Audit Report

Maryland Department of Health
Medical Care Programs Administration

May 2026

Public Notice

In compliance with the requirements of the State Government Article Section 2-1224(i), of the Annotated Code of Maryland, the Office of Legislative Audits has redacted cybersecurity findings and related auditee responses from this public report.

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Victoria L. Gruber
Executive Director

Brian S. Tanen, CPA, CFE
Legislative Auditor

DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF LEGISLATIVE AUDITS
MARYLAND GENERAL ASSEMBLY

May 20, 2026

Senator Shelly L. Hettleman, Senate Chair, Joint Audit and Evaluation Committee
Delegate Jared Solomon, House Chair, Joint Audit and Evaluation Committee
Members of Joint Audit and Evaluation Committee
Annapolis, Maryland

Ladies and Gentlemen:

We have conducted a fiscal compliance audit of the Maryland Department of Health (MDH) – Medical Care Programs Administration (MCPA) for the period beginning April 1, 2022 to March 31, 2025. MCPA administers the Medical Assistance Program (Medicaid), which provides health care benefits to eligible Maryland residents. This audit includes MCPA's primary functions such as monitoring of recipient and provider eligibility, the Medicaid Management Information System (MMIS II) security and controls, third party insurance recoveries, and payments for Medicaid recipients in hospitals, nursing facilities, in-home and community-based settings, and dental services. This activity accounted for approximately $5.4 billion of the $16.7 billion in MCPA expenditures for fiscal year 2025.

Our audit disclosed that MCPA did not ensure that issues identified with Medicaid eligibility determinations were corrected and that annual eligibility determinations were completed timely, potentially resulting in payments on behalf of ineligible individuals. For example, MCPA paid $2.3 million for 152 recipients who did not have required support of income and citizenship eligibility or were ineligible based on the documentation provided. In addition, MCPA did not ensure that Medicaid recipients age 65 or older had applied for Medicare, potentially resulting in the State paying for services that should have been covered by the federal government.

Our audit also disclosed that MCPA did not have effective processes to identify, prevent, and recover questionable Medicaid payments including $9.2 million in

payments on behalf of recipients who were incarcerated or deceased at the time of service. In addition, MCPA did not ensure that changes to recipient eligibility information were processed timely and accurately. MCPA also did not ensure that referrals of potential third-party health insurance information were investigated and recorded in MMIS II, which could result in MCPA improperly paying claims that should have been paid by a third-party. Similar conditions were noted in one or more prior audit reports but were not corrected.

Our audit further disclosed that MCPA did not ensure that continued stay reviews (CSRs) were conducted to verify that recipients in nursing facilities required the level of care provided and ultimately billed to Medicaid, a condition noted in our two preceding audit reports dating back to November 2019 but not sufficiently corrected. Specifically, we noted that CSRs were not completed for 4,425 recipients during calendar year 2024, resulting in a lack of assurance that the associated payments totaling $338.3 million were proper.

Our audit also included our review of an allegation received on our fraud, waste and abuse hotline which disclosed that MCPA did not approve home and community-based plans of service timely, resulting in numerous recipients not receiving required services and payments for services that were no longer medically necessary. For example, our review of 20 recipients' plans of service disclosed that the untimely approval resulted in 5 recipients not receiving critical services such as environmental adaptations and payments totaling $430,000 for services provided to 12 recipients that were not medically necessary.

Our audit also disclosed that MCPA did not ensure that all Community First Choice (CFC) program recipients received nurse monitoring visits to verify that they received personal assistance services in accordance with their service plans, including 365 recipients who were between 1 and 4.6 years overdue for a visit. MCPA also did not audit Medical Day Care and Supports Planning providers in accordance with its policy. Similar conditions were commented upon in our two preceding audit reports dating back to November 2019 but were not sufficiently corrected.

In addition, our audit disclosed that MCPA did not ensure that vendor employees with access to PII and PHI obtained criminal background checks as required by the contracts. Finally, MCPA did not have procedures to reconcile Medicaid expenditures recorded in MMIS II with the State's accounting records. As a result, MCPA did not detect that fiscal year 2023 and 2024 expenditures totaling $200.9 million were not recorded in MMIS II.

Furthermore, our audit disclosed a cybersecurity-related finding. However, in accordance with the State Government Article, Section 2-1224(i) of the Annotated Code of Maryland, we have redacted the finding from this audit report. Specifically, State law requires the Office of Legislative Audits to redact cybersecurity findings in a manner consistent with auditing best practices before the report is made available to the public. The term "cybersecurity" is defined in the State Finance and Procurement Article, Section 3.5-301(c), and using our professional judgment we have determined that the redacted finding falls under the referenced definition. The specifics of the cybersecurity finding were previously communicated to those parties responsible for acting on our recommendations.

In our preceding audit report, dated November 2, 2023, we reported that MCPA's accountability and compliance level was unsatisfactory in accordance with the rating system we established in conformity with State law. Based on the results of our current audit, we have concluded that MCPA's accountability and compliance level remains unsatisfactory. The primary factors contributing to the unsatisfactory rating were the significance of our audit findings and the number of repeat findings.

MDH's response to this audit, on behalf of MCPA, is included as Appendix B to this report. Consistent with State law, we have redacted the elements of MDH's response related to the cybersecurity audit finding. In accordance with State law, we have reviewed the response and, while MDH generally agrees with the recommendations in this report, we identified certain instances in which statements in the response disagree or appear to be inconsistent with a report finding and recommendation. In each instance, we reviewed and reassessed our audit documentation, and reaffirmed the validity of our finding.

In accordance with generally accepted government auditing standards, we have included general "auditor's comments" in Appendix A and within MDH's response to explain our position. We will advise the Joint Audit and Evaluation Committee of any outstanding issues that we cannot resolve with MDH.

We wish to acknowledge the cooperation extended to us during the audit by MCPA.

Respectfully submitted,

Brian S. Tanen

Brian S. Tanen, CPA, CFE
Legislative Auditor

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

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Background Information

Agency Responsibilities and Audit Scope

The Maryland Department of Health (MDH) Medical Care Programs Administration (MCPA) administers Medicaid, a joint federal and state entitlement program for low-income individuals (recipients). The program is administered by the states, which are required to provide healthcare coverage to all applicants who meet the program's eligibility criteria. In its capacity as Maryland's administering agency, MCPA is responsible for enrolling healthcare providers (such as physicians), establishing program regulations, setting provider payment rates, reviewing and paying provider claims, and obtaining federal reimbursement for eligible costs. MDH has agreements with the Department of Human Services (DHS) and the Maryland Health Benefit Exchange (MHBE) delegating its responsibility to them for Medicaid recipient eligibility determinations.

According to State records, MCPA's fiscal year 2025 expenditures totaled approximately $16.7 billion, including $10 billion that was federally funded (see Figure 1). During the period of June 30, 2022 through June 30, 2025, MCPA had vacancy rates that ranged from 13.0 percent to 15.3 percent. As of June 30, 2025, approximately 15.3 percent of the total 678 positions were vacant. These vacancies may have contributed, at least in part, to the findings in this report.

