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Maryland Focused Program Integrity Review

Final Report

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Objectives of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Maryland to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. The review also included a follow up on the Maryland's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in calendar year 2013.

Background: State Medicaid Program Overview

The CMS review team conducted the onsite portion of the focused program integrity review of the Maryland state Medicaid agency by meeting with representatives at the offices of the Maryland Department of Health and Mental Hygiene (DHMH). The DHMH is the organization that is responsible for implementing the Medicaid program in Maryland. Maryland is a Medicaid expansion state and has nearly 85 percent of its Medicaid beneficiary population participating in its statewide mandatory managed care program and 15 percent participating in its fee-for-service program. The state's Federal Medical Assistance Percentage is 50 percent. The total Medicaid expenditures for federal fiscal year (FFY) 2015 totaled approximately $9.6 billion dollars. Medicaid managed care services in Maryland are delivered through eight MCOs serving nearly 1.2 million Medicaid beneficiaries with expenditures totaling approximately $4.2 billion.

Methodology of the Review

In advance of the onsite visit, CMS requested that Maryland and the MCOs selected for the focused review complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. A four-person review team reviewed these responses and materials in advance of the onsite visit.

During the week of June 21, 2016, the CMS review team visited with representatives from the Office of the Inspector General (OIG) and the HealthChoice and Acute Care Administration (HACA). It conducted interviews with numerous state staff involved in program integrity and managed care. The CMS review team also conducted interviews with three MCOs and their special investigations units (SIUs). In addition, the CMS review team conducted sampling of program integrity cases and other primary data to validate the state and the selected MCOs' program integrity practices.

Results of the Review

The CMS review team also identified areas of concern with the state's managed care program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible, particularly those that remain from the earlier review. These issues and CMS's recommendations for improvement are described in detail in this report.

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

As mentioned earlier, approximately 1.2 million beneficiaries are enrolled in Medicaid, of which nearly 85 percent of the state's Medicaid population were enrolled in eight MCOs during FFY15. The state spent approximately $4.2 billion on their eight MCO contracts in FFY 2015.

The DHMH is responsible for evaluating the quality of care provided to eligible participants in contracted MCOs through the Maryland Medicaid managed care program, known as HealthChoice, which has been operational since June 1997. There are currently eight managed care organizations participating in HealthChoice: Amerigroup Community Care; Jai Medical Systems; Kaiser Permanente of the Mid-Atlantic States; Maryland Physicians Care (MPC); MedStar Family Choice; Priority Partners; Riverside Health of Maryland; and United Healthcare.

Maryland does not enroll Medicaid managed care providers centrally, but relies solely on each MCO's credentialing process to fulfill all provider enrollment functions. Reliance on the MCO credentialing process presents several operational challenges for an oversight agency; this prompted the state to request guidance regarding some best practices. The CMS review team provided the state with the *Medicaid Integrity Program Best Practices Annual Summary* of June 2011, which describes some benefits of a centralized provider enrollment process.

In addition, the state largely relies on the SIU personnel of the MCOs to detect, analyze, and investigate billing patterns from claims data for fraudulent activity in the Medicaid managed care program. This reliance makes the state dependent on the MCO's SIU personnel to control fraudulent activity, although the OIG is responsible for program integrity activities in the state's Medicaid managed care and fee-for-service operations. At the time of the review, the state had a total of 36 full time equivalent (FTE) positions dedicated to program integrity responsibilities; however, these program integrity responsibilities are primarily dedicated to the Maryland traditional or fee-for-service Medicaid program.

Summary Information on the Plans Reviewed

The CMS review team interviewed three MCOs as part of its review. The selected MCOs were MPC, Priority Partners, and MedStar Family Choice.

The MPC is a local, for-profit MCO owned by Meritus Health, Western Maryland Health Systems, and Holy Cross Health, among others. The MPC is a group practice of primary care doctors serving ten Maryland locations. The MPC is the fourth largest Medicaid MCO in the state and is located in Linthicum, Maryland.

