Department of Health and Human Services

Centers for Medicare & Medicaid Services

Maryland Focused Program Integrity Review

Final Report

July 2022

Table of Contents

Maryland Focused Program Integrity Review Draft Report
July 2022

Executive Summary

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, the Centers for Medicare & Medicaid Services (CMS) set forth its strategy to safeguard the integrity of the Medicaid program.[1] State Medicaid programs are required to have a fraud detection and investigation program and oversight strategy that meet minimal federal standards. To ensure states are meeting these requirements, CMS conducts focused program integrity reviews on high-risk areas, such as managed care, new statutory and regulatory provisions, nonemergency medical transportation, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. The value of performing focused program integrity reviews include: (1) providing states with effective tools/strategies to improve program integrity operations and performance; (2) providing the opportunity for technical assistance related to program integrity trends; (3) assisting CMS in determining/identifying future guidance that would be beneficial to states; and (4) assisting with identifying and sharing promising practices related to program integrity.

This report summarizes information gathered during a focused review of the Maryland Medicaid managed care program. The primary objective of the review was to assess the state's program integrity oversight efforts for Medicaid managed care. A secondary objective was to provide the state with useful feedback, discussions, and technical assistance resources that may be used to enhance program integrity in the delivery of these services.

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

In September 2021, CMS conducted a virtual focused review of the Maryland Department of Health (MDH). Within the MDH, program integrity oversight currently falls under the responsibility of the Maryland Office of Inspector General (MDH-OIG). This focused review helped CMS determine the extent of program integrity oversight of the managed care program at the state level and assess the program integrity activities performed by selected MCOs under contract with the State Medicaid Agency (SMA). CMS interviewed key staff and reviewed a sample of program integrity cases investigated by the MCOs Special Investigations Units (SIUs), as well as other primary data, to assess the state's and selected MCOs' program integrity practices. CMS also evaluated the status of Maryland's previous

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

corrective action plan, which was developed by the state in response to a managed care focused review conducted by CMS in 2016.

During this review, CMS identified a total of seven recommendations based upon the completed focused review modules, supporting documentation, and discussions and/or interviews with key staff. CMS also included technical assistance resources for the state to consider utilizing for its oversight of managed care. The review and recommendations encompass the following six areas:

1. State oversight of managed care program integrity activities
2. Provider screening and enrollment
3. MCO investigations of fraud, waste, and abuse
4. Encounter data
5. Payment suspensions based on credible allegations of fraud
6. Terminated providers and adverse action reporting

Overview of Maryland Medicaid

The MDH is the single state agency responsible for providing oversight of the medical assistance program and the contracted MCOs in Maryland. The MDH administers the state's Medicaid managed care program under the Maryland HealthChoice program. The Maryland HealthChoice program provides health benefits to eligible beneficiaries through nine MCOs: Aetna Better Health, Amerigroup Community Care, CareFirst Blue Cross Blue Shield Community Health Plan, Jai Medical Systems, Kaiser Permanente, Maryland Physicians Care, MedStar Family Choice, Priority Partners, and UnitedHealthcare Community Plan.

The MCOs are selected through an application process rather than a competitive bidding process. The Office of Health Care Financing oversees Maryland Medicaid, and the Office of Medical Benefits Management (specifically the Managed Care Administration Division) has primary responsibility for overseeing HealthChoice MCO contracting, regulations, and policies. The Managed Care Administration has four divisions: Community Liaison and Care Coordination; Complaint Resolution; Provider Network Management; and Quality Assurance.

In calendar year 2019, Maryland's Medicaid expenditures exceeded $12.6 billion, and the state had approximately 1.2 million beneficiaries enrolled. The Federal Medical Assistance Percentage matching rate was 50 percent. Approximately 85 percent of the Medicaid population was enrolled in nine managed care plans under the Medicaid HealthChoice program. Maryland's managed care expenditures were approximately $5,771,523,973, which includes both Medicaid and the Children's Health Insurance Program (CHIP), representing approximately 46 percent of total Medicaid expenditures.

Of the nine operating MCOs in the state, three were selected for interview during the virtual program integrity review: Aetna Better Health, Jai Medical Systems, and Kaiser Permanente. Table 1 and Table 2 below provide enrollment/SIU and expenditure data for each MCO that CMS interviewed.

