Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Maryland Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Maryland Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Maryland Department of Health and Mental Hygiene (DHMH), which is the State Medicaid Agency. The review team also conducted telephone interviews with four managed care entities (MCEs) and the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Maryland Office of Inspector General (MD-OIG), which is responsible for Medicaid program integrity in Maryland. This report describes two effective practices, five regulatory compliance issues, and five vulnerabilities in the State's program integrity operations.

The CMS is concerned that the review identified one partial repeat finding and one repeat vulnerability from its 2009 review of Maryland. The CMS will work closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Maryland improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Maryland's Medicaid Program

The DHMH administers the Maryland Medicaid program. As of January 1, 2012, the program served 995,922 beneficiaries. Maryland has enrolled 817,229 beneficiaries in 8 full service MCEs.

All told, the State had 43,152 participating fee-for-service (FFS) providers, while the various health plans each had between 583 and 13,799 affiliated providers. According to CMS financial data, total computable Medicaid expenditures for the State fiscal year (SFY) ending June 30, 2011 were nearly $6.1 billion.

Medicaid Program Integrity Division

The MD-OIG within the Administrative Services section of DHMH is the organizational component dedicated to anti-fraud and abuse activities. At the time of our review, the MD-OIG had 30 full-time equivalent (FTE) employees focusing on Medicaid program integrity. This represents a decrease of 4.5 FTEs from the 2009 review. The table below presents the number of preliminary and full investigations and overpayment amounts identified and collected for the

MD-OIG in the last four SFYs as a result of program integrity activities. The data on overpayments collected is very limited because several different components within the Maryland Medicaid Agency, including the Financial Compliance Unit, are responsible for collecting recoveries. The Agency does not report the totals from other components to the MD-OIG's office and does not identify the reason for the amounts collected from individual providers and entities.

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Overpayments Identified Through Program Integrity Activities	Overpayments Collected Through Program Integrity Activities***
2008	14	4	$9,684,421	N/A***
2009	16	7	$7,513,030	N/A***
2010	5	3	$10,259,366	N/A***
2011	14	8	$7,860,973	$ 79,363(part year)

* Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
** Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.
*** Note that in Maryland's annual State Program Integrity Assessment (SPIA) Reports, the State reported collections of $14,210,629 from its audit activities in Federal fiscal year (FFY) 2008, $14,630,896 in FFY 2009, and a tentative figure of $6,899,483 in the FFY 2010 SPIA survey, which was not published at the time this report was written.

Methodology of the Review

In advance of the onsite visit, the review team requested that Maryland complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, and managed care. A four-person team reviewed the responses and materials that the State provided in advance of the onsite visit. Telephone interviews were also conducted with four MCEs and the MFCU prior to the team going onsite.

During the week of July 17, 2012, the MIG review team visited the DHMH offices. The team conducted interviews with numerous DHMH officials. To determine whether MCEs were complying with the contract provisions and other Federal regulations relating to program integrity, the MIG team reviewed the State's managed care contracts. The team met separately with DHMH staff to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate Maryland's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the MD-OIG, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care and non-emergency medical transportation (NEMT). Maryland's Children's Health Insurance Program operates under Title XXI of the Social Security Act and was, therefore, not included in this review.

Unless otherwise noted, DHMH provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that DHMH provided.

RESULTS OF THE REVIEW

Effective Practices

As part of its comprehensive review process, the CMS invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Maryland reported collaborative practices with the Medicaid agency, contractors, and law enforcement on program integrity issues as well as a method of auditing paid claims that are processed through the Medicaid Management Information System (MMIS) when edits and audits are manually overridden.

Collaboration on Program Integrity Issues

The MD-OIG actively collaborates with the Medicaid program, contractors and law enforcement to identify program integrity issues, recover overpayments and refer providers for prosecution. The prior CMS review identified an MD-OIG workgroup which was a vehicle for this collaboration. The workgroup still operates and consists of representatives of the OIG, MFCU, the Medicaid agency, the Mental Hygiene Administration, the Developmental Disabilities Administration, the Alcohol and Drug Abuse Administration and the Office of Health Care Quality. The communication fostered in bi-weekly meetings helped to increase awareness of payment integrity issues that resulted in audit recoveries. It also helped to document a program integrity dimension to quality and other programmatic deficiencies which have resulted in the recovery of program dollars. This workgroup was still in operation at the time of our review.