Priority Partners is a local, for-profit MCO operated in the state and is owned by Johns Hopkins HealthCare LLC (JHHC) and the Maryland Community Health System. The JHHC provides health care services for four health plans: Priority Partners MCO; Johns Hopkins Employer Health Programs; Johns Hopkins US Family Health Plan; and Johns Hopkins Advantage MD. MedStar Family Choice is a local, for-profit, and provider sponsored MCO participating in the HealthChoice Program and the Maryland Children's Health Program operated by DHMH. MedStar Family Choice has providers throughout the Maryland and District of Columbia region

with access to primary care and specialty physicians at multiple office locations and MedStar Family Choices' ten hospitals.

Maryland's external quality review organization (EQRO) is the Delmarva Foundation. The EQRO is an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review (EQR); other EQR-related activities as set forth in 42 CFR 438.358; or both. The Delmarva Foundation performs these EQR-related activities in Maryland and creates a report which ranks health plans according to their scores on various performance measures, and is included with enrollment materials to help participants choose their plans. The state also offers MCOs performance incentives and disincentives to encourage quality care.

Enrollment information for each MCO as of June 2016 is summarized below:

Table 1.

	MPC	Priority Partners	MedStar Family Choice
Beneficiary enrollment total	197,559	254,534	72,177
Provider enrollment total	14,141	20,329	4,000
Year originally contracted	1996	1996	1996
Size and composition of SIU	3 FTEs	7.75 FTEs	1.5 FTEs
National/local plan	Local	Local	Local

Table 2.

MCOs	FFY 2013	FFY 2014	FFY 2015
MPC	$614.5 million	$748.5 million	$766.6 million
Priority Partners	$884.5 million	$1.0 billion	$1.1 billion
MedStar Family Choice	$117.5 million	$195.3 million	$303 million

State Oversight of MCO Program Integrity Activities

The office responsible for governing Maryland Medicaid is the Office of Health Care Financing. Within the Office of Health Care Financing, there are five administrations: Office of Eligibility Services; Office of Health Services; Office of Planning; Office of Finance; and the Office of Systems, Operations, and Pharmacy. Maryland's oversight of program integrity activities is managed through a collaborative effort between the OIG and HACA. The OIG is responsible for investigating Medicaid fraud, waste, and abuse. The HACA is responsible for coordination and oversight of the HealthChoice managed care program and the MCO contract requirements. The HACA is part of DHMH's Health Services Administration.

Maryland maintains fraud, waste and abuse policies and procedures in a fraud manual detailing how the OIG should conduct their reviews and audits of providers. In addition, Maryland's EQRO, the Delmarva Foundation, is contracted to conduct an annual systems performance review (SPR). The SPR consists of 11 assessment standards with some program integrity elements that are based upon all state and federal regulations referenced in the general MCO contract. The standards are applied to all eight MCOs, while standard 11 is specifically a fraud and abuse standard that calls for the MCOs to share their compliance plans and meet the

requirements outlined in 42 CFR 438. All MCOs were compliant in meeting these standards and achieved a score of 100 percent with the exception of one new plan; however, the new MCO did achieve the acceptable score of 80 percent established for new plans. For the purposes of this report, the EQRO assessment tool was not used to determine compliance with federal regulatory requirements, nor can we confirm whether the EQRO is contracted to review compliance with the federal regulations by the MCOs delegated contractors.

During their interview with the state, the CMS review team discussed uncorrected findings and vulnerabilities from their previous comprehensive program integrity review in July 2012. Some of the findings and vulnerabilities involved the state not modifying its provider enrollment forms and credentialing forms to require the disclosure of complete ownership, control, and relationship information, to include managing employees and agent information from individual practitioners and group practices. These uncorrected issues are further described in Section 2 of this report.

As a result of the network credentialing forms used in the managed care program remaining unmodified, the CMS review team identified one managed care federal regulatory concern at 42 CFR 438.610. Although, the disclosure is not a regulatory requirement for the managed care program, the regulation at 42 CFR 438.610 cannot be met unless the disclosures are collected in order for the appropriate parties, including contractors, vendors, or sub-contractors, to be searched for exclusions. Consequently, the state is not ensuring that its MCOs do not have a relationship with an individual or entity that is excluded from participation in any federal health care program, as stipulated in the regulation. Although the MCOs interviewed were not capturing ownership and control disclosures from delegate contractors, the state maintains that some of their other MCOs that were not a part of the onsite review do capture this information.

