The Maryland Department of Health's
Responses to the DLS FY 2020 Administration Budget Analysis
January 23, 2019 (House) and January 24, 2019 (Senate)

Policy Questions

MDH should comment on the status of the [direct care workforce retention study] report, the recommendations contained therein, and when the budget committees can anticipate the report being completed. (pg. 16)

The Department submitted the direct care workforce retention study report on January 21, 2019 to DLS. A copy of the requested report is attached to this response. Please see the report for the recommendations on the subject and topics requested by the Joint Chairs.

Budget Questions

DLS concurs with the Governor's Allowance. (pg. 2, 17)

The Department concurs and appreciates the General Assembly's support.

OLA Report on MDH Office of the Secretary
Status Report as of January 23, 2019

Please see the attached for the Department's response on the repeat audit finding review. The response was submitted to the Joint Audit Committee on Thursday, January 17, 2019 as requested by the Committee. The Joint Audit Committee, at its hearing on January 22, 2019, did not have any questions for the Department.

MARYLAND
Department of Health
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

January 21, 2019

The Honorable Nancy J. King
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chair
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

RE: 2018 Joint Chairmen's Report (Pages 74-75) - Maryland Department of Health - Direct Care Recruitment and Retention Study

Dear Chairs King and McIntosh:

In keeping with the requirements of the 2018 Joint Chairmen's Report (Pages 74-75), the Maryland Department of Health ("the Department" or "MDH") Office of Human Resources ("OHR") respectfully submits the following report on its study of "Direct Care Recruitment and Retention".

This report will first examine the premise that "vacancy rates of direct care staff, including nurses, physicians, and direct care aides, continues to climb across MDH…". The second premise this report will examine is that "one of the main reasons for the high vacancy rate is a lack of appropriate compensation…". Finally, this report will examine 1) whether an increase in compensation is likely to improve the recruitment and retention of staff, and 2) if so, what degree of compensation increase is likely to achieve this goal.

TERMINOLOGY AND METHODOLOGY

"Direct Care" Defined

The first hurdle in performing this study was establishing parameters on the job classifications that reasonably should be defined as "direct care staff". In attempting to set these parameters, the Department settled on a definition of "positions within the Department's hospitals and treatment facilities performing job functions primarily relating to the direct provision of professional medical care or therapeutic treatment (or direct support thereof)."

In examining whether a classification performs job functions in "direct support" of medical or therapeutic treatment, the Department considered positions 1) that are active and consistent participants in the patient's continuum of care, 2) that may report, recommend, administer, or implement medical or therapeutic techniques, interventions, medications, or treatments at the direction of - or in conjunction with - professional medical staff, or 3) that provide supervision, training, direction, and programmatic support to those tasked with direct patient care.

In applying those definitions, OHR settled upon 119 distinct job classifications[1]. These were the classifications contemplated in this study and to which the foregoing statistics and conclusions apply.

"Vacancy Rate" Defined

For the purposes of this study, "vacancy rate" is defined as the number of unfilled (open) PINs allocated to direct care at the 12 facilities, divided by the total number of PINs allocated to direct care:

$$\text{Vacancy Rate} = \frac{\text{Open Direct Care PINs}}{\text{Total Direct Care PINs}}$$

Multiplying the rate by 100, the net result is the percentage of direct care positions that remain unfilled at the date of examination.

Time Considerations

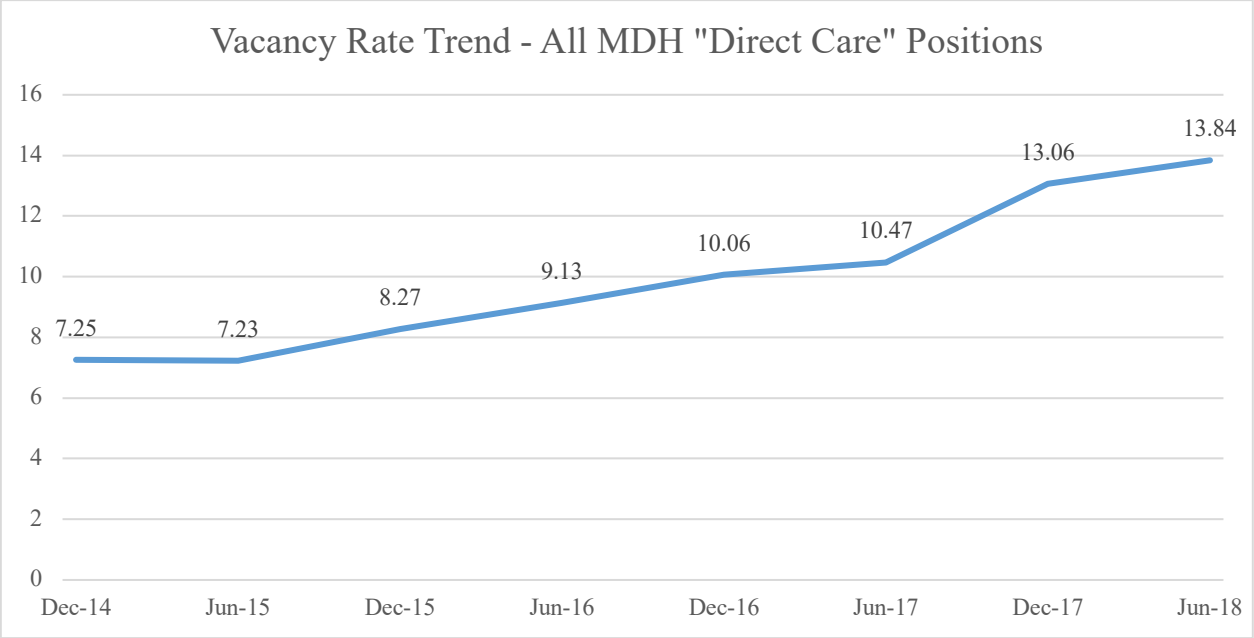
The vacancy rate is a constantly-shifting figure, as any separations from employment on a given day will skew the total number of open positions (the numerator in the equation). In order to normalize vacancy trends and account for unnatural, acute spikes in vacancy, OHR determined that best course of action was to examine the rates at pre-determined intervals at every 6 months on the dates ending a calendar year or a fiscal year: June 30 and December 31. This was done to account for employees' tendencies to resign or retire effective at the close of business on these dates, so as to begin their separation or retirement period effective either January 1 or July 1. Had OHR examined the beginnings of calendar years and fiscal years, the vacancy rate would have appeared artificially inflated, even where planful recruitment and back-filling efforts were already underway.