Problematic providers identified by the MD-OIG with the potential for a full audit may be discussed with the Executive Directors, or their designee(s), of the appropriate program and participating components during regularly scheduled workgroup meetings. The discussions help to solidify preliminary audit issues before the MD-OIG begins an audit. Once the audit is complete, the draft report is sent to the appropriate director for comment to ensure regulatory, policy and transmittal requirements have been appropriately applied. All reports with a significant dollar recovery are sent to the Office of the Attorney General for review to determine if the case is appropriate for a fraud prosecution by MFCU or for initiation of a civil false claims case. A recovery letter to the provider is drafted but not sent until the MFCU approves its release.

The MD-OIG also conducts quarterly meetings with the MFCU and the MCEs to discuss cases and possible referrals to the MFCU. If an MCE has opened a case on a provider that is also of concern to the MD-OIG, the issues are discussed to build a stronger case and consider the possibility for referral. If an MCE needs training on developing or documenting a case or if new areas of concern are identified by the participants, technical assistance is provided during these meetings.

Audit of Claims Paid Through Manual MMIS Overrides

In order to reduce Maryland Medicaid's improper payments and error rate, system generated reports on claims forced through the MMIS and manually processed adjustment claims are received and reviewed daily by the Claims Processing and Adjustment Unit. The Claims Audit Reviewers are required to perform a three percent review of all claims that appear on the system generated reports. This helps to identify possible payment errors made on claims that were allowed to go through the MMIS without being subject to the usual edits and audits. The turning off of MMIS edits and audits occurs in many State Medicaid claims processing systems for a variety of reasons. When it does, concerns about improper payments have been voiced by oversight agencies such as the U.S. Department of Health & Human Services-Office of Inspector General (HHS-OIG). Maryland's sampling procedure enables the State to catch payment errors and recoup incorrectly forced payments. The State has also sometimes identified underpayments as well. To ensure providers are compensated for underpayments, adjustment requests are forwarded to the Division of Adjustments and Payment Auditing.

In calendar year 2011, Maryland's report on "forced" claims identified 4,883 claims for which overpayments of $653,831 were made. The report on manual adjustments for the same time period identified 1,217 claims which were associated with $36,144 in overpayments and underpayments of $20,402.

Regulatory Compliance Issues

The CMS review team found five regulatory compliance issues related to program integrity in Maryland. These issues are significant and represent risk to the Maryland Medicaid program. Ranked in order of risk to the program, these compliance issues include: not complying with Federal regulations on the suspension of payments in cases where credible allegations of fraud are determined, not conducting complete exclusion searches, not collecting and reporting all required ownership and control and criminal conviction disclosures, and not complying with its Medicaid State Plan regarding False Claims education monitoring.

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.

The Federal regulation at 42 CFR 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the State Medicaid agency must suspend all Medicaid payments to a provider, unless the agency has good cause not to suspend payments or to suspend payment only in part. Under 42 CFR 455.23(d) the State Medicaid agency must make a fraud referral to either a MFCU or to an appropriate law enforcement agency in States with no certified MFCU. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary of the U.S. Department of Health & Human Services (HHS).

Under 42 CFR 455.23(g), State Medicaid agencies must maintain for a minimum of five years from the date of issuance all materials documenting the life cycle of a payment suspension that was imposed in whole or part; and all materials documenting each instance where a payment suspension was not imposed, imposed only in part, or discontinued for good cause. State

Medicaid agencies must also annually report to the Secretary summary information on suspensions of payments, including the nature of the suspected fraud, the basis for suspension, and the outcome of the suspension; and situations in which the State determined good cause existed to not suspend payments, to suspend payments only in part, or to discontinue a payment suspension as described in this section, including describing the nature of the suspected fraud and the nature of the good cause.

Maryland officials indicated that using the Federal authority in 42 CFR 455.23, the State Medicaid agency makes the final decision on initiating provider payment suspensions in cases of fraud. The MFCU can advise MD-OIG if it plans to seek a law enforcement exception and if specific types of provider behavior indicate fraud, but the State agency has the final say in deciding whether to suspend payments. During the review, however, the team observed that elements of the regulation were being inconsistently applied.