Figure 1
MCPA Positions, Expenditures, and Funding Sources

Full-Time Equivalent Positions as of June 30, 2025	
	Positions
Filled	574
Vacant	104
Total	**678**

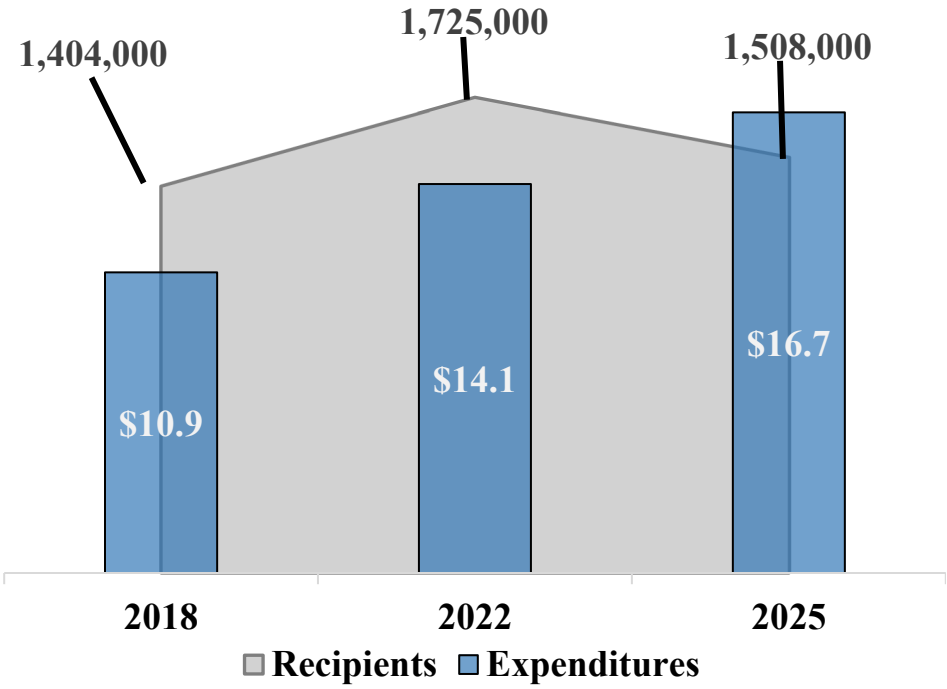
Fiscal Year 2025 Expenditures	
	Expenditures
Salaries, Wages and Fringe Benefits	$ 78,445,266
Technical and Special Fees	4,976,563
Operating Expenses	16,641,281,640
Total	**$ 16,724,703,469**

Fiscal Year 2025 Funding Sources	
	Funding
General Fund	$ 5,687,257,302
Special Fund	822,782,161
Federal Fund	10,059,499,536
Reimbursable Fund	155,164,470
Total	**$ 16,724,703,469**

Source: State financial and personal records

The vast majority of these expenditures related to services provided to the 1.5 million Maryland Medicaid recipients as of June 30, 2025 (see Figure 2). During the audit period there was a decrease in Medicaid recipients, due primarily to the end of the COVID-era continuous enrollment policy and resumption of normal eligibility redeterminations, which resulted in many recipients being disenrolled because they no longer met eligibility requirements.

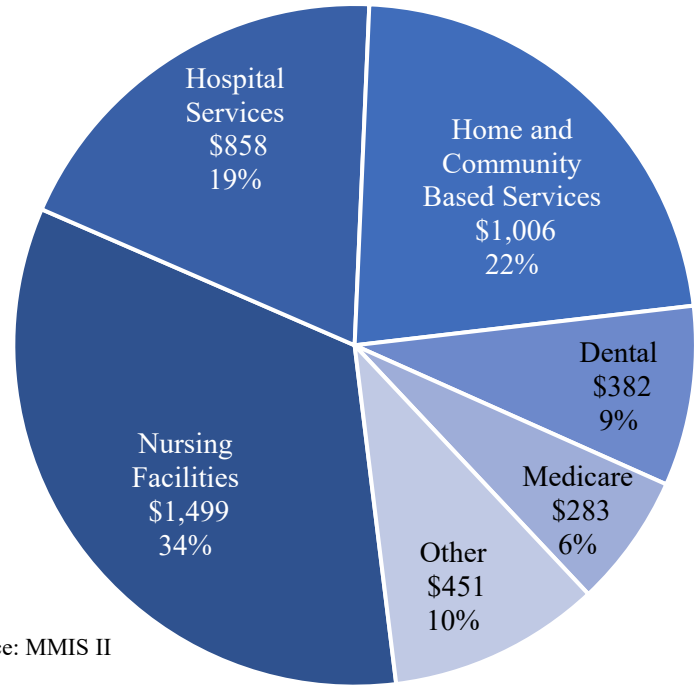
Figure 2
MCPA Medicaid Expenditures and Recipients
(Fiscal Years 2018 to 2025)



Source: State accounting records, MCPA records

The scope of this audit included MCPA's primary administrative functions. These functions accounted for $5.4 billion in fiscal year 2024 expenditures including $4.5 billion processed in MCPA's Medicaid Management Information System (MMIS II) (see Figure 3) and $920.3 million processed outside of MMIS II. In addition, we reviewed procedures and controls over activities that would impact all MCPA expenditures including MCPA's monitoring of MMIS II security and controls, recipient and provider eligibility, and third-party insurance recoveries.

Figure 3
Fiscal Year 2024 Medicaid Expenditures Processed via MMIS II by Service Type ($ in millions)



Source: MMIS II

We conduct several other audits that cover other Medicaid activities including MCPA's Managed Care Program, MCPA's monitoring of the Behavioral Health Administration's Administrative Service Organization, MCPA's Pharmacy Services, and MDH Office of the Secretary and Other Units [see Exhibit 1].

Unfunded Liabilities to the Federal Government

In our December 18, 2025 special report on *Statewide Review of Budget Closeout Transactions for Fiscal Year 2025*, we noted that MDH reported unfunded federal liabilities at the end of fiscal year 2025 totaling approximately $52 million[1] for which State general funds may be needed. Specifically, MDH reported a $27.3 million liability related to enhanced rates paid during fiscal year 2025 to Maryland Medicaid nursing facilities that were not approved by the federal

[1] The *Closeout* report identified total potential liabilities to the federal government of approximately $280.9 million as of June 30, 2025, which also included $228.9 million in unprovided for payables for expenditures that exceeded the appropriation plus disallowed federal fund claims related to MDH's Developmental Disabilities Administration.

government. In July 2025, the Centers for Medicare and Medicaid Services notified MDH that it would need to return federal funds obtained based on the unapproved rates. MDH determined that the disallowance totaled $89.7 million, which exceeded the available remaining general fund appropriation in fiscal year 2025 by $27.3 million.

MDH also reported a potential $24.7 million liability related to enhanced funding received under MCPA's Money Follows the Person (MFP) program. The State obtained federal funds covering 75 percent of its MFP expenditures instead of the more traditional 50 percent federal funding arrangement used in many other federal assistance programs. The additional 25 percent in enhanced federal reimbursements is required to be spent on additional MFP program expenditures. As noted in our last five *Statewide Review of Budget Closeout Transactions* reports dating back to fiscal year 2021, MDH has continuously not spent the enhanced funding on qualified MFP program expenditures resulting in a potential liability. MDH has until September 30, 2027 to spend these savings on MFP program expenditures or the funds will need to be returned to the federal government.[2]

Referral to Our Fraud, Waste, and Abuse Hotline

We received a referral to our fraud, waste, and abuse hotline that recipients were not approved for home and community-based services timely, resulting in significant delays in recipients receiving services. Based on our review, we were able to substantiate the allegation and identified certain deficiencies that require action by MCPA as further described in Finding 7. Our review did not identify any matters that warranted a referral to the Office of the Attorney General's Criminal Division.

Status of Findings from Preceding Audit Report

Our audit included a review to determine the status of the 10 findings contained in our preceding audit report dated November 2, 2023. See Figure 4 for the results of our review.

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

[2] The date to spend these savings was extended from September 2025 to September 2027 based on the federal Consolidated Appropriations Act, 2023.

remains unsatisfactory. The primary factors contributing to the current unsatisfactory rating were the significance of audit findings and the number of repeated findings.