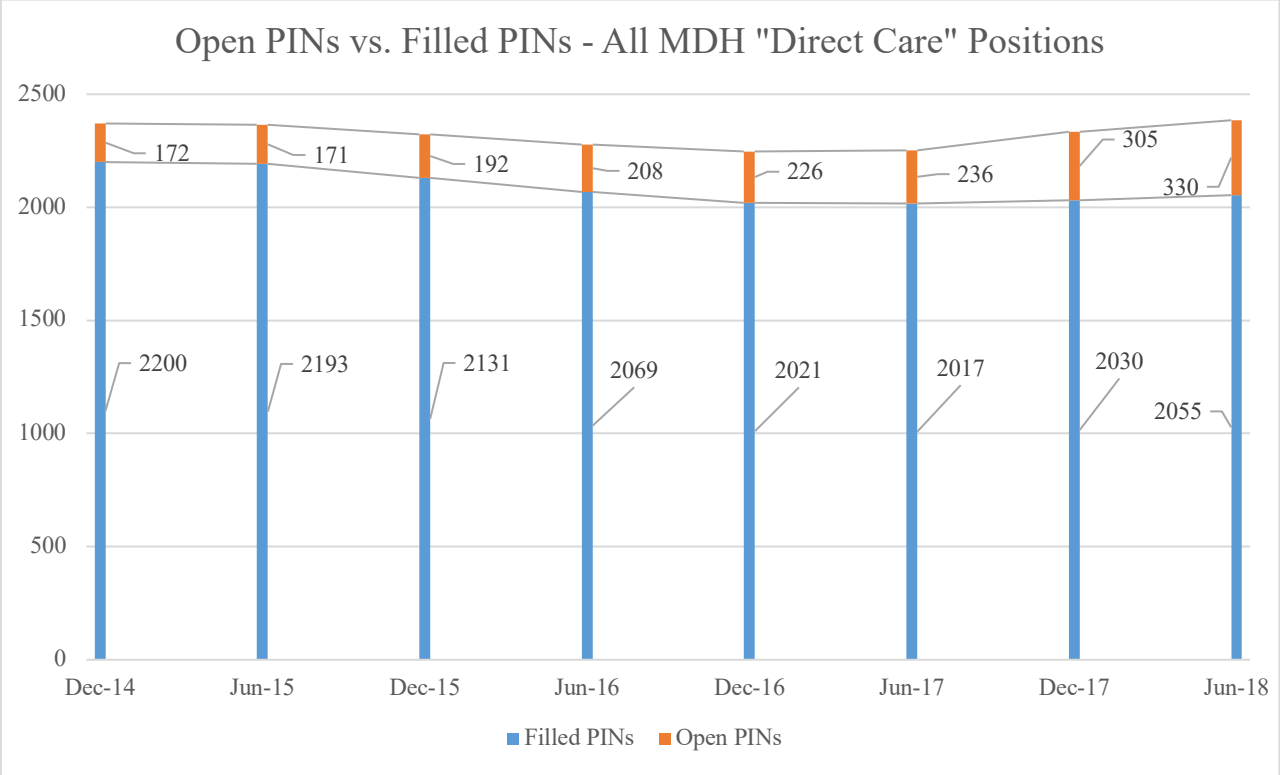
In determining a meaningful time span upon which to establish a trend, OHR concluded that the most reliable data could be pulled from the State's new Workday personnel system, which went live in October 2014. Therefore, the first data point used in this study was December 31, 2014, continuing every 6 months through June 30, 2018 for a total of 8 data points.