Table 1. Summary Data for Maryland MCOs[2]

	Aetna Better Health	Jai Medical Systems	Kaiser Permanente
Beneficiary enrollment total	49,573	29,633	70,892
Provider enrollment total	20,768	10,321	12,714
Year originally contracted	2017	1997	2014
Size and composition of SIU (FTEs)	1 FTE Investigator supported by a team of local and corporate SIU staff.	8 FTE	25 National SIU staff/3 local SIU including a manager and 2 SIU investigators
National/local plan	Local/National*	Local	National

* National Centers of Excellence are used for claims, encounters, and enrollment functions.

Table 2. Medicaid Expenditure Data for Maryland MCOs[3]

MCO	FY 2017	FY 2018	FY 2019
Aetna Better Health	$487,499*	$29,957,214	$83,874,938
Jai Medical Systems	$198,669,972	$194,417,656	$201,089,994
Kaiser Permanente	$306,926,389	$328,704,650	$347,680,989

* Aetna Better Health joined the Maryland Medicaid managed care program in October 2017.

Results of the Review

CMS evaluated the following six areas of Maryland's managed care program:

1. State oversight of managed care program integrity activities
2. Provider screening and enrollment
3. MCO investigations of fraud, waste, and abuse
4. Encounter data
5. Payment suspensions based on credible allegations of fraud
6. Terminated providers and adverse action reporting

CMS identified seven areas of concern with Maryland's managed care program integrity oversight that may create 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 through implementation of a

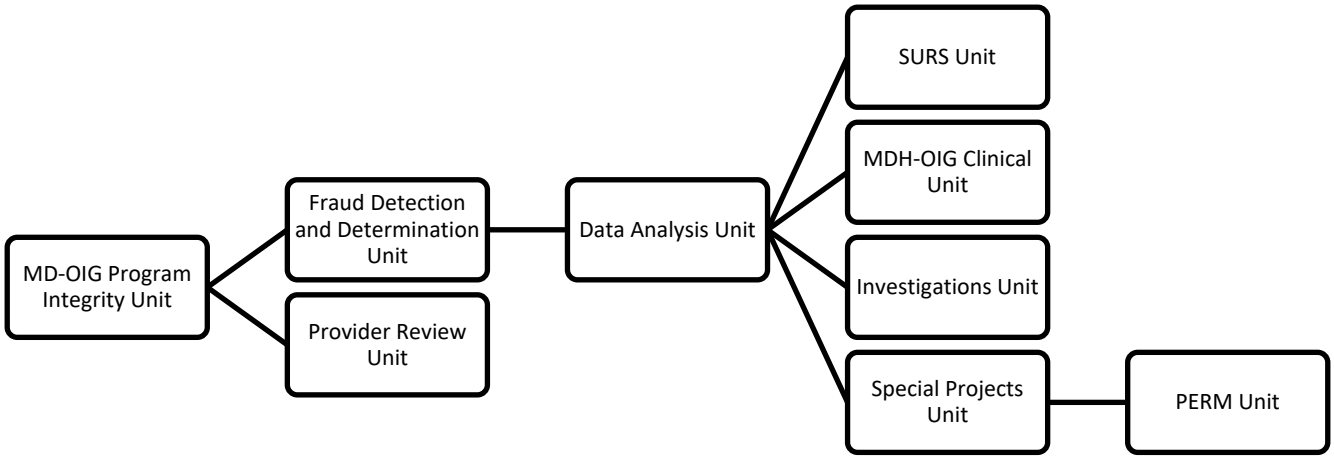
[2] The beneficiary enrollment numbers for Aetna Better Health are as of 7/1/2021, and Jai Medical Systems and Kaiser Permanente are as of 12/31/2019.
[3] Each of the MCOs submitted the expenditure data reported in Table 2. The state confirmed expenditure data during the review process. Discrepancies (if identified) were clarified prior to development of this report.

corrective action plan. These areas of concern and CMS' recommendations for improvement are described in detail below.