Figure 4
Status of Preceding Findings

Preceding Finding	Finding Description	Implementation Status
Finding 1	MCPA did not ensure that all referrals of potential third-party health insurance information were investigated and recorded in the Medicaid Management Information System (MMIS II), which could result in MCPA improperly paying claims that should have been paid by a third party.	**Repeated** (Current Finding 5)
Finding 2	MCPA did not have effective processes to identify, prevent, and recover questionable Medicaid payments, including $7.1 million in payments on behalf of incarcerated and deceased recipients.	**Repeated** (Current Finding 3)
Finding 3	MCPA did not ensure that changes to recipient Medicaid eligibility information were processed timely and accurately.	**Repeated** (Current Finding 4)
Finding 4	MCPA had not established adequate oversight to ensure that all Community First Choice (CFC) program recipients received personal assistance services in accordance with their plans of services.	**Repeated** (Current Finding 8)
Finding 5	MCPA did not monitor the utilization control agent contractor to ensure continued stay reviews of Medicaid recipients receiving services from nursing facilities were performed timely.	**Repeated** (Current Finding 6)
Finding 6	MCPA did not have an established process to ensure costly recipient ventilator care claims submitted by nursing facilities were valid, as required by State regulations.	Not Repeated
Finding 7	MCPA did not conduct the required audits of Medical Day Care (MDC) and Supports Planning providers, and the related audit policy and procedures were not sufficiently comprehensive.	**Repeated** (Current Finding 9)
Finding 8	MCPA did not adequately monitor the hospital claims audit contractor and had not collected or recovered improper claims identified by the contractor totaling $6.9 million.	Not Repeated

Figure 4 Status of Preceding Findings		
Preceding Finding	**Finding Description**	**Implementation Status**
Finding 9	Redacted cybersecurity-related finding.[3]	Status Redacted[3]
Finding 10	Redacted cybersecurity-related finding.[3]	Status Redacted[3]

[3] The finding description as well as the implementation status of this cybersecurity-related finding have been redacted for the publicly available report in accordance with State Government Article, Section 2-1224(i) of the Annotated Code of Maryland.

Findings and Recommendations

Recipient Eligibility

Background

The Medical Care Programs Administration (MCPA) has agreements with both the Maryland Health Benefit Exchange (MHBE) and the Department of Human Services (DHS) delegating responsibility for Medicaid eligibility determinations and redeterminations. MHBE is responsible for processing income-based determinations via the Maryland Health Connection (MHC) and DHS is responsible for processing non-income based determinations (such as, for applicants applying for other DHS benefits such as disability or Temporary Cash Assistance) via its web-based Eligibility and Enrollment (E&E) System. Applications that are rejected or flagged by MHBE are forwarded to DHS or MDH for additional processing and review. According to MCPA records, approximately 1.5 million individuals were enrolled in Medicaid as of June 30, 2025.

MCPA has several automated and manual processes to monitor MHBE and DHS eligibility determinations to identify questionable Medicaid activity including recipients who are incarcerated, deceased, missing social security numbers, or are receiving benefits in another state. Instances of questionable recipient eligibility information or activity are to be investigated and resolved by DHS or the Local Health Departments (LHDs) upon referral from MCPA, or in-house by MCPA employees. MCPA is responsible for overseeing the resultant investigative efforts to ensure the proper corrective actions were taken, such as removing eligibility for continued participation in Maryland's Medicaid program or recovering erroneously paid benefits.

Finding 1
MCPA did not ensure that issues identified with Medicaid eligibility determinations were corrected and that DHS and MHBE conducted timely eligibility redeterminations, potentially resulting in payments on behalf of ineligible individuals.

Analysis

MCPA did not ensure that issues identified with Medicaid eligibility determinations were corrected and that DHS and MHBE conducted timely eligibility redeterminations, potentially resulting in payments on behalf of ineligible individuals.

- MCPA did not ensure that DHS and the LHDs corrected issues identified during its quarterly review of initial eligibility determinations. Specifically, MCPA notified DHS and the LHDs of the issues identified but did not follow up to ensure they were corrected. Our analysis of 4 MCPA quarterly eligibility reviews during calendar years 2023 and 2024 disclosed that 306 of the 993 issues identified by MCPA were still not resolved as of May 2025. As a result, MCPA potentially paid for services provided to individuals who were ineligible for Medicaid. For example, MCPA paid approximately $2.3 million in calendar year 2024 for 152 recipients for whom the review disclosed did not have required support of income and citizenship eligibility or were ineligible based on the documentation provided.

- MCPA did not ensure that MHBE and DHS conducted annual eligibility redeterminations for all recipients as required by federal regulations. In response to our inquiries, MCPA obtained a report from the DHS E&E system as of October 2025 which identified 1,950 recipients that had not received an annual eligibility redetermination between December 2023 and September 2025. MCPA paid claims totaling approximately $7.1 million for 546 of these recipients after their respective redetermination due date. While MCPA advised that MHBE's MHC system would automatically disenroll recipients if a redetermination was not performed, it could not provide a similar report from MHBE to support this assertion.

Recommendation 1
We recommend that MCPA ensure that

a. issues identified with initial eligibility determinations, including those noted above, are timely resolved by DHS and the LHDs; and

b. DHS and MHBE conduct required annual redeterminations and take appropriate action when redeterminations are not completed, including those noted above.

Finding 2
MCPA did not ensure that recipients age 65 or older applied for Medicare, as required by State regulations.

Analysis
MCPA did not ensure Medicaid recipients age 65 or older had applied for Medicare. State regulations require Medicaid applicants age 65 years or older to furnish proof that they have applied for or are receiving Medicare. While applicants who enroll in Medicaid through MHBE are automatically disenrolled once they turn 65, applicants who enroll through DHS need to be manually

reviewed. MCPA management advised that it discontinued a process to ensure that manual reviews were performed by DHS to focus on other priorities during our audit period.

According to MCPA records, during calendar year 2024, MCPA paid claims totaling approximately $145 million for 4,873 recipients who were not enrolled in Medicare despite being potentially eligible based on their coverage group and age. Our test of 10 of these recipients with claims totaling approximately $1.9 million[4] disclosed that MCPA could not readily determine whether 6 recipients had applied for Medicare. According to MCPA records, calendar year 2024 Medicaid claims for these 6 recipients totaled approximately $1.3 million.

Timely enrollment in Medicare is significant because Medicare is federally funded while Medicaid costs are partially paid with State funds. Furthermore, providers must submit claims for Medicare reimbursement before submitting the claims for Medicaid reimbursement, which generally covers the Medicare coinsurance (normally 20 percent) and deductibles. Consequently, the amounts paid on fee-for-service claims by Medicaid for recipients who are dually eligible for Medicare and Medicaid are generally less than the amounts paid for recipients who only have Medicaid.

Recommendation 2
We recommend that MCPA ensure recipients age 65 or older have applied for Medicare, as required by State regulations.

Finding 3
MCPA did not have effective processes to identify, prevent, and recover questionable Medicaid payments including $9.2 million in payments on behalf of recipients who were incarcerated or deceased at the time of service.

Analysis
MCPA did not have effective processes to identify, prevent, and recover questionable Medicaid payments on behalf of incarcerated or deceased recipients.

Fee-for-Service Payments for Incarcerated Recipients
MCPA did not have an effective process to identify, prevent, and recover fee-for-service payments on behalf of incarcerated recipients. Under federal and State

[4] We selected 10 recipients over the age of 65 and who were included in a coverage group receiving supplemental security income or were medically-needy, with the most material claims during calendar year 2024.

regulations, Medicaid only covers certain fee-for-service claims (primarily inpatient hospital care) while a recipient is incarcerated.[5]

Our Data Analytics Unit independently obtained incarceration records[6] from the Maryland Department of Public Safety and Correctional Services (DPSCS) and matched this data to Medicaid Management Information System (MMIS II) claims paid between May 2022 and January 2025. The review identified $6.4 million in payments for 2,397 recipients who were incarcerated at the time of service including 1,042 incarcerated individuals that were also identified during our prior audit. Although MCPA performed weekly matches to DPSCS incarceration data, the matches did not identify 908 of the aforementioned 2,397 recipients for whom MCPA paid $1.7 million. In addition, MCPA did not correct 1,489 recipients identified by its matches for whom MCPA paid $4.7 million.

A similar condition was commented upon in our preceding audit report and in our June 23, 2020 performance audit report of *MDH's Efforts to Identify and Analyze Improper Medicaid Payments*. MDH's response to our prior report, on behalf of MCPA, indicated that it would establish a process to identify, prevent, and recover improper payments on behalf of incarcerated recipients by March 2024. MCPA could not readily explain why these recipients were not identified and/or investigated to prevent future payments.