The team reviewed the files for ten cases reportedly referred to the MFCU since March 25, 2011 for compliance with the regulation. All ten cases were well developed and documented. In many respects they could serve as a model for meeting the fraud referral performance standards. However, two of the case files did not contain the actual referral letter or clear evidence of whether the MFCU accepted or rejected the case. Five of the files did not show evidence that provider payments were suspended at the time of the referral or that a good cause exception had been requested in writing. The three remaining case files showed evidence of compliance with the regulation. In two instances, the providers had been terminated prior to the referral, and one provider with an excluded employee had fired the person and returned amounts equal to her salary and benefits. However, there was no evidence in the case files of quarterly recertifications, and the State could not document that it complied with the annual reporting requirements to the HHS Secretary as described in guidance issued by CMS on March 23, 2012.

In addition, the Memorandum of Understanding (MOU) that was in effect between MD-OIG and the MFCU at the time of the review only addressed referrals of suspected cases of provider fraud under 42 CFR 455.21 and not the new payment suspension requirements in the revised 42 CFR 455.23 regulation that took effect on March 25, 2011. A revised MOU had been drafted at the time of the on-site visit. The new agreement provided for an informal consultation process by which the MFCU could informally review potential fraud cases and advise the MD-OIG in writing whether to suspend payments or invoke a good cause exception before an official referral was made. However, the draft MOU did not address all of the new regulatory requirements. For example, it did not provide for quarterly recertification of payment suspension cases or good cause exceptions and did not address the requirement of annual reporting to the HHS Secretary. There is no regulatory requirement that such requirements be addressed in the MOU, but the team found no MD-OIG policies or procedures which otherwise directly addressed them.

Recommendations: Develop and implement policies and procedures that address the full range of requirements at 42 CFR 455.23. As soon as an investigation determines there is a credible allegation of fraud, suspend payments to providers or provide written documentation of a good cause exception not to suspend in the case files. Refer such cases to the MFCU and comply with the notification requirements of 42 CFR 455.23.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

The Federal regulation at 42 CFR 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS)[1] no less frequently than monthly.

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 interests 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.

Recommendations: Develop policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider. Search the LEIE (or the Medicare Exclusion Database [MED]) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

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

Under 42 CFR 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, date of birth (DOB), and Social Security Number (SSN) of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under 42 CFR 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under 42 CFR 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under 42 CFR 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under 42 CFR 455.104(c), the State agency must

[1] On July 30, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf for assistance in accessing the database at its new location.

collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCEs.

The prior CMS review found a number of issues with Maryland's FFS provider enrollment forms. In response, the State created a "Provider Ownership and Disclosure" form that went into effect in September 2011. While this addressed and resolved the issues found in the previous review, it did not address several new 42 CFR 455.104-related requirements that became effective as of March 25, 2011. For example, the revised form does not solicit the full enhanced business address information for every business location of corporate entities, as required under 455.104(b)(1)(i).

The regulation at 42 CFR 455.104(b)(1)(iii) requires collection of the tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or MCE) or in any subcontractor in which the disclosing entity (or fiscal agent or MCE) has a 5 percent or more interest. Although the form captures the SSN, it does not capture tax identification numbers for corporations or the required information related to subcontractors.

Additionally, while the information requested in Section C of the Provider Ownership and Disclosure form collects detailed information on persons with direct and indirect ownership and control interests, it does not capture certain relationship information required in 42 CFR 455.104 (b)(2). Specifically, it does not solicit information on family relationships between persons with reportable ownership or control interests in the disclosing entity and in subcontractors also owned by the disclosing entity. Further, the disclosure form only requests the name of managing employees and not their DOB, SSN, and address as required in the regulation.

Finally, the MCE representatives who were interviewed indicated that the MCEs fill out the same Provider Ownership and Disclosure form Maryland's FFS providers must complete as part of the provider enrollment process. Therefore, the same issues identified above with regard to this form also apply to the ownership and control disclosures submitted by the State's Medicaid MCEs.

Recommendations: Modify disclosure forms as necessary to capture all disclosures required under the regulation. The MIG made the same recommendation regarding the solicitation of ownership and control information in the FFS program in the 2009 review report.

The State does not capture criminal conviction disclosures from providers or contractors.
The regulation at 42 CFR 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made. In addition, pursuant to 42 CFR 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

The FFS Provider Ownership and Disclosure form, which individual practitioners and group practices are required to complete in Maryland, contains a minor discrepancy with the regulatory

requirement at 42 CFR 455.106. Section N.2. of the Provider Agreement only refers to Medicare (Title XVIII) and Medicaid (Title XIX) convictions. It does not reference Title XX, which is listed in the regulatory language. Since Maryland's Medicaid MCEs complete the same form as FFS Medicaid providers, the same issue applies to the solicitation of health care-related criminal convictions from the MCEs.