1. State Oversight of Managed Care Program Integrity Activities

In accordance with the state monitoring requirements set forth in §§438.66 and 438.602, the SMA must have in effect a monitoring system for all managed care programs which includes mechanisms for the evaluation of MCO performance in several key areas. The MDH-OIG Program Integrity Unit bears the primary responsibility for monitoring fraud, waste, and abuse reported by the MCOs and their providers. The Program Integrity Unit is comprised of the Fraud Detection and Determination Unit and the Provider Review Unit. The Fraud Detection and Determination Unit includes the Data Analysis Unit, which includes the Surveillance and Utilization Review Subsystem (SURS) Unit, the MDH-OIG Clinical Unit, the Investigations Unit, and the Special Projects Unit, which includes the Payment Error Rate Measurement (PERM) Unit. These relationships are visually represented in Figure 3.

Figure 3. MDH Organizational Hierarchy



Under § 455.21, the SMA is required to cooperate with the state Medicaid Fraud Control Unit (MFCU) by entering into a written agreement with the unit that provides a process for the referral of suspected provider fraud to the MFCU and establishes certain parameters for the relationship between the MFCU and the SMA. The state reported that it has a Memorandum of Understanding (MOU) in place with the MFCU to investigate and prosecute provider Medicaid fraud, as well as instances of abuse and neglect of vulnerable adults within the Medicaid program. The MOU is in place to ensure effective cooperation, communication, and coordination between MDH and the MFCU regarding the detection, investigation, and prosecution of all provider Medicaid fraud cases arising in the state. All case referrals from the MCOs must be communicated to both the MDH-OIG and the MFCU. The MFCU notifies the MDH-OIG of the status of ongoing cases in writing on a quarterly basis. The MCOs report their investigations monthly via reports submitted to the MDH-OIG. The MDH-OIG and the MFCU will discuss the referral

and decide who should take the lead on investigating a case. If the MDH-OIG accepts the case for investigation, OIG will follow its internal policies and procedures to conduct the investigation which include obtaining supporting documents, file review, data analysis, interviews, and research. If the MDH-OIG determines there is a credible allegation of fraud, MDH-OIG will refer the case to the MFCU.

The state also contracts with an independent External Quality Review Organization (EQRO), Qlarant Quality Solutions, Inc., that tracks compliance with federal and state requirements through desktop and onsite reviews, medical record reviews, customer service logs and policy reviews, and provider directory verification surveys. The EQRO reviews fraud and abuse policies and procedures as part of its comprehensive reviews performed every three years. The EQRO also performs other federally required quality assurance activities, such as validation of performance improvement projects, review of appeals/grievances/denials, and validation of performance measures.

In Maryland, the MCOs are contractually required to have a compliance plan that meets the requirements of § 438.608(a)(1). Maryland reviews the MCO's compliance plans through the external quality review process. The MCOs are responsible for submitting the documents related to their compliance plan, including policies, procedures, meeting minutes, and guidelines through the Qlarant review tool. Auditors then review the information to determine whether it complies with federal and state requirements. For comprehensive onsite reviews, this determination is supplemented by interviews with program staff to clarify questions and provide recommendations. For desktop reviews, these questions may be asked via email. Comprehensive onsite reviews are conducted once every three years. The MCOs are expected to achieve one hundred percent compliance with all standards, and if they receive partially met or unmet findings, the plans must submit a corrective action plan that illustrates how they will come into compliance. CMS found that all three MCOs interviewed had the required compliance plans in place that met the requirements of § 438.608(a)(1).

As required under § 438.608(a)(5), states must verify, by sampling or other methods, that services provided by network providers were received by enrollees. Verification of services is a valuable tool for identifying potential fraud not detected through data mining, post-payment reviews, and predictive modeling. All three MCOs interviewed confirmed they were performing some type of beneficiary verification; **however, CMS observed that the procedures for verification of beneficiary services vary widely from plan to plan, and contract language for this requirement is very vague.** The state did provide evidence, however, that the EQRO reviews the MCOs' compliance with the beneficiary verification requirement.

Recommendation #1: The state should strengthen its contract language regarding MCO beneficiary verification activities, consistent with § 438.608(a)(5). In addition, the state should ensure that all MCOs have consistent beneficiary verification policies and procedures that comply with the contractual requirement.