VACANCY RATE - TRENDS AND CONCLUSIONS

The vacancy rate trend for direct care positions is depicted in the graphs below:

[1] See Appendix A - Direct Care Classifications Contemplated in OHR Study





From these graphs, we can conclude that although total allocated direct care PINs have modestly increased from December 2014 to June 2018, the number of filled direct care PINs has failed to keep pace. Accordingly, the vacancy rate amongst these positions has risen from 7.25% to 13.84%.

COMPENSATION

State Employee Compensation Generally

At least some of the lag in hiring for direct care classifications in recent years can be attributed to

stagnant wages caused by the lack of across-the-board increment raises ("step increases") and cost-of-living adjustments (COLAs) for all State employees. Increment raises instill a sense of natural progression through one's career, rewarding seniority, experience, and loyalty to one's unit and mission. COLAs serve a different but important function, adjusting salaries to keep up with inflation so that State employees may maintain a consistent standard of living for performing the same work.

The last across-the-board increment raise for State employees was in FY2017, paid on July 1, 2016 or January 1, 2017, depending on the individual employee's entry-on-duty (EOD) date. There were no increment raises in FY2018, and most employees are aware that none are forthcoming in FY2019. Before the increments in FY2017, the last ones were in FY2015.

The last cost-of-living adjustment for State employees was on January 1, 2015. Most employees are aware that there is another 2% COLA set to hit January 1, 2019, with an additional 0.5% COLA and a one-time $500 bonus to follow on April 1, 2019. The April enhancements were triggered by the State's achievement of a particular level of budget surplus for the upcoming year.

Existing Enhancements to Salary Aimed at Recruitment and Retention

In spite of these across-the-board enhancements, salaries for many of the direct care professions have failed to keep pace with those of competing employers in the area. MDH is in direct competition with the likes of the University of Maryland system, the Johns Hopkins system, MedStar Health, LifeBridge Health, Sheppard Pratt Health System, and several faith-based hospital systems in recruiting for skilled and unskilled medical services professionals. Absent the ability to match base salaries for these competing employers, MDH has partnered with the Department of Budget and Management (DBM) to institute several ancillary benefits of employment that can supplement the salaries of those who qualify.

Members of Collective Bargaining Units E (Health Care Professionals) and G (Engineering, Scientific, and Administrative Professionals) are eligible for up to $500 of reimbursement for tuition or training costs in furtherance of an education credential that is reasonably related to the employee's current work or intended career path. To date, 30 employees have taken advantage of the program.

Moreover, members of Bargaining Unit E who perform clinical or administrative functions directly related to the practice of nursing are eligible for a pair of bonus programs. The Registered Nurse Hiring Bonus Program provides for a $1,000 bonus to nurses who begin work in an eligible nursing classification, complete six months of satisfactory employment (i.e. pass their initial probationary period), and receive no disciplinary action beyond a written reprimand. Nurses in the same classifications also may qualify for the Registered Nurse Retention and Attendance Bonus Program, which provides for a $750 quarterly bonus (up to $3,000 annually) for meeting easily-attained performance and attendance criteria. For example, in Q2 2018, over 92% of eligible nurses within MDH qualified for this bonus.

Forthcoming Solutions to Attract and Retain Direct Care Talent

MDH worked with DBM throughout late-2018 to finalize a list of select direct care classifications in which there are consistently elevated rates of vacancy, short tenure, demonstrable difficulties in soliciting applications, and low rates of acceptance of job offers. As part of this analysis, the parties examined the degree to which MDH direct care work is comparable in scope, clientele, and working conditions to those of competing hospital systems. The parties also examined the total

compensation package offered by each system and evaluate the extent to which State benefits and leave packages meet or exceed those offered by the competing systems. The MDH Office of Human Resources also spoke with executive staff and hiring managers at each of its hospitals in order to get a pulse on the compensation and benefits features most coveted by prospective employees.

Overwhelmingly, prospective employees tended to place the highest value on raw total compensation coupled with salary enhancements they viewed as easily attainable. In other words, prospective employees calculated the total compensation package: the sum of raw salary, bonuses, tuition reimbursements, and other enhancements. They then compared that figure to a similar figure for competing employers. As a result, they did not view a bonus program as a means to retain their employment. Rather, they viewed it as a surefire component of their total compensation - one whose absence would quickly find them applying for work at a competing employer.

OHR examined this feedback in conjunction with its data from the Nurse Retention and Attendance Bonus program. It concluded that consistently 90-to-95% of its nurses met the easily-attainable criteria to qualify for the quarterly bonus, and close to 90% received all four quarterly bonuses for a total salary enhancement of $3,000. Noting that the overwhelming majority of its nursing workforce qualified, MDH approached DBM with this data. Together, MDH and DBM entered into "economic reopener" negotiations with AFT Healthcare on the premise that an across-the-board salary enhancement might be more appropriate and less administratively taxing.