Payments on Behalf of Deceased Recipients

MCPA did not ensure certain recipients reported as deceased were investigated and removed from Medicaid in a timely manner. MCPA performed a monthly match of Medicaid recipient records to the federal Social Security Administration and MDH Vital Statistics Administration (VSA) death records. Recipient records that are exact matches to death records are automatically disenrolled. MCPA forwarded the remaining match results to DHS and the LHDs to investigate the matches and disenroll any deceased recipients from Medicaid within 30 days in accordance with MDH's standard operating procedures. Our review of MCPA records disclosed that 7,851 (56 percent) of the 14,146 recipients reported as deceased between April 2024 and March 2025 had not been investigated as of April 2025, including 4,006 recipients reported as deceased over six months earlier. MCPA advised that it was aware that these cases were not resolved within the required timeframe but did not track the status of these cases and could not document any follow-up with DHS and the LHDs.

[5] These individuals' healthcare costs are generally paid by DPSCS.

[6] The data we obtained from DPSCS covered the period between July 2017 and March 2025 and included the periods of incarceration based on dates of inmate intake, transfer, and release.

MCPA also did not identify and investigate payments with a date of service after the recipient's date of death. We performed a match between MMIS II claims with service dates between May 2022 and December 2024 and the VSA death records as of May 2025. Our match identified 18,086 claims totaling $2.8 million (associated with 4,510 recipients) for services after the recipient's reported date of death. At our request, MCPA investigated 35 of these recipients[7] and determined that 30 recipients with claims totaling $458,000 were deceased prior to the medical service represented by the claims. As of December 2025, MCPA advised that it had recovered $178,000 of these claims.

A similar condition was commented upon in our two preceding audit reports dating back to November 2019. MDH's response to the prior report, on behalf of MCPA, indicated that it had already taken action to identify and remove deceased recipients from Medicaid and pursue recovery of improper payments made after the recipients' dates of death. However, as noted above, MCPA did not ensure recipients reported as deceased were investigated and removed from Medicaid in a timely manner and did not have a process to identify and investigate payments for services after the date of death.

Recommendation 3
We recommend that MCPA establish effective processes over questionable Medicaid payments. Specifically, MCPA should establish processes to

a. identify, prevent, and recover improper fee-for-service payments related to incarcerated recipients (repeat); and

b. ensure deceased recipients are removed from Medicaid in a timely manner and investigate and pursue the recovery of improper payments after the recipients' dates of death, including those noted in our analysis (repeat).

Finding 4
MCPA did not ensure that changes to recipient Medicaid eligibility information were processed timely and accurately.

Analysis
MCPA did not ensure that changes to recipient Medicaid eligibility information were processed timely and accurately. MCPA is notified via automated reporting processes when recipient information in MMIS II differs from information on DHS' and MHBE's recipient systems, and MCPA staff manually update MMIS II with the correct information based on its investigation. Our review disclosed that

[7] We selected recipients with material claims after their date of death.

MCPA did not follow up on these notifications timely and according to MCPA records, there were approximately 157,000 notifications outstanding as of April 2025, including 41,000 outstanding from 1 to 3.6 years.

MCPA also did not ensure that errors identified during supervisory reviews of eligibility changes were subsequently corrected. MCPA's supervisory review of approximately 9,000 changes made to eligibility information between August 2022 and March 2025 identified 1,000 changes that required correction because they did not agree to the supporting documentation. Our test of 50 of these changes disclosed that 8 changes identified between June 2023 and March 2025 were still not corrected in MMIS II as of July 2025.

Similar conditions were commented upon in our preceding audit report, in which we noted that 93,000 notifications were outstanding as of February 2023. MDH's response to that report, on behalf of MCPA, indicated that MCPA would ensure recipient eligibility information in MMIS II is updated timely and errors to recipients' eligibility are corrected by December 2023. While MCPA took certain actions to address the notification backlog including temporarily reassigning staff to process notifications, these actions ultimately did not result in notifications being processed timely. In addition, as noted above, the errors in changes to recipient eligibility information were not always subsequently corrected. MCPA attributed the backlog to inadequate staffing and the increase in notifications received after the COVID-19 public health emergency.

Recommendation 4
We recommend that MCPA ensure recipient eligibility information is updated timely and accurately, and that errors to recipient eligibility information in MMIS II are corrected (repeat).

Third-Party Liability

Finding 5
MCPA did not ensure that all referrals of potential third-party health insurance information were investigated and recorded in MMIS II, which could result in MCPA improperly paying claims that should have been paid by a third-party.

Analysis
MCPA did not ensure that all referrals of third-party health insurance information were investigated and recorded into MMIS II. MCPA receives referrals of other potentially liable parties from several sources including its third-party liability

vendor, MCOs, DHS, and MHBE. Federal and State regulations provide that Medicaid shall be the payer of last resort and that it shall only be used to pay costs not covered by others, such as third-party insurers. Federal regulations further require MCPA to follow up on the potential third-party insurance information within 60 days of notification. We reviewed MCPA's procedures for processing referrals received from the third-party liability vendor and the MCOs, which accounted for 216,000 and 232,000, respectively of the 526,000 referrals received in calendar year 2024.

- MCPA did not verify that all third-party insurance identified by the third-party liability vendor was automatically interfaced into MMIS II as intended. Our review disclosed that, as of December 2025, approximately 292,000 (74 percent) of the 396,000 referrals submitted between April 2024 and March 2025 were not recorded in MMIS II. For example, insurance information provided by the vendor in May 2024 for 11,297 recipients was not interfaced into MMIS II. MCPA advised there were multiple reasons why the information would not be interfaced, such as duplicate or incomplete referrals but could not document that it investigated these referrals to determine why they did not interface.

  Since the insurance information was not recorded in MMIS II, the claims would not be subject to any review to determine if some or all of the claims should have been paid by others. In this regard, our analysis[8] of claims for the aforementioned 11,297 recipients, with dates of service between June 2024 and February 2025, identified 38,765 claims totaling $14.6 million for 2,231 recipients that were paid entirely by MCPA. In response to our request, MCPA investigated 10 of these claims[9] totaling approximately $206,000 and determined that 5 claims totaling $104,000 should have been paid by the recipient's third-party insurance and needed to be recovered.

- MCPA did not investigate all MCO referrals of possible third-party insurance. Specifically, according to MCPA records, approximately 166,000 of the 325,000 referrals from MCOs between January 2024 and May 2025, had not been investigated as of August 2025, including 116,000 that were outstanding for at least six months. MCPA management attributed the backlog to the manual process used for MCO referrals that were more time-intensive to investigate. Although MCPA advised that it was working to automate the

[8] Our analysis was based on recipients with open insurance spans and excluded recipients who only had vision and/or dental insurance coverage.

[9] We selected recipients with material claims between June and December 2024.

MCO referral process, this process has not been implemented as of November 2025.

A similar condition related to third-party insurance coverage was commented upon in our preceding audit report and similar conditions related to MCO referrals have been commented upon in our two preceding audit reports dating back to November 2019. MDH's response to the prior report, on behalf of MCPA, indicated that MCPA would ensure that referrals received from the third-party liability vendor were interfaced into MMIS II by the beginning of calendar year 2024 and that it had already taken action to ensure MCO referrals were investigated timely. However, as noted above, MCPA did not ensure that all referrals received from its vendor were recorded in MMIS II and did not investigate all MCO referrals.

Recommendation 5
We recommend that MCPA ensure that

a. all third-party health insurance information provided by its third-party liability vendor are interfaced with MMIS II (repeat), and
b. all MCO insurance referrals are recorded into MMIS II timely (repeat).

Program Oversight

Background

MCPA is responsible for ensuring that Maryland Medicaid recipients receive high quality services and for verifying the propriety of the related provider payments. Based on our assessment of significance and risk we reviewed MCPA's oversight of nursing, hospital, dental, and home and community-based services (HCBS) which include the Community First Choice (CFC) and Medical Day Care (MDC) programs.[10] We also reviewed MCPA's oversight of the utilization control agent (UCA) contractor, the hospital claims audit contractor, and the dental administrative service organization which assist MCPA in the administration and monitoring of these programs.

[10] The CFC program provides services to eligible recipients that are intended to enable them to remain at home and the MDC program provides eligible recipients the opportunity to receive medical care during the day in a community-based setting.

Finding 6
MCPA did not ensure that the UCA contractor performed continued stay reviews (CSRs) of Medicaid recipients in nursing facilities.