2. Provider Screening and Enrollment

To comply with §§ 438.602(b)(1)-(2), 438.608(b), 455.100-106, 455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, all providers of the MCO must enroll with the Maryland Medicaid HealthChoice program through the state's Electronic Provider Revalidation and Enrollment Portal (ePREP). The MCO must ensure that all providers are registered in Maryland's ePREP provider enrollment system prior to contracting and credentialing with the provider. This requirement applies to all provider types and specialties, and is inclusive of the billing, rendering, ordering, prescribing, referring, sponsoring, and attending providers. This requirement is supported by the Maryland HealthChoice MCO Agreement, Section N (3).

The Maryland HealthChoice MCO Agreement further specifies in Section N (2), that the MCO must maintain written policies and procedures for selecting and retaining network providers in accordance with the requirements of § 438.12 and the applicable provider panel provisions of Maryland Insurance Article § 15-112. The MCO must use the Maryland Uniform Credentialing Form for the credentialing of all network providers. The MCO is responsible for monitoring the MDH's correspondence and any database publicizing department-initiated terminations of providers from the HealthChoice program. Terminated or excluded providers must be terminated from their contract, and the MCO must not initiate a contract with a terminated or excluded provider.

In accordance with § 455.436 and Section N (3) of the HealthChoice MCO Agreement, the MCO is required to search the Department of Health and Human Service's OIG List of Excluded Individuals/Entities (LEIE), the General Services Administration's System for Award Management (SAM), the Social Security Administrations Death Master File, and the National Plan and Provider Enumeration System for individuals excluded from the Medicaid Program. These searches are performed upon enrollment, and the LEIE and SAM are required to be checked at least monthly thereafter, using the names of all contracted individuals and entities, and those with an ownership interest, and their agents and managing employees.

As also supported by Section N (3) of the HealthChoice MCO Agreement, MCOs must obtain federally required disclosures from all enrolled network providers and subcontractors in accordance with § 455 Subpart B and § 1002.3, as related to ownership and control, business transactions, and criminal conviction for offenses against federally related health care programs including Medicare, Medicaid, or CHIP. The MCO must screen all individuals listed on the disclosure form including providers and non-providers, such as board members, owners, agents, and managing employees. The information is obtained through provider enrollment forms and credentialing and re-credentialing packages. Also, in Section N (3) of the HealthChoice MCO Agreement, MCOs are required to ensure that all its network providers are screened, enrolled, and revalidated by the State as Medicaid providers, in accordance with 42 CFR part 455, subparts B and E, and validate enrollment by verifying against the Department's full fee-for-service provider file. Each of the MCOs interviewed and the state indicated they recredential providers every 3 years.

CMS regulations at § 455.432 requires that the state Medicaid agency conduct pre-enrollment and post-enrollment site visits of providers who are designated as ‘‘moderate’’ or ‘‘high’’ categorical risks to the

Medicaid program. The MDH follows the Medicaid Provider Enrollment Compendium and aligns its definitions of high, moderate, and low/limited risk providers to the compendium. The MDH has more stringent requirements for certain high and moderate risk provider types as part of their provider enrollment process. As stated in MDH regulations, COMAR Section 10.09.36.03 – Conditions for Participation, "A. To participate in the Program, the provider shall: … (4) Allow the Department or its agents to conduct unannounced on-site inspections of any and all provider locations; (5) Allow the Department or its agents to require all providers to consent to criminal background checks, including fingerprinting…" During the review period, Program Integrity met with the MCOs to discuss high risk providers in an effort to prevent additional fraud or abuse. Additionally, Program Integrity has created a database to track information submitted by the MCOs which allows the data to be combined to highlight high risk providers. This information is distributed to the MCO's and discussed at the quarterly meetings. Program Integrity also runs similar data analysis on the FFS data. Because all contracted and credentialed providers for the MCO must have passed the state's criteria, higher risk provider types are subjected to additional enrollment requirements with the state, such as a site visit prior to enrollment for certain provider types.