Following negotiations to this effect, AFT Healthcare and the State of Maryland entered into a supplemental economic agreement in late December 2018. In addition to a 3% COLA effective July 1, 2019, the other major feature of this agreement was to substitute the two nursing bonuses (so-called "Hiring" and "Retention") and replace them with an Annual Salary Review constituting a one-grade increase in salary for nursing classifications (and a few select others). In essence, the nursing staff are trading easily-attained bonuses for a similarly-valued enhancement to raw salary.

MDH is confident that this will pay dividends for recruitment despite being relatively budget-neutral. For one, MDH can advertise positions on job boards featuring a higher raw salary range. This should entice more "clicks" and, correspondingly, more applications, as the applicants will not have to piece together the features of the bonus programs to understand the total compensation being offered. This will also reward existing employees who no longer have to place restrictions on their leave usage in order to achieve a bonus simply to enhance their raw salary.

Another result of economic reopener negotiations with AFT Healthcare is the creation of a framework for a student loan repayment program for those in qualifying healthcare classifications. Qualifying employees may be eligible for a maximum of $20,000 in student loan repayment assistance over a 10-year period.

In summary, the combination of the COLA and the ASR should bring the Department closer in line with the raw salary figures offered by competing nursing employers, while the student loan repayment program should mimic certain fringe benefits offered by those same employers. The sum-total compensation package for nurses will be greatly enhanced as of July 1, 2019, and should help reduce some of the current nursing recruitment and retention difficulties the Department is currently experiencing.

Please note that as of the date of this letter, negotiations with AFSCME Maryland - Council 3 are incomplete. Though MDH anticipates that certain salary enhancements for non-professional direct

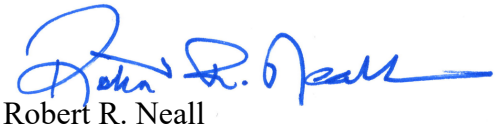
care classifications may result from those negotiations, we cannot comment on the final extent of those enhancements at this time.

CONCLUSION

MDH thanks the Committees for raising the issue of compensation amongst direct care classifications. We look forward to working with the Legislature and our colleagues at DBM to ensure that compensation in these areas of critical need remain competitive in the years to come.

For further information, please contact Webster Ye, Deputy Chief of Staff, at (410) 767-6480 or at webster.ye@maryland.gov.

Sincerely,



Robert R. Neall
Secretary

cc: Sarah Albert, Department of Legislative Services

APPENDIX A
"Direct Care" Classifications Contemplated in OHR Study

Activity Therapy Associate I
Activity Therapy Associate II
Activity Therapy Associate III
Activity Therapy Manager

Art Therapist I
Art Therapist II
Art Therapist Supervisor
Asst Dir Of Nursing Med
Asst Dir Of Nursing Perkins
Asst Dir Of Nursing Psych
CAMH Associate I
CAMH Associate II
CAMH Associate III
CAMH Associate Lead
CAMH Associate Supv
CAMH Specialist I
CAMH Specialist II
Clinical Nurse Specialist Med
Clinical Nurse Specialist Psych
Dance Therapist II
Dental Hygienist III
Dentist III Residential
Dentist III, Residential
Developmental Disabil Assoc
Developmental Disabil Assoc Super
Dir Nursing Med
Dir Nursing Psych
Direct Care Asst I
Direct Care Asst II
Direct Care Trainee
Licensed Clinical A/D Counselor
Licensed Practical Nurse I
Licensed Practical Nurse II
Licensed Practical Nurse III Adv
Licensed Practical Nurse III Ld
Mental Health Assoc III
MH Graduate Professional Counselor
MH Professional Counselor
MH Professional Counselor Adv
Music Therapist I
Music Therapist II
Music Therapist Supervisor
Nursing Education Supervisor
Nursing Education Supervisor Perkins
Nursing Instructor
Nursing Instructor Perkins
Occupational Therapist II
Occupational Therapist III Adv
Occupational Therapist III Lead
Occupational Therapist Institutional
Occupational Therapist Supervisor
Occupational Therapy Asst I
Occupational Therapy Asst II
Physical Therapist II
Physical Therapist III Lead

Physical Therapist Supervisor
Physical Therapy Assistant II
Physician Assistant II
Physician Clinical Specialist
Physician Clinical Staff
Physician Program Manager I
Physician Program Manager II
Physician Program Manager III
Physician Program Manager IV
Physician Supervisor
Psychiatrist Clinical Administrator, MDH Central
Psychiatrist Clinical Graduate, MDH Central
Psychiatrist Clinical Graduate, MDH Rural
Psychiatrist Clinical Manager, MDH Rural
Psychiatrist Clinical, MDH Central
Psychiatrist Clinical, MDH Rural
Psychologist I
Psychologist I Perkins
Psychologist II
Psychologist II Perkins
Psychologist Intern
Psychology Associate Doctorate
Psychology Associate Doctorate Perkins
Psychology Associate I Masters
Psychology Associate III Masters
Psychology Services Chief
Registered Nurse
Registered Nurse Charge Med
Registered Nurse Charge Perkins
Registered Nurse Charge Psych
Registered Nurse Manager Med
Registered Nurse Manager Perkins
Registered Nurse Manager Psych
Registered Nurse Perkins
Registered Nurse Quality Imp Med
Registered Nurse Quality Imp Psych
Registered Nurse Supv Med
Registered Nurse Supv Perkins
Registered Nurse Supv Psych
Resident Associate I Sett
Resident Associate II Sett
Resident Associate Lead Sett
Resident Associate Supervisor Sett
Security Attend I
Security Attend II
Security Attend II Hosp Police
Security Attend III
Security Attend LPN
Security Attend Manager I
Security Attend Manager II
Security Attend Supv