Subsequently, the state is not able to ensure that its MCOs check the exclusion status of persons with an ownership or control interest in the contractor, and agents and managing employees of the contractor on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); and the National Plan and Provider Enumeration System (NPPES) upon enrollment and reenrollment. In addition, the names of any person with an ownership or control interest, or who is an agent or managing employee of the delegate contractors are not checked against the LEIE and EPLS monthly thereafter.

Furthermore, the state has not incorporated language regarding collecting the disclosures from delegate contractors in their MCO contract. Therefore, MCOs are not contractually required to collect disclosures from delegate contractors, nor were they collecting such disclosures at the time of the review. In addition, the state does not ensure the delegate contractors are notified and educated on checking their own employees in accordance with the CMS State Medicaid Director's Letter (SMDL) #09-001 dated January 16, 2009.

MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Maryland's Managed Care Organization HealthChoice Provider Agreement states that the MCO agrees to comply with the following:

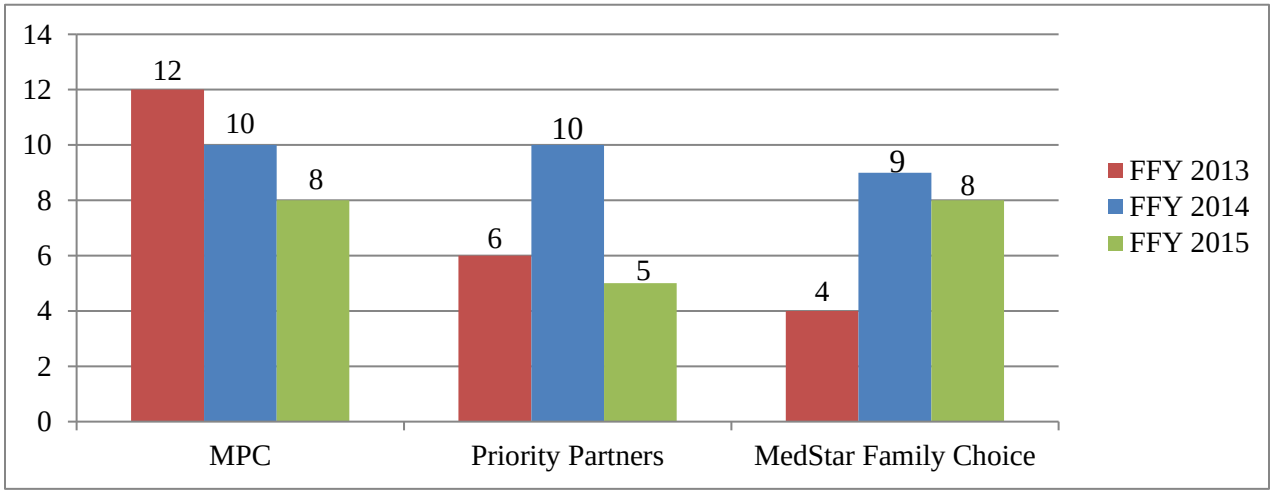
> "Maryland Annotated Code Health-General Article, Title 15 and the Insurance Article provisions referenced therein, the regulations of the HealthChoice Program at COMAR 10.09.62 – 10.09.75, and 10.09.86 (Appendix E), several of which are specifically referenced herein, as well as 42 CFR Part 438, any other applicable provisions of federal law, the Maryland Code, the Code of Maryland Regulations, transmittals, and guidelines issued by the Department in effect at any time during the term of this Agreement."

The MCOs submit monthly reports of fraud, waste, and abuse activity to the DHMH, which are then sent to the OIG for review on a monthly basis. The contract does include language that requires the MCO to report suspected provider fraud, waste, or abuse to the Maryland Medicaid Fraud Control Unit (MFCU). The plans make referrals directly to the OIG and the MFCU simultaneously. The state is in the process of improving and standardizing the reports from the MCOs.