3. MCO Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

As required by § 438.608(a)(1) and §§ 455.13-17, Maryland has an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs. Maryland's Medicaid HealthChoice Program Agreement with its MCOs states under Program Integrity Section K., "Consistent with 42 CFR 438.608, to implement and require its responsible subcontractors to implement procedures that are designed to detect and prevent fraud, waste, and abuse, which includes a compliance program…" The program agreement also requires the MCO to promptly and concurrently report to the MD-OIG and the MFCU all fraud and abuse, including fraud by employees and subcontractors of the MCO, enrollment agents, and recipients within 15 calendar days of the discovery of a suspected incident. In accordance with §438.602(f), the MCO is also required to promptly report any potential fraud, waste, abuse, or information it has received from whistleblowers relating to the integrity of the MCO, its network providers, or its subcontractors.

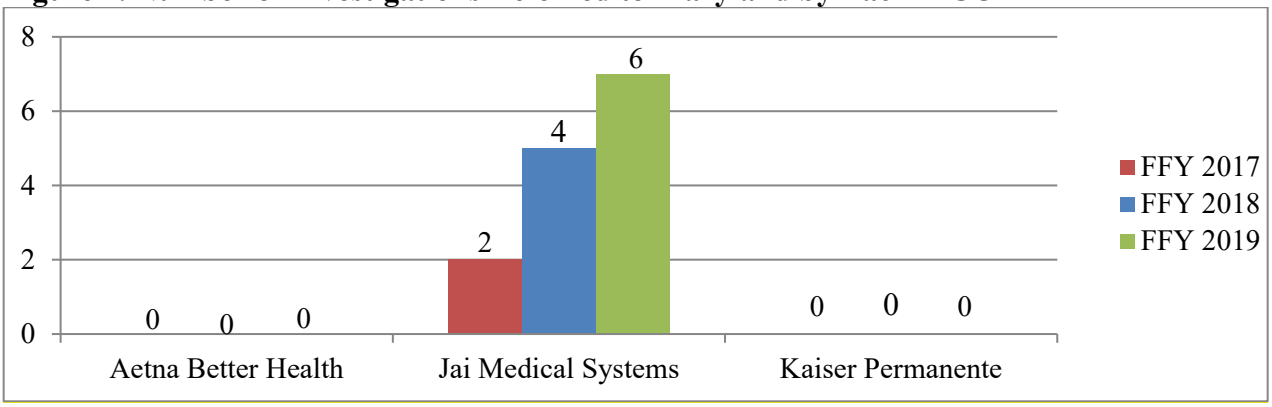
The MDH-OIG Program Integrity Unit created a database to track information submitted by the MCOs which allows the data to be combined to highlight high-risk providers. This information is distributed to the MCOs and discussed at the quarterly meetings. The MDH-OIG conducts quarterly collaborative program integrity sessions with the MCOs and other stakeholders to discuss pertinent program integrity issues pertaining to fraud, waste, and abuse matters and relevant contractual concerns. The MDH-OIG conducts training during these meetings, to include the distribution and discussion of the most current CMS toolkits, types of findings, and providers that are being investigated. During these quarterly meetings, the state has discussed the desire to increase referrals to the MDH-OIG and the nature of cases being referred. The attendees include representatives from each MCO's compliance department and SIU, MDH-OIG, and the MFCU. **It was noted that, during the review period, the SMA did not mandate**

or enforce attendance at these meetings even though the contract requires, "… MCO program integrity representatives to attend in-person meetings with the Department and report ongoing efforts to detect and prevent fraud, waste, and abuse." During the interview with Kaiser Permanente, it was determined the MCO did not attend these quarterly meetings.

MCO Oversight of Network Providers

CMS confirmed that each of the MCOs interviewed has SIUs. The SIU staffing levels reported by all three plans ranged from 1 to 25 FTEs dedicated to Maryland Medicaid. **However, in terms of referrals and investigations, the program integrity efforts of all three reviewed SIUs appear to be inadequate**. Figure 4 describes the number of investigations referred to Maryland by each MCO.

Figure 4. Number of Investigations Referred to Maryland by Each MCO



During the interview process with the MCOs it was noted that two of the MCOs did not conduct unannounced investigative provider site visits. Aetna Better Health indicated they performed a small number of unannounced on-site visits. The contract with the MCOs does not contain language addressing unannounced provider site visits.