Security Attendant Nursing I,Perkins
Security Attendant Nursing II,Perkins
Social Work Manager, Health Svcs
Social Work Prgm Admin, Health Svcs
Social Work Supv Health Svcs
Social Worker Adv Health Svcs
Social Worker I, Health Svcs
Social Worker II, Health Svcs
Speech Pathologist Audiologist III
Speech Pathologist Audiologist IV
Therapeutic Recreator I
Therapeutic Recreator II
Therapeutic Recreator Supervisor
Therapy Services Mgr I

MARYLAND
Department of Health

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

Office of the Secretary and Other Units Legislative Audit

Written Testimony before the Joint Audit Committee
Tuesday, January 22, 2019

Frederick Doggett, Inspector General

Introduction

Thank you for the opportunity to appear before you to discuss the Office of the Inspector General's (OIG) follow-up work related to the Office of Legislative Audit's (OLA) recent reports on the Maryland Department of Health's (MDH) Office of the Secretary and Medicaid programs.

Upon taking office in January 2018, Secretary Neall established audit compliance as an operational priority within the Department. This "tone at the top" is an important component of the Department's internal control structure that helps to increase accountability among Department managers for audit findings and required corrective actions. The Secretary's emphasis on compliance has also raised the profile of the OIG, putting our office in better position to partner with Department leaders in working to resolve difficult issues. The OIG has also worked to enhance our partnership with OLA. I very much appreciate OLA staff's willingness to identify potential audit issues early in their process and to work with management and the OIG towards effective resolution in the interest of good government.

The OIG's role with regard to OLA reports is twofold. First, our office acts as the MDH liaison with OLA, helping to ensure that MDH programs provide timely and responsive information to OLA auditors as they conduct reviews and develop draft and final reports. The OIG devotes approximately two full-time equivalent positions to these liaison duties. In addition, in early 2018 the OIG created a database for monitoring OLA findings and recommendations, as well as the Department's progress on corrective actions. Since inception of the database, MDH programs have successfully resolved 28 findings and 124 recommendations covering 15 audit reports. As of today, the Department continues to work toward resolution of an additional 32 findings and 75 recommendations from five completed audits. Also, the OIG uses the database to track 12 ongoing OLA audits of various MDH programs.

In addition to its liaison duties, the OIG dedicates a five-person audit team to follow up on OLA's findings. Specifically, once the MDH program reports that its corrective actions are complete, the OIG team tests relevant transactions, reviews documentation, and interviews staff to

independently validate MDH efforts to resolve the findings. The results of our testing are then shared with program managers and MDH leadership so that any remaining corrective steps can be completed.

Status of Corrective Actions: OLA's Office of the Secretary and Medicaid Reports

In the 17 months since OLA issued the two reports discussed at today's hearing, MDH has made significant progress. Based on OLA and OIG follow-up work to date, the OIG concludes that MDH has fully addressed 14 of 32 findings in the original reports. Moreover, MDH managers have put in place corrective actions – including, for example, enhanced processes and controls, revised agreements with other State agencies, and contract solicitations – that should, when fully implemented, resolve an additional 14 findings. In summary, the OIG believes that management's actions are responsive to 28 of the 32 findings, or 88 percent. The findings yet to be resolved are information technology-related and will likely require additional time and resources.

Office of the Secretary

OLA issued its initial report on the Office of the Secretary and Other Units in August 2017. The report contained 17 findings and 49 recommendations. Six of the findings were repeated from OLA's previous report, issued in 2015. Between March and June 2018, OLA performed a follow-up audit on nine of the 17 findings and concluded that MDH corrected four of the nine findings reviewed, including two repeats.

Beginning in October 2018, the OIG conducted follow-up reviews of the remaining open findings and recommendations. We concluded that as of January 2019, MDH resolved six of the original findings, including two repeats. Corrective actions are in place that should resolve an additional eight findings, for a total of 14 out of 17. Details of the OIG's findings, including brief descriptions of ongoing corrective actions, are included as Attachment 1 to this testimony.

Medical Care Programs Administration

OLA issued its initial report on Medical Care Programs Administration (MCPA) in August 2017. The report contained 15 findings and 44 recommendations. Six of the findings were repeated from OLA's previous report, issued in 2015. Between March and June 2018, OLA performed a follow-up audit on eight of the 15 findings and concluded that MDH corrected two of the eight findings reviewed.

