCA vendor. The current procurement draft fully contains this language. | | |

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## Claims Processing

**Finding 10**
**Claims that were suspended by automated edits within MMIS II and subsequently reviewed and paid were not subject to sufficient supervisory review and approval.**

**We recommend that MCPA**

**a. ensure all forced claims are subject to documented supervisory review by an employee independent of the claims processing, and**

**b. review the aforementioned claims processed by the aforementioned employee and recover any amounts improperly paid.**

| Agency Response | | | |
|---|---|---|---|
| **Analysis** | | | |
| **Please provide additional comments as deemed necessary.** | | | |
| **Recommendation 10a** | Agree | **Estimated Completion Date:** | 12/31/19 |
| **Please provide details of corrective action or explain disagreement.** | MCPA agrees to establish a work task group to review all edits for appropriateness and create a process to increase verification of forced 3% to 10%. Additionally, MCPA will request staffing increase for the purpose of training and assigning staff to this process. | | |
| **Recommendation 10b** | Agree | **Estimated Completion Date:** | 6/30/2020 |
| **Please provide details of corrective action or explain disagreement.** | MCPA will review all claims that were within Finding #10. All claims that were wrongfully forced and paid to the hospital in error; will be recouped. | | |

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## Information Systems Security and Control

**Finding 11**
**MCPA did not have sufficient procedures and controls to restrict access to MMIS II. For example, 727 MMIS II active users could view the names and social security numbers of 3.5 million active and inactive Medicaid recipients.**

**We recommend that MCPA**

**a. perform periodic reviews to ensure that PII is properly restricted to authorized employees and remove unnecessary employee access to PII, including those noted above;**
**b. follow up with units that do not respond to the monthly user access reports; and**
**c. establish user password controls that comply with the aforementioned State of Maryland Information Technology Security Manual.**

| Agency Response | | | |
|---|---|---|---|
| **Analysis** | | | |
| **Please provide additional comments as deemed necessary.** | | | |
| **Recommendation 11a** | Agree | **Estimated Completion Date:** | 12/31/2019 |
| **Please provide details of corrective action or explain disagreement.** | MMIS-II is due to be replaced by a modular solution which will be required to support the granular, role-based, least privileged access required to support this level of access control. In the meantime MCPA will create a new security code for the Recipient Screen inquiry level which will show the SSN. The existing security code for inquiry will mask the SSN. MCPA will only grant access to the SSN on Recipient Screen 1 to those users that can justify their need for such access.<br><br>MCPA will ensure that the appropriate granular levels of access security are included in the new modular systems to protect recipients PII. | | |
| **Recommendation 11b** | Agree | **Estimated Completion Date:** | 12/31/2019 |
| **Please provide details of corrective action or explain disagreement.** | The SLS unit within MCPA will continue the sending of the monthly reports out to the MMIS II security officers requiring their response and confirmation of their user's MMIS II access or noted changes that were needed. It will be noted on the monthly report failure to respond within 14 days will result in the notification back to them that the user ID's contained within that monthly report will be deactivated accordingly. | | |
| **Recommendation 11c** | Agree | **Estimated Completion Date:** | 7/31/2020 |

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| **Please provide details of corrective action or explain disagreement.** | In order to log into MMIS-II, the user must first authenticate onto ADC using ACF2, which does meet the aforementioned MD DoIT security requirements. The MMIS-II user-id and security-code are secondary. No one can access MMIS-II without first authenticating through ACF2. In order to further tighten security MCPA will modify MMIS-II login procedure such that each MMIS-II user-id will be linked to a single ACF2 loginid. This will ensure that the individual signing in to MMIS is the same individual that authenticated through ACF2. |

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