Overpayments

In accordance with § 438.608(d), which requires the MCO contract to include provision for the treatment of recoveries made by the MCO of overpayments to providers, the Maryland state legislature enacted state regulation 10.67.07.01(L)(1) which specifies that, "Overpayments recovered by an MCO, including those recovered due to waste, fraud and abuse, may be retained by the MCO, so long as it is reported to the Department." **However, neither this Maryland regulation, nor the MCO agreement specifies the process, timeframes, and documentation required for reporting the recovery of all overpayments. The state reported a process in place for the reporting of overpayments to the state, but this process was not included in the MCO Agreement during the review period.** Pursuant to § 438.608(d)(1)-(2), this information is required to be included in the MCO contract or agreement with the state. However, the state indicated that the MD-OIG developed

a new database to more accurately monitor, track, and verify overpayments identified and collected by the MCOs. As of June 2022, the database is being used.

Pursuant to § 436.608(c), the contract with the MCOs should ensure that MCOs report excess capitation or other contract overpayments to the state within 60 calendar days. **The MDH reported there was a process in place during the review period; however, this was not addressed in the MCO contract. In addition, there was a lack of policies and procedures to verify that overpayments, including the federal share of overpayments, for MCOs were correctly reported, even though the MCOs are contractually required to submit an annual report of overpayment recoveries.** The state indicated that they were unable to isolate overpayments specifically attributable to the MCOs. The state indicated, however, that this change will be made in the 2023 MCO contracts and related regulations.

Prior to 2018, the MCOs reported overpayment information via the HealthChoice Financial Monitoring Report tool, which directed plans to report expenses net of other party liability. An annual audit was conducted by an external certified public accounting firm to validate the expenditures reported by the individual MCOs. After 2018, the MDH's amended process for identifying and recovering overpayments included the following:

- The MDH defined "overpayment" as any payment made by the program to a provider in excess of the correct program payment amount for a service, or any payment for services made by the program or an MCO which, at the time of payment, or at a subsequent date, is determined to be inappropriate, inaccurate, or in excess of the correct amount of the procedural code billed, for reasons including but not limited to improper claiming, lack of medical necessity, unacceptable practices, fraud, waste, or abuse, or provider mistake.
- The MCOs were required to develop a mechanism for network providers to report overpayments, return the overpayment within 60 days of identifying, and notify the MCO in writing of the reason for the overpayment.
- The MCOs were required to report both monthly and annually all overpayments identified and recovered, specifying the overpayments due to fraud.
- Overpayments recovered by the MCO, including those recovered due to fraud, waste, or abuse, may be retained by the MCO, as long as the overpayment is reported to MDH.
- If MDH, the federal government, or its agents identified the potential fraud, waste, or abuse that lead to the recovery of funds paid to an MCO provider, and the MCO did not previously identify and report the provider for potential overpayments, MDH has the right to recover from the MCO the entire amount of the overpayment.
- If the MCO identifies the overpayment but does not initiate the recovery within 90 days after the completion of their investigation, MDH has sole right of recovery for the overpayment.
- The MCOs have appeal rights for any MDH overpayment recoveries

There were no cases reported to the MD-OIG by Aetna Better Health and Kaiser Permanente, and an overall low number of case referrals by Jai Medical Systems**. Overall, the number of overpayments**

identified and recovered by each MCO does not correspond with the number of investigations reported. Overpayments are being identified, but there are not corresponding cases being reported to the MDH-OIG and the MFCU. Although the MCOs are not normally required to return overpayments from their network providers to the state, § 438.608(d) requires the state obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process. Without these adjustments, MCOs could be receiving inflated rates per member per month. Tables 5-A, 5-B, and 5-C describe each MCO 's recoveries from program integrity activities.

Table 5-A Aetna Better Health's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	0	0	0	0
2018	3	0	$0	$0
2020	31	31	$189,985.09	$44,644.56

Table 5-B. Jai Medical System's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	39	17	$13,750.87	$13,750.87
2018	39	12	$116,212.24	$116,212.24
2019	39	13	$480,477.81	$480,474.89

Table 5-C. Kaiser Permanente's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	0	0	$0	$0
2018	0	0	$0	$0
2019	0	0	$0	$0

Recommendation #2: The state should require mandatory attendance of all MCO program integrity representatives at in-person meetings with the Department to ensure the MCO's report ongoing efforts to detect and prevent fraud, waste, and abuse in accordance with the contract.