Analysis
MCPA did not ensure that its UCA contractor performed CSRs of Medicaid recipients in nursing facilities. The CSRs help verify that recipients required the level of care provided and ultimately billed to Medicaid by nursing facilities. The contract required the UCA contractor to perform quarterly CSRs of recipients during their first year in a nursing facility and annually thereafter. According to State records, MCPA paid the UCA contractor approximately $1.3 million to perform CSRs during calendar year 2024.

Our review disclosed that MCPA did not track the CSRs performed for each recipient to ensure the UCA contractor completed all required reviews. Our analysis of 14,609 Medicaid recipients[11] residing in nursing facilities during calendar year 2024 disclosed that 4,425 recipients (30 percent) had not received a CSR during the year as required. As a result, MCPA lacked assurance that these recipients required the level of care provided and that the related payments, which totaled $338.3 million during calendar year 2024, were proper.

Since MCPA did not monitor the UCA contractor for timely completion, it was not aware of the missing CSRs and therefore could not properly determine whether to assess liquidated damages against the UCA contractor, even though the contract provided that MCPA could assess $75 for each CSR that was not completed. In this regard, MCPA could have assessed liquidated damages totaling approximately $332,000 for the aforementioned 4,425 uncompleted CSRs.

A similar condition was commented upon in our two preceding audit reports dating back to November 2019. MDH's response to our preceding report, on behalf of MCPA, indicated that it would monitor the UCA contractor's completion of CSRs and assess liquidated damages if performance was below the contractual standards. However, as noted above, MCPA was still not tracking the completion of CSRs and did not assess liquidated damages provided for in the contract.

[11] Our analysis focused on recipients with a first date of service between January and July 2024 and at least five months of claims during calendar year 2024. The first date of service represents the earliest date in calendar year 2024 that the recipient received services from the nursing facility; many of these recipients also received nursing facility services prior to January 2024.

Recommendation 6
We recommend that MCPA monitor the UCA contractor to ensure CSRs are performed and assess related liquidated damages as permitted by the contract (repeat).

Finding 7
MCPA did not approve HCBS plans of service timely, resulting in numerous recipients not receiving required services and payments for services that were no longer medically necessary.

Analysis
MCPA did not approve HCBS plans of service timely, resulting in numerous recipients not receiving required services and payments for services that were no longer medically necessary. According to MCPA records, during fiscal year 2024 MCPA paid approximately $1.02 billion for HCBS on behalf of 97,900 recipients. Recipients deemed eligible for HCBS work with Supports Planning providers paid by MCPA to develop a plan that identifies the services to be received based on their assessed needs (such as feeding, medication, and hygiene) which are submitted to MCPA for approval.

We received an allegation to our fraud, waste, and abuse hotline that recipients were not approved for HCBS timely resulting in significant delays in recipients receiving these services. Our review substantiated the allegation but did not identify any matters that warranted referral to the Office of the Attorney General's Criminal Division. Specifically, our review of MCPA records as of June 2025 disclosed that 842 initial service plans had been pending approval for more than 15 days, including 234 plans that were pending approval between 3 months to 2.5 years. We also noted that the annual plan updates for 2,407 recipients were not approved timely, including 1,293 plans that were pending approval between 3 months to 3.2 years.

The untimely approval of these plans is significant as our review of 20 of the updated plans[12] disclosed that 5 plans identified additional services (such as environmental adaptations and transportation to appointments) that were not provided to the recipient due to the plan not being approved. In addition, MCPA paid $430,000 for services provided to 12 recipients despite the plans noting that certain services were no longer needed. For example, one plan submitted in July 2022 reduced the recipient's personal assistance services; however, the plan was

[12] We selected updated plans that appeared to have a significant delay for approval.

not approved until October 2025, resulting in MCPA paying $54,000 for unnecessary services.

In February 2024, MCPA contracted with the UCA contractor to supplement the approval process and in October 2024 the UCA contractor assumed all responsibility for approving HCBS plans. The contract provided that the UCA contractor is to approve these plans within 15 days. As noted above, as of June 2025, the UCA contractor was still addressing the backlog of unapproved plans. MCPA advised that the backlog should be resolved by April 2026.

Recommendation 7
We recommend that MCPA ensure initial and updated HCBS plans are approved timely and any additional services are added and unnecessary services are discontinued, including those noted above.

Finding 8
MCPA did not establish adequate oversight to ensure that all CFC program recipients received personal assistance services in accordance with their individual plans of service.

Analysis
MCPA did not ensure that all CFC program recipients received personal assistance services in accordance with their individual plans of service. CFC is a community-based Medicaid program in which elderly or disabled individuals who would otherwise live in a nursing facility are able to live in their own homes. CFC recipients receive assistance with daily living activities from personal assistance providers, under agreements with MCPA, in accordance with a plan of service. LHDs contract with nurse monitors[13] to evaluate the quality of personal assistance services provided to the CFC recipients. State regulations provide that the nurse monitor contact CFC recipients (virtual or in-person visits) at least every 6 months. According to State records, fiscal year 2024 payments to personal assistance and nurse monitoring providers (through the LHDs) totaled approximately $477.9 million and $7.9 million, respectively.

Our review disclosed that as of June 2025, MCPA had not implemented a process to ensure that each recipient received the required number of nurse monitoring visits. According to MCPA records, 9,175 recipients were receiving personal assistance services as of July 2025. Our analysis of recipient data in MDH's Long Term Services and Supports (LTSS) system disclosed that 229 recipients

[13] MDH has designated LHDs as the sole providers of nurse monitoring services for CFC recipients, however LHDs are permitted to subcontract this service.

had never had a nurse monitor visit despite receiving services for 6 months to 10.6 years. Additionally, 902 recipients (9.8 percent) were more than 60 days overdue for their nurse monitoring visit, including 365 recipients who were between 1 and 4.6 years overdue for a visit. The Baltimore City LHD accounted for 293 of the 365 overdue recipients.

A similar condition was commented upon in our two preceding audit reports dating back to November 2019 which also noted that the Baltimore City LHD accounted for the majority of the overdue cases. MDH's response to our prior report, on behalf of MCPA, indicated that MCPA would establish a process to ensure that participants received nurse monitoring services at the minimum frequency by December 31, 2023 and that it had already taken action to address the non-compliance by Baltimore City LHD. While MCPA had established monitoring procedures, as noted above MCPA had not implemented this process as of June 2025 and could not document specific actions it had taken to address the continued non-compliance by Baltimore City LHD.

Recommendation 8
We recommend that MCPA

a. **implement a process to ensure that all CFC recipients are monitored by nurses (repeat), and**
b. **develop a plan to address the longstanding instances of non-compliance for the aforementioned LHD (repeat).**

Finding 9
MCPA did not conduct the required audits of MDC and Supports Planning providers in accordance with its policy.

Analysis
MCPA did not conduct the required audits of MDC and Supports Planning providers in accordance with its policy. MDC is a community-based group program that offers eligible Medicaid recipients health, social, and personal support in a day-care setting in accordance with their individualized plans of care as an alternative to institutional care. Supports Planning providers develop service plans for recipients in the CFC program. According to MCPA records, during calendar year 2024, MCPA paid 116 MDC and 27 Supports Planning providers approximately $151.7 million and $58.3 million, respectively, for these services.

- MCPA did not conduct audits for 26 (23 percent) of the 114 MDC providers during calendar years 2023 and 2024. The audits are required by MCPA

policy[14] and ensure that providers are in compliance with MDC program requirements and the propriety of the related payments. In addition, our review of 20 audits[15] that were performed during calendar years 2023 and 2024 disclosed that 8 audits did not include the minimum number of recipients and 3 did not review the minimum number of claims required by MCPA policy.[16] MCPA also did not document how it selected recipients and claims tested and the specific claims reviewed for any of the 20 audits and did not expand testing when these audits identified improper or unsupported claims (totaling $97,000), as intended by its policy.

- MCPA's annual audits of Supports Planning providers did not properly assess whether the providers met program requirements and provided satisfactory services to CFC recipients. Specifically, our test of 20 Supports Planning provider audits[17] performed in calendar year 2024 disclosed that none assessed whether the provider met with recipients at the required intervals and properly completed recipients' plans of service. In addition, 8 audits did not assess whether the providers' staff had passed criminal background checks and/or met education and work experience requirements. MCPA subsequently provided us with completed criminal background checks for 17 of the 20 staff for whom the requirement was not assessed but was unable to provide us with the results for the remaining 3 staff as of January 2026.