The MPC was the only MCO interviewed that was verifying receipt of services with beneficiaries. During interviews with MedStar Family Choice and Priority Partners, the CMS review team determined that receipt of services were not being verified. Also, MedStar Family Choice stated that they were unaware of the MCO contract requirement to verify receipt services with Medicaid beneficiaries. This was cited in the previous comprehensive program integrity review report in 2013.

Table 3 lists the number of referrals that MPC, Priority Partners, and MedStar Family Choice made to the state in the last three FFYs. Overall, the number of Medicaid provider investigations referred to the state by each of the MCOs is low when compared to the size of the plan. The level of investigative activity has not changed over time.

Table 3.



The CMS focused review revealed that Maryland MCO case referrals, which are supposed to be investigations involving a credible allegation of fraud, are not appropriately defined and categorized by the MCOs. Therefore, the MCOs are referring cases to the state that do not meet the state's standards of an actual credible allegation of fraud case referral. This difference in what constitutes a case referral by the MCOs caused the MCOs and the state to report conflicting case referral totals.

Table 4 below illustrates that the number of referrals reported by the MCOs significantly differed from those accepted and tracked by the state. Based upon the state's definition of a proper credible allegation of fraud case referral, the total number of credible allegation of fraud cases that the MCOs are identifying and referring is extremely low relative to the size of the Maryland Medicaid managed care program.

Table 4.

FFY	Total # MCO Investigations Referred to the State by the MCOs	Total # MCO Referrals Accepted by the State as a Suspected Fraud Case
2013	22	10
2014	29	1
2015	21	7

Since there is a variance between how the MCOs define a case referral versus what the state records and accepts as a case referral, the state should meet with the MCOs to clearly outline what constitutes an acceptable MCO case referral. From FFY 2013 to 2015, there was approximately a 75 percent variance in the total volume of fraud referrals reported by the MCOs

and the state's tracking of valid fraud referrals received from the MCOs. The state needs to create a better reporting mechanism between the MCOs and the state, so that case referrals are clearly defined and result in a more consistent accounting of suspected fraud case referrals leading to both parties reflecting identical totals. The state should work with the MCOs on identifying the cases that have a credible allegation of fraud and correct the case referral process by ensuring that the MCOs utilize the CMS referral standards. The CMS federal regulatory referral standards have historically assisted states in providing a standard baseline for cases referrals, which will allow the state and the MCOs to appropriately track suspected fraud case referrals more consistently.

A sampling of OIG managed care investigations found some instances where Medicaid services were provided and tests performed without evidence of medical necessity; however, these cases were treated as rule violations and not necessarily as instances of fraud. The CMS review team discovered the MFCU denied these cases and the provider was educated on how to bill for procedures in the future. The state also informed the review team about one case where Priority Partners self-disclosed a nurse who was altering patient medical records to improve Healthcare Effectiveness Data and Information Set scores to give the false impression of improved performance regarding the delivery of care and service. The nurse was terminated from the group, a referral was made to the MFCU, and the state redistributed the money to the providers.

MCO Compliance Plans

The state does require its MCOs to have a compliance plan to guard against fraud and abuse in accordance with the requirements at 42 CFR 438.608. The state does have a process to review the compliance plans and programs. All of the MCOs provided the CMS review team with a copy of their compliance plans that have been submitted to the state. A review of these plans revealed they were in compliance with 42 CFR 438.608. As required by 42 CFR 438.608, the state does review the MCO's compliance plan and communicates approval/disapproval with the MCOs. As previously referenced, the state also reviews this requirement for compliance plans as part of their annual SPR conducted by their EQRO.