Throughout 2018, the OIG conducted follow-up reviews of the remaining open findings and recommendations. We concluded that as of January 2019, MDH has corrected eight of the original 15 findings, including two repeats. Corrective actions are in place that should resolve an

additional six findings, for a total of 14 out of 15. Details of the OIG's findings, including brief descriptions of ongoing corrective actions, are included as Attachment 2 to this testimony.

I am happy to answer any questions.

Attachment 1

OLA Audit of the Office of the Secretary and Other Units (Issued August 2017)
January 2019 Status Update

Summary: OLA's 2017 report included 17 findings; six were repeated from 2015. As of October 2018, OLA determined that four findings had been corrected. Two of the corrected findings were repeat findings. Based on additional actions taken since OLA's last fieldwork, the OIG concludes that six findings are now corrected and that corrective actions for the remaining eleven are ongoing.

Finding Details and Status of Corrective Actions

Finding	Status	Comments
Finding 1 MDH did not provide adequate guidance and oversight regarding 304 Interagency Agreements valued at $329.5 million that MDH administrations entered into with units of State universities.	**Corrective actions implemented. Awaiting testing by OLA**	OLA/OIG concluded in their follow-up review that two of five OLA recommendations have been satisfied. MDH: • Enhanced the standard Interagency Agreement template. • Provided updated procurement training classes to MDH employees
Finding 2 MDH did not establish procedures to ensure that the agencies responsible for administering Interagency Agreements verified that the appropriate services were provided by State universities at agreed upon costs	**Corrective actions implemented. Awaiting testing by OLA**	OLA/OIG follow up - three of four OLA recommendations have been satisfied. MDH: • Implemented a practice of performing evaluations on all MIPAR employees twice annually. • Established a process of examining invoices biweekly to reconcile approved time sheets. • Has began the process of eliminating all MIPAR position in the future.
Finding 3 MDH did not always comply with State procurement requirements requiring the award of sole source and emergency contracts.	**Corrective actions implemented. Awaiting testing by OLA**	OLA concluded that two of four OLA recommendations were satisfied. The OIG concluded that one additional recommendation was satisfied since OLA's follow-up. MDH: • Established training classes for employees on sole source and emergency contracts.

Attachment 1

		• Ensures that only accurate information is permitted to be directed to BPW and that any required amendments are mitigated timely
Finding 4 MDH did not have a formal monitoring procedure to ensure that it consistently complied with publication requirements for service and information technology awards.	**Corrective actions implemented. Awaiting testing by OLA**	OLA made one recommendation. The OIG concluded that MDH is still working on corrective actions to resolve this finding. MDH: • MDH has established new Contract Award Evaluation Committee procedures and has established a Procurement Transaction Signature/Approval Checklist requiring relevant documentation in procurement files and supervisor's review of such documentation. • MDH has provided mandatory training on contract monitoring to all procurement personnel.
Finding 5 MDH did not always comply with State procurement regulations with respect to bidding requirements and retention of critical procurement documentation.	**Confirmed corrected by OLA**	OLA made five recommendations and determined in their follow-up review that MDH has taken corrective actions to resolve this finding.
Finding 6 Supervisory oversight of federal fund reimbursement requests was not always effective. (REPEAT)	**Confirmed corrected by OLA**	OLA made two recommendations and determined during their follow-up review that MDH has taken corrective actions to resolve this finding.
Finding 7 OIG has not audited certain private providers for more than five years and did not always conduct private provider audits in a comprehensive manner. (REPEAT)	**Confirmed corrected by OLA & DBM**	OLA made two recommendations and deemed this finding corrected at their follow-up review. OIG: • Developed several internal monitoring and tracking schedules to ensure that future audits are developed in a timely and comprehensive manner.
Finding 8 OIG did not have a formal process for oversight and monitoring to ensure corrective actions were taken by both LHDs and private providers.	**Confirmed corrected by DBM**	OLA made one recommendation. DBM auditors reviewed OIG's corrective actions and deemed this finding corrected. OIG:

Attachment 1

		• Established a formal process to actively monitor providers' corrective actions taken to address their audit findings.
Finding 9 Sensitive personally identifiable information within NEDSS database and HMIS data file was stored without adequate safeguards.	**Confirmed corrected by OLA**	OLA made one recommendation which they deemed corrected during their follow-up review. MDH: • Implemented the encryption of sensitive personally identifiable information within NEDSS database and HMIS data file.
Finding 10 Network access to critical MDH internal network devices was not properly restricted, intrusion detection prevention system coverage was not complete or adequate, and certain wireless connections were not configured securely. (REPEAT)	**Corrective actions in process**	OLA/OIG follow-up review - two of five recommendations have been satisfied. MDH: • Configured its firewall to properly protect all critical network devices and confirmed that all inbound and outbound traffic are monitored at Headquarters and Springfield Hospital Center.
Finding 11 Malware protection for MDH computers was not sufficient to provide OIT with adequate assurance that these computers were properly protected. (REPEAT)	**Corrective actions in process**	OLA/OIG follow-up review – MDH is still in progress of implementing three OLA recommendations made. MDH: • Currently conduct reviews that identify computers whose patches are outdated • OIT managed computer vulnerable software products are being periodically patched with exceptions.
Finding 12 Information technology contractors had unnecessary network-level access to the MDH network.	**Corrective actions in process**	OLA made two recommendations which OIG concluded are still in progress during their follow-up review. • Implemented a new internal control approval policy for their on-site contractors at Headquarters to grant new contractors six months access which is renewable upon request.
Finding 13 Controls were not established to ensure collections were properly accounted for, deposited and secured.	**Corrective actions implemented.**	OIG concluded in their follow-up review that three of five recommendations have been implemented. MDH:

Attachment 1

	Awaiting testing by OLA	• Implemented five corrective actions. MDH has taken steps to ensure that deposit verification are performed by the Chief or Deputy Chief of General Accounting, both of whom do not handle or record collections. • Implemented procedures that secure the Department's mail from unauthorized access
Finding 14 MDH did not adequately pursue collection of certain Division of Cost Accounting and Reimbursement delinquent accounts receivable. (REPEAT)	**Corrective actions implemented. Awaiting testing by OLA**	OLA made one recommendation. MDH has implemented some corrective actions to resolve the finding. OIG determined during their follow-up review that the corrective actions are still in progress. MDH: • Implemented a new procedure to ensure that accounts receivable is adequately pursued for collection by mailing billing statements on a monthly basis and requiring field office supervisor review. • Established new procedures that require field supervisors to complete an attestation confirming their review of accounts appearing on aging reports.
Finding 15 Overtime earned by certain Secure Evaluation and Therapeutic Treatment Program employees for an extended period appeared questionable and was not investigated.	**Corrective actions implemented. Awaiting testing by OLA**	OLA made two recommendations. OIG concluded in their follow-up review that corrective actions are still in progress. MDH • Implemented a new overtime voucher and approval process for certain Secure Evaluation and Therapeutic Treatment Program Units (nursing, Residential, and Police).
Finding 16 MDH did not comply with certain corporate purchasing card requirements relating to the sharing of cards and certain purchasing activities.	**Confirmed corrected by OIG**	OLA made three recommendations, and OIG determined that corrective actions have been implemented to resolve this finding. MDH: • Limited to use of corporate purchasing card to only three DGA staff.

Attachment 1

Finding 17 MDH physical inventory procedures did not comply with certain DGS requirements. (REPEAT)	**Corrective actions implemented. Awaiting testing by OLA**	OLA made three recommendations. OIG determined during their follow-up review that corrective actions are still in progress to resolve this finding. MDH: • Completed a comprehensive physical inventory and adopted new procedures for monitoring inventory controls and investigating missing/stolen items. • Supplied its units with Radio-frequency Identification (RFID) scanners to efficiently conduct physical inventories, report, and identify missing items expeditiously.

Attachment 2

OLA Audit of Medical Care Programs Administration (Issued August 2017)
January 2019 Status Update

Summary: OLA's 2017 report included 15 findings; six were repeated from 2015. As of November 2018, OLA determined that two findings had been corrected. Based on additional actions taken since OLA's last fieldwork, the OIG concludes that eight findings are now corrected and that corrective actions for the remaining seven are ongoing.

Finding Details and Status of Corrective Actions

Finding	Status	Comments
Finding 1 MCPA did not assign a temporary enrollment status to 11,153 new enrollees, resulting in delays in placing individuals in MCOs.	**Confirmed corrected by OLA**	OLA made two recommendations and determined in their follow-up review that corrective actions have been taken to resolve this finding.
Finding 2 The current MOUs with DHS and MHBE are not sufficient to ensure that eligibility determinations are timely and proper. (REPEAT)	**Corrective actions implemented. Awaiting testing by OLA**	OLA made four recommendations. OIG determined in their follow up that these recommendations are still in progress.
Finding 3 MCPA did not take timely follow-up action on questionable enrollee eligibility information it identified and did not ensure that critical eligibility information was properly recorded on MMIS II. Our test disclosed certain overpayments.	**Corrective actions implemented. Awaiting testing by OLA**	OLA concluded that four of eight recommendations have been satisfied. The OIG concluded that two additional recommendations have been addressed since OLA's last fieldwork. MCPA: • Worked with local health departments to process 2,219 of the 4,851 cases identified by OLA with missing social security numbers. The remaining cases did not require an SSN to initially enroll in Medicaid. • Continues to work with DHS to reduce the number and age of overdue redeterminations. By August 2018, the number of overdue redeterminations (overdue by more than 60