Similar conditions with MDC provider audits were commented upon in our two preceding audit reports dating back to November 2019. MDH's response to our prior report, on behalf of MCPA, indicated that it would perform the required number of MDC provider audits by the end of calendar year 2024 and that it had already established a policy to expand testing when deficiencies are identified. However, as noted above, MCPA did not audit all providers and did not expand testing when the audits disclosed improper or unsupported claims.

Recommendation 9
We recommend that MCPA

a. audit MDC providers in accordance with its policy (repeat), ensure that audits include the minimum number of recipients and claims, and expand audit testing when significant deficiencies are identified (repeat); and

[14] In January 2025, MCPA policy related to MDC providers was updated to require audits once every three years, instead of once every two years.
[15] Test items were selected based on the number of claims reviewed and the total amount of improper claims identified during the audit.
[16] MCPA policy provides that MDC audits are to include testing of between 3 to 6 recipients (based on the total recipients served by the provider) and 31 claims for each selected recipient.
[17] Test items selected based on providers that received material payments in calendar year 2023.

b. properly assess whether the Supports Planning providers met program requirements and provided satisfactory services to CFC recipients.

Information System Security and Controls

We determined that Finding 10 related to "cybersecurity," as defined by the State Finance and Procurement Article, Section 3.5-301(c) of the Annotated Code of Maryland, and therefore is subject to redaction from the publicly available audit report in accordance with the State Government Article 2-1224(i). Consequently, the specifics of the following finding, including the analysis, related recommendations, along with MDH's responses, have been redacted from this report copy.

Finding 10
Redacted cybersecurity-related finding.

Criminal Background Checks

Finding 11
MCPA did not ensure that vendor employees obtained criminal background checks, as required by the contracts.

Analysis
MCPA did not ensure that vendor employees obtained criminal background checks, as required by the contracts. MCPA advised us that individuals convicted of certain crimes (such as theft, fraud, and violent offenses) should not have access to PII and PHI. MCPA also advised that a criminal background check requirement generally should be included in all contracts that involved PII or PHI. During our fieldwork, we identified seven vendors[18] with access to PII and PHI that MCPA collectively paid $22.5 million during fiscal year 2025 according to State records, five of which had requirements for criminal background checks.

Our review disclosed that MCPA did not obtain criminal background checks from any of the five vendors whose contracts included a criminal background check requirement. Subsequent to our inquiries, MCPA obtained the criminal background checks from two of these vendors. Our review of the documentation

[18] The services provided by these contractors included referring third-party health insurance information, scanning medical documents, electronically recording claims data in MMIS II, auditing hospital claims, managing recipients' dental benefits, and performing utilization reviews.

obtained from these vendors did not identify any individuals with criminal convictions. As of December 2025, MCPA was unable to provide us with background checks for the remaining three vendors.

Recommendation 11
We recommend that MCPA

a. ensure that all required criminal background checks are obtained and reviewed, including those noted above; and
b. take appropriate action for any individual identified as having a criminal conviction.

Reconciliation of MMIS II to State Accounting Records

Finding 12
MCPA did not have procedures to reconcile Medicaid expenditures recorded in MMIS II with the State's accounting records and could not readily explain $200.9 million in expenditures that were not recorded in MMIS II.

Analysis
MCPA did not have procedures to reconcile Medicaid expenditures recorded in MMIS II with the State's accounting records for fiscal years 2023 and 2024, resulting in unexplained variances totaling approximately $200.9 million going undetected. According to State accounting records, Medicaid expenditures totaled $12.7 billion in both fiscal years 2023 and 2024.

After we brought this matter to MCPA's attention in March 2025, MCPA performed reconciliations for these years and identified that expenditures in the State's accounting records exceeded expenditures in MMIS II during fiscal years 2023 and 2024 by $15.4 million and $185.5 million, respectively. MCPA could not readily explain these discrepancies and advised that it did not consider the variances significant enough to pursue further. Medicaid expenditures must be recorded in MMIS II to enable MDH to recover federal reimbursement for the cost of the services. The aforementioned variances raise concerns about whether MCPA has recorded all eligible expenditures in MMIS II to enable the recovery of federal funds.

Recommendation 12
We recommend that MCPA establish procedures to periodically (at least annually) reconcile financial activity recorded in MMIS II and the State's accounting records and resolve any variances, including those noted above.

Audit Scope, Objectives, and Methodology

We have conducted a fiscal compliance audit of the Maryland Department of Health (MDH) – Medical Care Programs Administration (MCPA) for the period beginning April 1, 2022 and ending March 31, 2025. The audit scope for this audit included MCPA's primary administrative functions and excluded the procedures and controls over the Managed Care Program, the Behavioral Health Administration's Administrative Service Organization, and the Maryland Pharmacy Program, which are reviewed under three separate audits (as previously explained in the Background Information section of this report).

The audit was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

As prescribed by the State Government Article, Section 2-1221 of the Annotated Code of Maryland, the objectives of this audit were to examine MCPA's financial transactions, records, and internal control, and to evaluate its compliance with applicable State laws, rules, and regulations.

In planning and conducting our audit, we focused on the major financial-related areas of operations based on assessments of significance and risk. The areas addressed by the audit included the Medicaid Management Information System (MMIS II), recipient and provider eligibility, third party insurance recoveries, nursing facilities, hospital services, dental services, Medicare enrollment, and home, community-based services programs, and information systems security and controls. We also reviewed MCPA's oversight of certain contractors which assist MCPA in the administration and monitoring of these programs. In addition, we reviewed certain activities related to a referral to our fraud, waste, and abuse hotline. Finally, we determined the status of the findings contained in our preceding audit report.

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

regulations because the State of Maryland engages an independent accounting firm to annually audit such programs administered by State agencies, including MCPA.

Our assessment of internal controls was based on agency procedures and controls in place at the time of our fieldwork. Our tests of transactions and other auditing procedures were generally focused on the transactions occurring during our audit period of April 1, 2022 to March 31, 2025, but may include transactions before or after this period as we considered necessary to achieve our audit objectives.

To accomplish our audit objectives, our audit procedures included inquiries of appropriate personnel, inspection of documents and records, tests of transactions, and to the extent practicable, observations of MCPA's operations. Generally, transactions were selected for testing based on auditor judgment, which primarily considers risk, the timing or dollar amount of the transaction, or the significance of the transaction to the area of operation reviewed. As a matter of course, we do not normally use sampling in our tests, so unless otherwise specifically indicated, neither statistical nor non-statistical audit sampling was used to select the transactions tested. Therefore, unless sampling is specifically indicated in a finding, the results from any tests conducted or disclosed by us cannot be used to project those results to the entire population from which the test items were selected.

We also performed various data extracts of pertinent information from the State's Financial Management Information System (such as revenue and expenditure data). The extracts are performed as part of ongoing internal processes established by the Office of Legislative Audits and were subject to various tests to determine data reliability. We determined that the data extracted from this source were sufficiently reliable for the purposes the data were used during this audit.

We also extracted data from Medicaid Management Information System (such as claims payments and recipient information) for the purpose of selecting test items and performing data analytics. We also extracted data from the Maryland Department of Health's Vital Records database, as well as from certain other State records, such as those maintained by the Department of Public Safety and Correctional Services and the State Lottery and Gaming Control Agency, for the purpose of testing recipient eligibility. We performed various tests of the relevant data and determined that the data were sufficiently reliable for the purposes the data were used during the audit. Finally, we performed other auditing procedures that we considered necessary to achieve our audit objectives. The reliability of data used in this report for background or informational purposes was not assessed.

MCPA's management is responsible for establishing and maintaining effective internal control. Internal control is a process designed to provide reasonable assurance that objectives pertaining to the reliability of financial records; effectiveness and efficiency of operations, including safeguarding of assets; and compliance with applicable laws, rules, and regulations are achieved. As provided in *Government Auditing Standards*, there are five components of internal control: control environment, risk assessment, control activities, information and communication, and monitoring. Each of the five components, when significant to the audit objectives, and as applicable to MCPA, were considered by us during the course of this audit.