Encounter Data

The state does receive and review all encounter data from the MCOs and maintains the ability to run program integrity related analysis of that data. The OIG does not perform any data analysis, unless there is a complaint that calls for the OIG to specifically look into a managed care provider's activities. Typically, the OIG will contact the MCO and request additional information, in the event they need to look into a complaint. In addition, the OIG expressed their desire to perform more internal data analysis with the managed care encounter data and will be considering making those program enhancements soon.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state does require MCOs to report on overpayments recovered from providers as a result of MCO fraud and abuse investigations or audits, but does not require the MCOs to return overpayments to the state. The state does not collect any overpayments from MCO network providers. The overpayment amounts are consequently offset on the MCOs' financial reports for rate setting. In addition, the MCOs are directed to report expenses net other party liability via a

data collection tool called the HealthChoice Financial Monitoring Report (HFMR). The MCOs' HFMRs are audited annually by an external CPA firm to validate the expenditures reported.

The table below shows the respective amounts reported by MPC for the past three FFYs.

Table 5-A.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	37	12	$50,628	$17,907
2014	47	10	$58,008	$16,896
2015	33	8	$74,129	$17,779

Considering MPC's $766.6 million annual budget, the amount of overpayments identified in Table 5-A is significantly low. Furthermore, the MCO reported conducting an average of 39 preliminary investigations per year between FFY 2013 through FFY 2015, resulting in an average of 10 cases of credible allegations of fraud being referred to the state. As these totals reflect the highest investigation figures of all the MCOs reviewed in Maryland, the low number of investigations raises concerns about the volume of improper payments and particularly overpayments that may be undetected by the MCOs operating in Maryland. These figures drop even more significantly for the other MCOs reviewed as depicted below.

The table below shows the respective amounts reported by Priority Partners for the past three FFYs.

Table 5-B.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	13	8	$1.3 million	$242,754
2014	21	10	$295,143	$239,704
2015	20	5	$338,255	$265,692

Priority Partner's Compliance Department has defined an investigation as an inquiry and/or a request for assistance which requires less than 20 hours of analysis to substantiate the presence of an alleged compliance and/or privacy impropriety. Expansion to a full investigation may include, but not be limited to: the scope of investigation, timeframe reviewed, diagnosis and/or procedure codes, and other lines of business impacted by non-compliance. The overpayments recovered by Priority Partners reflect the actual amount of monies repaid by providers in each FFY year and some of these amounts may be attributable to a prior year investigation that involved the state accepting multi-year negotiated repayment plans.

In FFY 2013, the amount total overpayments recovered were impacted by two investigations as follows:

- Priority Partners vigorously pursued collection of an overpayment in the amount of $680,550, including litigation in which it secured a default judgment against the provider for approximately $634,620. The provider liquidated and no assets have been identified by the MCO to satisfy the judgment.
- Another provider ceased making payments on a multi-year repayment plan. The liability amount still outstanding is approximately $200,000. The MCO has referred the matter to its legal advisors, with respect to pursuing legal action.

The table below shows the respective amounts reported by MedStar Family Choice for the past three FFYs.

Table 5-C.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	6	4	$7,508	$7,508
2014	9	9	$14,536	$14,536
2015	8	8	$10,015	$10,015

As depicted in Table 5-C, MedStar Family Choice does not carry a high caseload of investigations, nor have they identified a significant amount of overpayments for recovery. Since MedStar Family Choice offsets all provider overpayments against future provider billings, the total recoveries are equal to the total overpayments identified for this MCO. At the time of the onsite review, MedStar Family Choice maintained that claim recoveries and cost avoidance measures were trending upwards, as a result of their continued enhancement of program integrity activities.

Overall, the volume of investigations conducted and overpayments recovered is low when considering the annual budgets of the MCOs reviewed during the onsite. The MCO program integrity full investigative activity mainly decreased over the three year review period for each MCO reviewed, and therefore indicates the need for increased efforts dedicated to investigating, identifying, and recovering overpayments to providers. In addition, the establishment or strengthening of cost avoidance measures at the MCO level would further assist in preventing overpayments to providers and lessen the need for recoveries.

Payment Suspensions

In Maryland, Medicaid MCOs are not contractually required to suspend payments to providers at the state's request. The state confirmed that there is no contract language mirroring the payment suspension regulation at 42 CFR 455.23. However, the state provided the CMS review team with an undated policy and procedure containing the elements of 42 CFR 455.23. The state's memorandum of understanding with the MFCU dated July 2012, also contains language regarding Maryland's payment suspension process. The state mentioned the payment suspension policy and procedure was a part of their fraud manual.