Recommendations: Develop policies and procedures for the appropriate collection of disclosures from FFS and MCE providers regarding persons with an ownership or control interest, or persons who are agents or managing employees of the providers, who have been convicted of a criminal offense related to Medicare, Medicaid, or Title XX since the inception of the programs. Modify disclosure forms and MCE contracts as necessary to capture all disclosures required under the regulation at 42 CFR 455.106.

The State does not comply with its State plan regarding False Claims education monitoring. Section 1902(a)(68) of the Social Security Act [42 U.S.C. 1396a(a)(68)] requires a State to ensure that providers and contractors receiving or making payments of at least $5 million annually under a State's Medicaid program have (a) established written policies for all employees (including management) about the Federal False Claims Act, whistleblower protections, administrative remedies, and any pertinent State laws and rules; (b) included as part of these policies detailed provisions regarding detecting and preventing fraud, waste, and abuse; and (c) included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent State laws and rules.

The Medicaid agency's Provider Enrollment Unit collects attestations from entities receiving or making annual payments under the State Plan of at least $5 million that such entities are in compliance with the requirements of the regulation. The leadership of this unit told the review team that providers who are required to attest have been receiving notifications since 2007, but the State agency has not verified the attestations by reviewing source documentation as required in the State Plan due to lack of staff. Reports by the Maryland's External Quality Review Organization (EQRO) document that the State's Medicaid MCEs do provide information on False Claim Act issues and whistleblower protections in the materials they provide to MCE enrollees and employees. However, the EQRO review does not address the requirement that qualifying entities disseminate similar written policies to any contractor or agent.

Recommendation: Implement policies and procedures to monitor compliance of qualifying providers and contractors with False Claims Act education requirements in accordance with Maryland's Medicaid State Plan.

Vulnerabilities

The Maryland Medicaid program is at risk because it has a number of vulnerabilities in its program integrity activities identified by the review team. In order of risk, they include: failure to conduct complete exclusion searches, failure to capture full ownership and control, business transaction, and criminal conviction disclosures from managed care and NEMT network providers, and failure to require verification of services in the managed care program.

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

The regulations at 42 CFR 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request. If the State neither collects nor maintains complete information on owners, officers, and managing employees in the MMIS or another searchable database, then the State cannot conduct adequate searches of the LEIE or the MED.

The CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the EPLS on a monthly basis.

Maryland's MCEs do not conduct complete searches for individuals and entities excluded from participating in Medicaid. During interviews, the four MCEs indicated that they check providers against the MED upon initial enrollment and then monthly thereafter. However, the EPLS is not being searched on a monthly basis. Furthermore, since the Maryland Uniform Credentialing form does not solicit information about all the parties who must be checked for exclusions or debarments, the MCEs are not in a position to do complete LEIE and EPLS checks on persons with ownership or control interests in network providers or their agents or managing employees.

As the NEMT broker contracts were not furnished, the team was unable to determine if county NEMT brokers were required to conduct initial and monthly exclusion and debarment checks on their network providers and affiliated parties. During interviews, staff who oversee the NEMT program indicated that the program checks the MED upon the enrollment of NEMT service providers and annually thereafter. However, monthly checks of the MED are not conducted, and the EPLS is not being searched.

Recommendations: Amend MCE and NEMT contracts to require the appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Require the contractor to search the LEIE and the EPLS upon enrollment, reenrollment, credentialing or recredentialing of network providers, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Not capturing ownership and control disclosures from network providers.
Under 42 CFR 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, DOB, and SSN of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

The MCEs in Maryland use the Maryland Uniform Credentialing form to enroll network providers. Per both the State and the MCE representatives interviewed, this is required by the Maryland Insurance Administration. The Maryland Credentialing form asks for the name and address of the owner (corporation board and officers) or person (or entity) with a controlling interest in the entity or subcontractor. It also solicits the name and address of managing employees. It does not request enhanced corporate owner address information, DOBs, SSNs and Tax ID information where applicable, and information on the relationships of persons with ownership and control interests as well as the names of other disclosing entities owned or controlled by the MCE. The team found that one MCE attempted to solicit the full range of ownership and control information by using an additional enrollment form along with the Maryland Credentialing forms. However, the supplementary enrollment form did not capture the DOB and SSN for managing employees. The other three MCEs did not use a supplemental credentialing form.