		days) was reduced by approximately 92 percent, from 64 to five.
Finding 4 MCPA did not take timely action to ensure recipients age 65 or older had applied for Medicare as required by State regulations. (REPEAT)	**Corrective actions implemented. Awaiting testing by OLA**	OLA made two recommendations. MCPA continues to take corrective action to resolve this finding. MCPA: • Established new standard operating procedures and generates reports monthly identifying active recipients age 65 and older who are not enrolled in Medicare. • Sends letters to Medicaid recipients turning 65. MCPA • Began submitting monthly reports to DHS identifying active recipients age 65 and older who are not enrolled in Medicaid in October 2017 for follow-up and corrective action. • Monitors DHS's efforts by re-running the report every 90 days, to determine the status of the previously identified recipients. • Sent 271 letters in June, and immediately disenrolled 256 recipients from HealthChoice. • Analyzed the results of the new procedures in September 2018 and identified 128 of the 271 (47 percent) recipients had enrolled in Medicare as a result of the letter. In addition, nine were identified in the excepted group. 134 (50 percent) were disenrolled/closed from Medicaid as a result of not enrolling in Medicare.
Finding 5 MCPA did not ensure that all reports of potential third-party health insurance for Medicaid recipients were received and properly investigated in a timely manner. (REPEAT)	**Confirmed corrected by OLA**	OLA initially reported this finding as resolved; however, based on their recent audit review, OLA has indicated that they may reach a different conclusion.
Finding 6 MCPA did not always assess damages against its MCO enrollment broker which continuously failed to meet minimum enrollment levels required by the contract. (REPEAT)	**Confirmed corrected by OIG**	Effective October 2017 MCPA will no longer be responsible for the contract with the MCO enrollment broker or assessing damages. MHBE will be responsible.

Attachment 2

Finding 7 MCPA has not conducted required audits of hospital claims processed since calendar year 2007. (REPEAT)	**Corrective actions implemented. Awaiting testing by OLA**	OIG: • Expects to award a new RAC contract by January 2019. • Has developed a plan to resolve the audit backlog.
Finding 8 MCPA did not adequately monitor the vendors responsible for conducting credit balance audits and utilization reviews of long-term care facilities and/or hospitals.	**Corrective actions implemented. Awaiting testing by OLA**	OLA made 2 recommendations and determined during their follow-up review that one of the recommendations have been corrected. MCPA: • Drafted a new RFP that will better define the deliverables, as well as penalties for non-performance, for subsequent vendors.
Finding 9 MCPA did not monitor the ASO to ensure that deficiencies noted during provider audits conducted by the ASO were corrected and related overpayments were recovered.	**Confirmed corrected by OIG**	OLA made one recommendation and determined that corrective actions have been implemented to resolve this finding. MCPA: • Implemented and is using a "tracker" to capture all audit information.
Finding 10 MCPA did not ensure the ASO resolved rejected behavioral health claims timely, resulting in the payment of potentially improper claims and the loss of federal fund reimbursements.	**Confirmed corrected by OLA**	OLA made three recommendations and determined in their follow-up review that corrective actions have been taken to resolve this finding.
Finding 11 Access controls over the ASO's servers hosting the portal and the web-server software were inadequate, intrusion detection prevention system coverage did not exist for encrypted traffic, and sensitive PII was stored without adequate safeguards. (REPEAT)	**Corrective actions implemented. Awaiting testing by OLA**	OLA determined that one of three recommendations was implemented; the OIG subsequently concluded that one more recommendation had been satisfied. MCPA: • Began the implementation of the IDPS along with FireEye network threat prevention solution in April 2018. Projected date for full configuration and implementation: 12/31/18.
Finding 12 MCPA did not ensure that the former DBA was properly administering the dental benefits program and was conducting required provider audits, and did not ensure bank accounts were reconciled, and sensitive data were secured.	**Confirmed corrected by OIG**	MCPA: • Assigned additional staff to provide expanded oversight, including tracking and monitoring. • Begun resolving outstanding claims within the timeframe required for federal reimbursement.

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		• Developed a detailed audit plan, including steps for resolving audit findings. • Begun properly performing bank reconciliations. • Ensured SOC 2 Type 2 reviews are completed annually.
Finding 13 Sensitive PII within the EDITPS database was stored and transmitted without adequate safeguards, and MCPA did not remediate 20 of the 21 reported security vulnerabilities identified in a consultant's report on EDITPS.	**Corrective actions in process**	MCPA implemented two of five recommendations. OIG in their follow up review determined that one additional recommendation was implemented. Two recommendations are still in progress. MCPA: • Is in discussion with DoIT and has developed a statement of work to request resources to implement this recommendation and resolve the audit finding.
Finding 14 MCPA did not obtain documentation to support labor and overhead charges invoiced by UMBC, representing 72 percent of amounts billed during fiscal year 2015 under the agreement.	**Confirmed corrected by OIG**	MCPA: • Established procedures to monitor cost and verify supporting documentation to the invoices billed by UMBC. • Receives, in lieu of timesheets, an account document of labor charges from UMBC allocating each employee's salary and fringe benefits to the programs billed.
Finding 15 MCPA did not authorize UMBC to transmit sensitive Medicaid protected health information to a third-party vendor for data storage and did not ensure UMBC executed a data-sharing agreement with this vendor as required by federal regulation.	**Confirmed corrected by OIG**	MCPA: • Documented its agreement between UMBC and third-party contractors. • Entered in to a BAA as required.