The CMS review team found that the state does not routinely require the MCOs to suspend payments, although they have a policy and procedure in place that does require MCOs to suspend payments in cases where there is a credible allegation of fraud. Payment suspensions have only occurred in the managed care program when the state has initiated action directing the networks to suspend payments to a provider that may be operating in the Medicaid managed care program. Since the state does not routinely analyze and investigate managed care claims data, payment suspensions do not happen frequently in the managed care program.

A sampling of cases demonstrated that most of the providers that were placed on payment suspension by the state were not network providers. The CMS review team found no instances where payment suspensions were initiated by the MCO across the entire managed care program. During the interview with MedStar Family Choice, the SIU staff claimed to have no reason to suspend a provider because they can always offset the overpayment against future claims. The MCO preferred to use a post payment review process in place of a payment suspension process.

Terminated Providers and Adverse Action Reporting

The state MCO contract does allow the MCOs to terminate a provider for quality of care issues; billing issues; suspected fraud or abuse; suspended licensure; or exclusion through federal or state database checks. The Maryland COMAR 10.09.65.17B(4) requires the MCOs to report terminations to the state. If the MCO is terminating the contract, a notice is required to be sent to the state within 90 days before the effective date of the termination. If the provider is terminating the contract, a notice is sent to the state within 10 days after the MCO receives the notice from the terminating provider.

Although the state does require MCOs report all adverse actions taken on provider participation and the MCOs report all adverse actions due to integrity or quality to the state on the monthly MCO activity report, interviews with the MCOs revealed some uncertainty as to the requirement to report adverse actions due to quality issues. Therefore, the state should reiterate to MCOs their responsibility for reporting to the state whenever they deny enrollment of a provider into their network based on concerns related to fraud, integrity, or quality. All MCOs indicated that they have the authority to terminate providers for fraud or for business reasons, and do not have to wait to be notified of actions taken at the state level before taking action against providers.

The state maintains its own state exclusion list and shares the information on terminated providers across its managed care plan network. In addition, the state has the necessary access to the established CMS secure web-based portal, the MFT TIBCO server, which facilitates the sharing of information by states regarding terminated Medicaid providers and allows the state to terminate enrollment of providers terminated by Medicare, other state Medicaid programs, or the Children's Health Insurance Program in accordance with the regulation at 42 CFR 455.416.

Table 6:

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated For Cause in Last 3 Completed FFYs	
MPC	2013	10	2013	10
	2014	28	2014	26
	2015	38	2015	25
Priority Partners	2013	2,170	2013	6
	2014	1,982	2014	4
	2015	2,010	2015	0
MedStar Family Choice	2013	258	2013	0
	2014	359	2014	0
	2015	398	2015	0

Overall, the number of providers terminated for cause by the plans appears to be low, compared to the number of providers in each of the MCO's networks and compared to the number of providers disenrolled or terminated for any reason.