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

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

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

State Government Article Section 2-1224(i) requires that we redact in a manner consistent with auditing best practices any cybersecurity findings before a report is made available to the public. This results in the issuance of two different versions of an audit report that contains cybersecurity findings – a redacted version for the public and an unredacted version for government officials responsible for acting on our audit recommendations.

The State Finance and Procurement Article, Section 3.5-301(c), states that cybersecurity is defined as "processes or capabilities wherein systems, communications, and information are protected and defended against damage, unauthorized use or modification, and exploitation." Based on that definition, and in our professional judgment, we concluded that a finding in this report falls under

that definition. Consequently, for the publicly available audit report all specifics as to the nature of the cybersecurity finding and required corrective actions have been redacted. We have determined that such aforementioned practices, and government auditing standards, support the redaction of this information from the public audit report. The specifics of the cybersecurity finding have been communicated to MCPA and those parties responsible for acting on our recommendations in an unredacted audit report.

In our preceding audit report, we reported that MCPA's accountability and compliance level was unsatisfactory, in accordance with the rating system we established in conformity with State law. Our current audit disclosed that MCPA's accountability and compliance level remains unsatisfactory. The primary factors contributing to the unsatisfactory rating were the significance of our audit findings and the number of repeat findings. Our rating conclusion has been made solely pursuant to the aforementioned law and rating guidelines approved by the Joint Audit and Evaluation Committee. The rating process is not a practice prescribed by professional auditing standards.

The response from MDH, on behalf of MCPA, to our findings and recommendations is included as an appendix to this report. Depending on the version of the audit report, responses to any cybersecurity findings may be redacted in accordance with State law. As prescribed in State Government Article, Section 2-1224 of the Annotated Code of Maryland, we will advise MDH regarding the results of our review of its response.

Exhibit 1
Listing of Most Recent Office of Legislative Audits
Fiscal Compliance Audits of Maryland Department of Health Units
As of April 2026 (Page 1 of 2)

	Name of Audit	Areas Covered	Most Recent Report Date
1	Medical Care Programs Administration – Managed Care Program	Managed Care Program, known as HealthChoice including oversight of the nine private Managed Care Organizations	01/14/26
2	Behavioral Health Administration and Medical Care Programs Administration - Administrative Service Organization for Behavioral Health Services	• Behavioral Health Administration • Medical Care Programs Administration Administrative Service Organization for Behavioral Health Services	10/03/25
3	Regional Institutes for Children and Adolescents	• John L. Gildner Regional Institute for Children and Adolescents • Regional Institute for Children and Adolescents – Baltimore	08/25/25
4	Developmental Disabilities Administration	Developmental Disabilities Administration	06/18/25
5	Regulatory Services	• 22 Health Professional Boards and Commissions • The Office of Health Care Quality	04/09/25
6	Vital Statistics Administration	Vital Statistics Administration	03/19/25
7	Prevention and Health Promotion Administration - Office of Population Health Improvement - Office of Preparedness and Response - Office of Provider Engagement and Regulation	• Prevention and Health Promotion Administration • Office of Population Health Improvement • Office of Preparedness and Response • Office of Provider Engagement and Regulation – Office of Controlled Substances Administration • Office of Provider Engagement and Regulation – Prescription Drug Monitoring Program	08/09/24
8	Pharmacy Services	Pharmacy Services	08/09/24
9	Laboratories Administration	Laboratories Administration	06/05/24

Exhibit 1
Listing of Most Recent Office of Legislative Audits
Fiscal Compliance Audits of Maryland Department of Health Units
As of April 2026 (Page 2 of 2)

Name of Audit		Areas Covered	Most Recent Report Date
10	State Psychiatric Hospital Centers	• Clifton T. Perkins Hospital Center • Eastern Shore Hospital Center • Spring Grove Hospital Center • Springfield Hospital Center • Thomas B. Finan Hospital Center	05/29/24
11	Health Regulatory Commissions	• Maryland Health Care Commission • Health Services Cost Review Commission • Maryland Community Health Resources Commission	01/25/24
12	Office of the Secretary and Other Units	• Office of the Secretary • Deputy Secretary and Executive Director for Behavioral Health • Deputy Secretary for Developmental Disabilities • Deputy Secretary for Public Health • Deputy Secretary for Health Care Financing and Chief Operating Officer • Deputy Secretary for Operations	10/19/23
13	Chronic Care Hospital Centers	• Deer's Head Center • Western Maryland Hospital Center	05/10/23
14	Intellectual Disabilities Residential Centers	• Holly Center • Potomac Center • Secure Evaluation and Therapeutic Treatment	10/24/22
15	Office of the Chief Medical Examiner	Office of the Chief Medical Examiner	05/12/22

APPENDIX A

Auditor's Comments on the Maryland Department of Health's Response

The Maryland Department of Health (MDH) cover letter indicates that the unsatisfactory rating does not accurately reflect the current compliance environment, operational controls, or corrective action progress. In addition, the letter asserts that the report does not sufficiently distinguish between unresolved compliance failures and issues already actively remediated or substantially corrected prior to issuance, and does not adequately reflect the operational complexities associated with administering one of the State's largest and most federally regulated programs. The letter further asserts significant concerns regarding the audit methodology and resulting characterization of MCPA's operational performance, including that the report does not consistently account for corrective actions already implemented prior to report issuance or provide sufficient transparency regarding how progress toward remediation is evaluated and reflected in the final audit determination.

As noted in the Audit Scope, Objectives, and Methodology section, our audit covered the period beginning April 1, 2022 and ending March 31, 2025. Our assessment of internal controls was based on agency procedures and controls in place at the time of our fieldwork and our tests of transactions and other auditing procedures were generally focused on the transactions occurring during this period. Furthermore, the Audit Scope, Objectives, and Methodology section states that our reports generally do not address activities we reviewed that are functioning properly.

Our audit report also clearly describes the factors contributing to the unsatisfactory rating, which were the significance of the findings and the number of repeat findings. These findings, which MDH management generally agreed were accurate, were due to conditions that existed during the period reviewed for which the referenced corrective action had not been implemented. As indicated in MDH's response, the corrective action proposed by MDH for all recommendations is anticipated to be completed in the future or was completed subsequent to our fieldwork. The impact of this corrective action was not included in our scope and will be evaluated during our next audit.

As a result, we continue to believe that our report provides an accurate characterization of the procedures and controls in place during the period covered by our audit, and that the unsatisfactory rating is warranted and the related results are supported and presented in a fair and transparent manner.

APPENDIX B

May 13, 2026

Mr. Brian S. Tanen, CPA, CFE
Legislative Auditor
Office of Legislative Audits
The Warehouse at Camden Yards
351 West Camden Street, Suite 400
Baltimore, MD 21201

Dear Mr. Tanen,

Thank you for the opportunity to review the draft audit report of the Medical Care Programs Administration (MCPA) for the period beginning April 1, 2022 and ending March 31, 2025. The Maryland Department of Health (MDH) remains committed to maintaining strong program integrity across Medicaid, safeguarding taxpayer resources, and ensuring beneficiaries receive accurate and timely services.

MCPA has treated every finding identified in this audit as a priority and acted decisively to implement targeted corrective actions focused on strengthening internal controls, enhancing system automation, and improving vendor oversight. Since the conclusion of the Office of Legislative Audits (OLA)'s fieldwork last year, MCPA has fully resolved 5 of the 12 findings identified in the report – including 2 repeat findings – and partially resolved 1 additional repeat finding, with most remaining corrective actions for the remaining 6 findings expected to be completed by the end of 2026.

While the Department values OLA's recommendations to improve MCPA's ability to effectively deliver services, MCPA does not agree that an "unsatisfactory" rating accurately reflects the Administration's current compliance environment, operational controls, or corrective action progress. As written, the report does not sufficiently distinguish between unresolved compliance failures and issues already actively remediated or substantially corrected prior to issuance. In several instances, the report also does not adequately reflect the operational complexities

associated with administering one of the State's largest and most federally regulated programs during a period of significant system modernization and transition.