Recommendation #3: To ensure compliance with the requirements of § 438.608(a)(7), which requires the prompt referral of any potential fraud, waste, or abuse that the MCO identifies, the state should work with the MCOs to develop more case referrals and routinely provide specific program integrity training in identifying, investigating, and referring potential fraudulent billing practices by providers to enhance the quality of cases being referred by the MCOs. The state should provide specific feedback to the MCOs regarding the quality and quantity of the MCO case referrals.

Recommendation #4: The contract with the MCOs should be amended to ensure MCOs report excess capitation or other contract overpayments to the state within 60 calendar days pursuant to § 436.608(c). As noted above, the state indicated that this change will be made in the 2023 MCO contracts and related regulations.

Recommendation #5: The state should establish an effective mechanism to monitor, track, and verify the accurate reporting of overpayments identified and collected by the MCOs. Furthermore, the state should ensure the MCOs develop and maintain adequate overpayment identification/collection/reporting policies and procedures consistent with § 438.608(d). As noted above, the state indicated that the MD-OIG developed a new database to more accurately monitor, track, and verify overpayments identified and collected by the MCOs. As of June 2022, the database is being used.

4. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 further specifies that state MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including allowed amount and paid amount, that the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Encounter data is validated annually through a joint process conducted by Qlarant and The Hilltop Institute. Hilltop serves as MDH's data warehouse vendor. Hilltop also works with the Medicaid Office of Finance to develop capitation rates that are certified by Optumas, the state's actuary. The MDH receives encounter data from the MCOs on a daily basis. The MCOs are required to report encounter data within 60 calendar days after receipt of the claim from the provider. The MCO reports encounter data utilizing a secure on-line data transfer system. The MCOs are required to submit encounters for all services, including paid, denied, and sub-capitated claims. Encounter data is audited on an annual basis by a third-party contractor, Myers and Stauffer, to validate the accuracy of the data submitted by the MCOs. The audited MCO financial data is used as the base period in developing actuarially sound capitation rates.

CMS did not identify any recommendations regarding Maryland's use of encounter data for Medicaid oversight.

5. Payment Suspensions

Pursuant to §§ 455.23 and 438.608(a)(8), Maryland's Medicaid MCOs are contractually required to suspend payments to providers at the state's request. Payments to providers must be suspended when the MDH-OIG determines there is a credible allegation of fraud, unless there is good cause not to suspend payments, or to suspend payments only in part. Staff of the MDH-OIG Program Integrity Unit perform a preliminary review and determine whether there is evidence of a credible allegation of fraud. If evidence of a credible allegation of fraud is determined, the MDH-OIG Program Integrity Director shall informally consult with the Director of the MFCU to determine further action. The state may suspend a provider without first notifying the provider of its intention to suspend payment. When an investigation leads to the initiation of a payment suspension in whole or in part, the MDH-OIG must make a fraud referral to the MFCU.

If the MFCU or other law enforcement agency accepts the fraud referral for investigation, the payment suspension may be continued until the investigation and any associated enforcement proceedings are completed. On a quarterly basis, the MDH-OIG will request certification from the MFCU or other law enforcement agency that the referral continues to be under investigation, thus warranting continuation of the suspension. If the MFCU or other law enforcement agency declines to accept the fraud referral for investigation, the payment suspension must be discontinued unless the MDH has alternative federal or state authority to impose a suspension or makes a fraud referral to another law enforcement agency. Payments may not be suspended if it is determined there is a good cause not to suspend or to suspend only in part.

Only one of the three MCOs had a suspension policy in place. Kaiser Permanente did not have a policy in effect until April 11, 2019 of the review period and Jai Medical Systems' policy only addresses terminations and sanctions, not suspensions. However, as of June 2022, the MD-OIG has developed policies and guidelines for how MCOs implement payment suspensions for credible allegations of fraud and is currently working to include this requirement in the MCO contracts.