Recommendations for Improvement

- Strengthen MCO program integrity oversight by conducting monthly or bi-monthly meetings with the MCOs' SIU staff to include participation from the program integrity staff and managed care compliance staff to improve communication.
- Review the contracts with MCO delegates and subcontractors, to ensure compliance with all the requirements of 42 CFR 438.
- Modify the MCO contract to ensure that managed care provider enrollment or credentialing forms require the disclosure of complete ownership, control, and relationship information from all MCO network providers, to include managing employees and agent information from individual practitioners and group practices. Also, include contract language requiring MCOs to notify the state of such disclosures on a timely basis.
- Require MCOs and MCO delegates to search the LEIE, EPLS, SSA-DMF, and NPPES upon contract execution, and check the LEIE and EPLS monthly thereafter by the name of any person with an ownership or control interest, or who is an agent or managing employee. The state should amend the standard MCO contract to ensure all contracted individuals and entities are searched for exclusions in accordance with 455.436. Furthermore, all Medicaid managed care providers should be trained to search their employees for exclusion from federal programs.
- Develop and implement procedures to verify whether services billed by providers were received by MCO enrollees.
- Develop MCO case referral policies and procedures to improve upon the case referral reporting discrepancies between the OIG and the MCOs. Ensure that the MCOs identify cases where a credible allegation of fraud exists by meeting with the MCOs to discuss and define what constitutes a suspected fraud case referral.
- Ensure that all SIU and MCO support staff are receiving appropriate training in identifying and investigating potential fraudulent billing practices by Medicaid providers and that MCOs refer all Medicaid suspected fraud and abuse cases to the state in writing and conform to the fraud referral performance standards issued by the Secretary. Work with the MCOs to develop specific program integrity training on how to meet all Medicaid program integrity requirements.
- Given the limited number of provider investigations and referrals by the MCOs along with the low number of overpayments and terminations that the MCOs reported, ensure that MCOs are allocating sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud.
- Continue efforts to improve the state agency's ability to analyze information from surveillance and utilization review systems and encounter data reported by MCOs. Perform data mining activities to proactively drive improvement in identifying fraud, waste, and abuse in the Maryland Medicaid managed care program.
- Incorporate payment suspension language in the state's contract with the MCOs covering all aspects of the federal payment suspension regulation found at 42 CFR 455.23, so that MCOs are contractually required to suspend payments to network providers. In addition, ensure that the MCOs are trained on the payment suspension process.

- Monitor and track the overpayments reported by the MCOs and verify that overpayments are fully reported by the MCOs.
- The state should encourage the MCOs to explore establishing cost avoidance measures or strengthen existing cost avoidance activities to assist in preventing overpayments to providers and decrease the necessity for recovery efforts.

Section 2: Status of Corrective Action Plan

Maryland's last CMS program integrity review was in July 2012, and the report for this review was issued in May 2013. The report contained five findings and five vulnerabilities. During the onsite review in June 2016, the CMS review team conducted a thorough review of the corrective actions taken by Maryland to address all issues reported in calendar year 2013. The findings of this review are described below.

Findings

1. ***The state does not suspend payments in cases of credible allegations of fraud or maintain proper documentation on suspensions of payments for annual reporting to the Secretary.***

   Status at time of the review: Corrected

   The state has a policy and procedure in place that addresses 42 CFR 455.23. The state demonstrated compliance with 42 CFR 455.23, despite not incorporating this language into their general contract with the MCOs. The state provided the CMS review team with a copy of a payment suspension report.

2. ***The state does not conduct complete searches for individuals and entities excluded from participating in Medicaid. The state does not require individual practitioners and practitioners enrolled in group practices to complete the Provider Ownership and Disclosure section of the Provider Application. Therefore, the state cannot collect and store in a searchable database information related to any persons who have ownership or control interest in, or who are agents or managing employees of, solo practitioners or group practices. This does not allow the state to conduct complete searches for individuals excluded by HHS-OIG at the time of enrollment, reenrollment, or on a monthly basis. In addition, the state acknowledged that the EPLS is not searched either at initial enrollment, reenrollment, or on a monthly basis as required in this regulation.***

   Status at time of the review: Not corrected

   - The state told the CMS review team that it does not think the regulation at 42 CFR 455.104 requires individuals and groups to file a disclosure. Therefore, the state has not addressed this issue.
   - The CMS review team referred to a CMS/Medicaid Integrity Group (MIG) letter sent to the state on Feb 28, 2014. The letter discussed the state's position and referenced a February 26, 2014, meeting between the MIG and the state program integrity staff. The

MIG further explained in the letter to the state that since March 25, 2011, the disclosures were required to comply with the new federal regulation at 42 CFR 455.436.

- To be in full compliance with the regulation at 42 CFR 455.436, ongoing EPLS searches must take place, along with searches of the SSA-DMF and the NPPES at the time of a provider's enrollment and reenrollment. The state was unable to demonstrate compliance in this area.