Although the State and the MCEs indicated that they are following the State Insurance Administration's regulatory guidelines for credentialing, there is nothing that precludes them from requiring additional information that would normally be collected from FFS providers.

Lastly, the NEMT broker contracts were not provided. Therefore, the team was unable to determine if the county transportation brokers required NEMT network providers which qualified as disclosing entities to solicit the same ownership and control disclosure information that FFS providers are required to furnish. The team was also not given an NEMT provider application and thus could not determine if appropriate 42 CFR 455.104-related disclosures were requested on that document.

Recommendations: Develop policies and procedures and modify managed care and NEMT contracts to require, or ensure that managed care and NEMT enrollment forms require the disclosure of complete ownership, control, and relationship information from all MCE and

NEMT network providers. Include contract language requiring the MCEs and county NEMT brokers to notify the State of such disclosures on a timely basis.

Not adequately addressing business transaction disclosures in network provider contracts. (Uncorrected Repeat Vulnerability)

The regulation at 42 CFR 455.105(b) requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors.

The prior CMS review found that MCEs did not require network providers to disclose applicable business transactions upon request. The State modified the Code of Maryland Regulations at 10.09.69.17 to require such disclosures upon request. However, Medicaid agency managed care staff indicated that the contract with the MCEs does not require network providers to disclose the required business transaction information on request that is stipulated at 42 CFR 455.105. In addition, none of the MCE network provider agreements or credentialing applications reviewed by the team contained language requiring providers to furnish the same information that 42 CFR 455.105 would otherwise require from FFS providers. Following the onsite visit, the State also provided the review team with a sample NEMT provider agreement. However, this document was incomplete. Consequently, the team could not determine if the relevant business transaction disclosure requirement was in the contracts between the counties and NEMT providers and drivers.

Recommendation: Modify managed care and NEMT network provider agreements to require disclosure upon request of the information identified in 42 CFR 455.105(b). The MIG made the same recommendation regarding business transactions for MCE provider agreements in 2009.

Not capturing criminal convictions from network providers.

The regulation at 42 CFR 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made. In addition, pursuant to 42 CFR 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

The Maryland Uniform Credentialing form does not require disclosure of health care-related criminal conviction information that would otherwise be required from FFS Medicaid providers under 42 CFR 455.106. Specifically, the provider enrollment form does not ask for health care-related criminal conviction disclosures for the full range of parties affiliated with the applying entity, such as persons with ownership or control interests, agents and managing employees. Additionally, in the section on criminal history, the Maryland Uniform Credentialing form only requests disclosures for misdemeanor convictions during the past ten years and not from the inception of the Federal health care programs.

The NEMT broker contracts were not provided. Therefore, the team was unable to determine if the county transportation brokers required NEMT network providers to solicit health care-related

criminal conviction disclosures on the part of persons with ownership or control interests in the provider, or agents or managing employees since the inception of Medicare, Medicaid and Title XX as required in the regulation. The team also was not given an NEMT provider application and thus could not determine if health care-related criminal conviction information was requested on that document.

Recommendations: Modify the MCE and NEMT broker contracts to require, or ensure that network provider enrollment forms require, the disclosure of health care-related criminal convictions on the part of persons with an ownership or control interest, or persons who are agents or managing employees of network providers. Include contract language requiring MCEs and the county NEMT brokers to notify the State of such disclosures on a timely basis.

Not verifying with managed care enrollees whether services billed were received.
The regulation at 42 CFR 455.20 requires the State Medicaid agency to have a method for verifying with beneficiaries whether services billed by providers were received.

Maryland meets the requirement of 42 CFR 455.20 by sending explanations of medical benefits to beneficiaries. However there is no contractual requirement for MCEs to conduct verification of service. Three of the four MCEs that the team interviewed conduct verification of service by sending out explanation of benefits. However, one MCE does not conduct verifications, noting to the team that it was not contractually required to do so.

Recommendation: Develop and implement procedures to verify with MCE enrollees whether services billed by providers were received, and require that such verifications be performed in the State's MCE contracts.

CONCLUSION

The identification of five areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, five areas of vulnerability were identified. The CMS is particularly concerned over the two uncorrected repeat findings and vulnerabilities. The CMS expects the State to correct them as soon as possible.

To that end, we will require Maryland to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Maryland will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Maryland has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The State of Maryland applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity. The Medicaid Integrity Group looks forward to working with the State of Maryland on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.