Recommendation #6: The state should ensure all MCOs develop written policies and procedures for payment suspensions in cases of credible allegations of fraud that comply with §§ 455.23 and 438.608(a)(8). As noted above, as of June 2022, the MD-OIG has developed policies and guidelines for how MCOs implement payment suspensions for credible allegations of fraud and is currently working to include this requirement in the MCO contracts.

6. Terminated Providers and Adverse Action Reporting

Consistent with § 438.608(a)(4), (b) and 455, subparts B and E, the state is required to include provision for MCO notification to the state when the MCO receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO. This requirement is

supported by the Maryland MCO HealthChoice Agreement, 10.67.04.17 § (B) (4), which requires: (a) when an MCO and provider terminate their contract the MCO shall provide the Department with a written notice regarding the termination; (b) if the MCO is terminating the contract, the notice required in §B(4)(a) of this regulation shall be provided 90 days before the effective date of the termination; (c) if the provider is terminating the contract, the notice required in §B(4)(a) of this regulation shall be provided within 15 days after the MCO receives the notice from the terminating provider.

Aetna Better Health provides notice of provider termination to the state in accordance with state regulations. The MDH sends an official email to the MCO when a provider has been terminated by the state "for cause."

Jai Medical Systems notifies the state when it terminates or disenrolls a provider's contract for any reason, including "for cause" terminations. Jai Medical Systems does not notify other MCOs of these actions because the state will notify the other MCOs when a provider is terminated due to fraud, waste, or abuse (i.e., "for cause"). The state provides notices of providers terminated "for cause" through email to Jai Medical Systems. Once received, Jai Medical Systems will check credentialing and payment databases for the provider. If the provider is in these databases, they will be immediately terminated for cause.

Kaiser Permanente notifies the state when it terminates, de-credentials, or disenrolls a provider's contract for cause. Kaiser Permanente notifies other MCOs of these actions. When notices are received from the state, the internal Medicaid Operations Department notifies the Credentialing Department. If the provider is determined to be active with Kaiser Permanente, their name is submitted to downstream departments to be terminated from the organization.

CMS determined that the MDH was not uploading MCO "for cause" terminated providers into the CMS Data Exchange system known as DEX (formerly TIBCO) during the review period, as required by CMS regulations and guidance. Providers terminated by MCOs from participation in their networks are not required to be reported in DEX.

Overall, the number of providers terminated "for cause" by the plans appears low, compared to the number of providers enrolled with the MCOs and compared to the number of providers dis-enrolled or terminated for cause. Table 6 depicts the number of provider terminations by MCO.

Table 6: Provider Terminations in Managed Care

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FYs	Total # of Providers Terminated for Cause in Last 3 Completed FYs
Aetna Better Health	2017 0 2018 2 2019 2	2017 0 2018 0 2019 0
Jai Medical Systems	2017 637 2018 361 2019 305	2017 1 2018 2 2019 1
Kaiser Permanente	2017 257 2018 286 2019 293	2017 13 2018 5 2019 16

Recommendation #7: The state should ensure each MCO has policies and procedures in place for ensuring providers terminated by the MCOs "for cause" are effectively terminated and reported to CMS' Data Exchange (DEX) as required by Section 6501 of the Affordable Care Act.

Status of Maryland's 2016 Corrective Action Plan

Maryland's previous focused program integrity review was in June 2016, and the final report was issued in March 2017. The report contained ten recommendations. The CMS completed a desk review of the corrective action plan in March 2019. The desk review indicated that all findings had been satisfied. The State was notified of corrective action plan closure on March 28, 2019.

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:

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- Access the Provider Requirements website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Provider-Requirements to address site visit requirements.
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCU.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address Overpayment and Recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- 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. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Conclusion

CMS supports Maryland's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified seven areas of concern and instances of non-compliance with federal regulations that should be addressed immediately.

We require the state to provide a corrective action plan for each of the recommendations within 30 calendar days from the date of issuance of the final report. The corrective action plan should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies have been addressed and will not reoccur. The corrective action plan should include the timeframes for each corrective action 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 corrective action plan, 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 issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

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