3. The state does not capture required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)

Status at time of the review: Not corrected

- As referenced above, the state told the CMS review team that it does not think the regulation at 42 CFR 455.104 requires individuals and groups to file a disclosure. Therefore, the state has not addressed this issue.
- The CMS review team referred to the above-mentioned MIG letter sent to the state on February 28, 2014, which discussed the state's position and referenced a February 26, 2014, meeting between the MIG and the state program integrity staff. The MIG letter further explained to the state that since March 25, 2011, the disclosures were required to comply with the new regulation at 42 CFR 455.436.
- The state was unable to demonstrate compliance in this area, since disclosures for agents and managing employees of individual practitioners and group practices was not collected. The state would have to collect the disclosures containing these the names to conduct the search of all required federal databases at the appropriate intervals.

4. The state does not capture criminal conviction disclosures from providers or contractors.

Status at time of the review: Corrected

The state added the required language regarding criminal convictions as stipulated in 42 CFR 455.106 to their provider applications.

5. The state does not comply with its state plan regarding False Claims Act (FCA) education monitoring.

Status at time of the review: Corrected

The state conducts sampling annually to comply with its state plan requirement for FCA education monitoring.

Vulnerabilities

1. Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

Status at time of the review: Not corrected

Similar to the second CAP finding above, the state has not incorporated language regarding this requirement in their MCO contract.

2. ***Not capturing ownership and control disclosures from network providers.***

   Status at time of the review: Not corrected

   - Similar to the third CAP finding above, the state has not incorporated language regarding this requirement into their MCO contract. Therefore, the MCOs are not contractually required to collect disclosures from delegate entities, nor were they collecting such disclosures at the time of the review.
   - The MCOs are not collecting all disclosures so that all managing employees and agents can be checked against the federal exclusion databases in accordance with 42 CFR 455.436, and are not ensuring that providers are notified and educated on checking their own employee's in accordance with the CMS SMDL #09-001.

3. ***Not requiring the disclosure of business transaction information from MCO network providers. (Uncorrected Repeat Vulnerability)***

   Status at time of the review: Corrected

   All credentialing forms have been modified to capture the disclosure of business transactions from MCO network providers.

4. ***Not collecting criminal conviction information from MCO network providers. (Uncorrected Repeat Vulnerability)***

   Status at time of the review: Corrected

   All credentialing forms have been modified to collect criminal conviction information from MCO network providers.

5. ***Not verifying with managed care enrollees whether services billed by MCO network providers were received. (Uncorrected Repeat Vulnerability)***
   Status at time of the review: Not corrected

   During the MCO interviews, all plans stated that they were not verifying receipt of services with beneficiaries. One plan, Priority Partners, stated that it was unaware of the contract requirement to verify services with beneficiaries.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Maryland to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to Maryland are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.

Conclusion

The CMS focused review identified areas of concern and an instance of non-compliance with federal regulations which should be addressed immediately.

We require Maryland to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

CMS looks forward to working with Maryland to build an effective and strengthened program integrity function.

Official Response from Maryland
May 2017

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor – Boyd K. Rutherford, Lt. Governor – Dennis R. Schrader, Secretary

May 26, 2017

Laurie Battaglia
Director Division of State Program Integrity
Center for Medicare & Medicaid Services
7500 Security Blvd, Mal Stop AR-21-55
Baltimore, MD 21244

Sent via email: Laurie.Battaglia@cms.hhs.gov

Re: State of Maryland – Program Integrity Review
Date of Review: June 2016

Dear Ms. Battaglia,

The Maryland Department of Health is submitting a response to the Department of Health and Human Services Centers for Medicare and Medicaid Services Center for Program Integrity's final report. Attached please find a corrective action plan for each of the final report's recommendations.

We acknowledge your request that Maryland provide quarterly reports to CMS detailing the number of provider investigations conducted by each of our MCOs, as well as the number of suspected fraud referrals provided to the Department by the MCOs. We will send these quarterly reports to the Division of State Program Integrity beginning July 2017.

If you have any questions, please contact Monchel Pridget, HealthChoice and Acute Care Administration, by email at Monchel.Pridget@maryland.gov or phone at 410-767-5946.

Sincerely,

Shannon McMahon
Deputy Secretary for Health Care Financing

Enclosures

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