Additionally, the Department has significant concerns regarding aspects of the audit methodology and resulting characterization of MCPA's operational performance. The Department is concerned that the report does not consistently account for corrective actions already implemented prior to report issuance or provide sufficient transparency regarding how progress toward remediation is evaluated and reflected in final audit determinations.

The Department's detailed responses to each audit finding are enclosed. MDH remains fully committed to compliance with applicable federal and state requirements, responsible stewardship of public resources, and continuous operational improvement across the Maryland Medicaid program. We also welcome continued dialogue regarding how long-term corrective action progress and complex operational modernization efforts can be more accurately reflected within future audit reporting.

If you have any questions or require additional information, please do not hesitate to contact me.

Sincerely,

Meena Seshamani, M.D., Ph.D.
Secretary

Enclosures

cc: Kate Wolff, MPA, Chief of Staff, MDH
Emily Berg, Deputy Chief of Staff, MDH
Perrie T. Briskin, Deputy Secretary, Health Care Financing and Medicaid, MDH
Liz Schuelke, Chief of Staff, MDH
Clint Hackett, Deputy Secretary for Operations, MDH
Frederick D. Doggett, Director, Internal Controls, Audit Compliance & Information Security, MDH
Deneen Toney, Deputy Director, Audit & Compliance, Internal Controls, Audit Compliance & Information Security, MDH
Carlean Rhames-Jowers, Chief Auditor, Internal Controls, Audit Compliance & Information Security, MDH

Maryland Department of Health
Medical Care Programs Administration

Agency Response Form

Recipient Eligibility

Finding 1
MCPA did not ensure that issues identified with Medicaid eligibility determinations were corrected and that DHS and MHBE conducted timely eligibility redeterminations, potentially resulting in payments on behalf of ineligible individuals.

We recommend that MCPA ensure that

a. **issues identified with initial eligibility determinations, including those noted above, are timely resolved by DHS and the LHDs; and**
b. **DHS and MHBE conduct required annual redeterminations and take appropriate action when redeterminations are not completed, including those noted above.**

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.	Due to emergency federal legislation passed during the COVID-19 pandemic, state health agencies were mandated to temporarily suspend annual redeterminations. The Families First CoronaVirus Response Act 2020 required States to provide continuous eligibility, and redeterminations did not resume until April 2023 with the Consolidated Appropriations Act of 2023. States were required to maintain original certification periods so the entire Medicaid population could not be fully redetermined until the end of the public health emergency (PHE) until March 2024. It is also important to note that a "flagged" status in the program integrity review process does not confirm ineligibility; rather, it signifies a procedural requirement for further evidence, such as a signature or updated income verification. MDH acknowledges OLA's best practice recommendation for more timely follow-up to ensure these internal findings are resolved by delegated agencies within prescribed timeframes.		
Recommendation 1a	**Agree**	**Estimated Completion Date:**	8/1/2026

Maryland Department of Health
Medical Care Programs Administration

Agency Response Form

Please provide details of corrective action or explain disagreement.	The Maryland Department of Health (MDH) remains committed to ensuring the integrity of Medicaid eligibility determinations. The 306 cases cited by the Office of Legislative Audits (OLA) represent instances identified through MCPA's internal Program Integrity (PI) quality assurance reviews where additional documentation or caseworker verification was required to satisfy program standards. MCPA has taken immediate steps to strengthen the resolution of issues identified during quarterly eligibility reviews: ● MCPA has implemented a centralized tracking log to monitor each finding and its resolution status. ● Effective August 1, 2026, MCPA will require DHS and LHDs to respond to all PI findings within 60 days. ● MDH has established a formal escalation process for items remaining outstanding beyond the required timeframe, ensuring executive leadership involvement for unresolved cases.		
Recommendation 1b	**Agree**	**Estimated Completion Date:**	12/31/26
Please provide details of corrective action or explain disagreement.	MCPA has taken steps to ensure that annual redeterminations are conducted timely and that appropriate corrective actions occur when redeterminations are not completed. The 1,950 identified cases are non-Modified Adjusted Gross Income (non-MAGI) and must be completed by the Department of Human Services (DHS). **DHS (non-MAGI)** In order to hold DHS accountable for performing annual redeterminations, MCPA is committed to working in close collaboration with our partner agency to monitor redetermination reports, identify overdue reviews, and escalate with leadership when necessary. DHS has requested to have a new Annual Redetermination Overdue report generated in the Eligibility & Enrollment (E&E) system that will identify initiated redeterminations that remain incomplete. After that report is functional, it will be generated monthly and reviewed by both MCPA and DHS staff to identify overdue or incomplete redeterminations. MCPA will require DHS to complete all overdue determinations within 30 days and will clearly communicate this expectation. If overdue		

	redeterminations are not completed within the established timeframe, MCPA will implement and communicate appropriate corrective actions. In addition, MCPA is working on improving our technical systems and collaboration with Maryland Benefits to develop an enhanced automated process within the E&E system for tracking and coding redetermination cases not processed by the 45th day. This system feature will further strengthen oversight and timeliness of redetermination processing. The issue cited in this audit finding applies to non-MAGI cases and therefore does not apply to the Maryland Health Benefit Exchange that handles MAGI cases.

Maryland Department of Health
Medical Care Programs Administration

Agency Response Form

Finding 2
MCPA did not ensure that recipients age 65 or older applied for Medicare, as required by State regulations.

We recommend that MCPA ensure recipients age 65 or older have applied for Medicare, as required by State regulations.

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.	In OLA's analysis, it is noted that MCPA paid $145 million in claims during calendar year 2024 for 4,873 recipients who were not enrolled in Medicare despite appearing potentially eligible based on age and coverage group. In March 2026, the Social Security Administration informed MCPA that 1634 designated states, including Maryland, had been impacted by longstanding technical issue, that a significant portion of Maryland MCPA population (67% or 3,251 individuals) were supposed to be auto-enrolled in Medicare due to their Supplemental Security Income (SSI) status but were never enrolled in Medicare due to the SSA system glitch. As a result of this system's issue, affected individuals remained enrolled solely in Medicaid coverage despite otherwise meeting the criteria for automatic Medicare enrollment. The issue seems to date back prior to the audit period and affected individuals vary from age 64 to age 99 affecting multiple cohorts and enrollment years. Beginning in April 2026, MCPA confirmed with SSA that SSA will prospectively enroll affected individuals into Medicare Part B and pay the applicable Part A premium where appropriate. Individuals approaching age 65 will receive proper enrollment upon attaining Medicare eligibility age moving forward. This will greatly help to ensure that recipients age 65 or older have applied for Medicare.		
Recommendation 2	**Agree**	**Estimated Completion Date:**	12/31/26
Please provide details of corrective action or explain disagreement.	MCPA agrees with the importance of ensuring that Medicaid recipients transition to Medicare upon reaching age 65, in accordance with COMAR 10.09.24.03. As the payer of last resort, Medicaid requires beneficiaries to utilize all other available health insurance resources. MDH currently operates a proactive "courtesy notice" system, where recipients are notified 90 days prior to their 65th birthday of the requirement to apply for Medicare. MDH acknowledges the OLA recommendation to provide more formal oversight to ensure that the		

	Department of Human Services (DHS) verifies that all recipients aged 65 and older have applied for Medicare. MCPA also recognizes that, despite the issue originating from inconsistencies and limitations within external SSA Medicare enrollment data, additional safeguards and oversight mechanisms are needed within the eligibility process to better identify and address individuals who may not have successfully transitioned to Medicare coverage. Maryland relies heavily on federal data exchanges and SSA files support these determinations. MCPA acknowledges that supplemental monitoring, enhanced system controls, and more formalized procedures may reduce the risk of individuals remaining enrolled in full Medicaid coverage without appropriate Medicare enrollment. This process will include the following controls: ● **Monthly Monitoring:** DHS will provide MCPA, on a monthly basis in advance of the standing **MDH/DHS Benchmark meeting,** a report identifying all individuals who became Medicare-eligible within the prior 30 days, including an indicator of whether a Medicare application has been submitted. ● **Delinquency Tracking:** Individuals who have not applied for Medicare within 30 days of eligibility will be classified as non-compliant. MCPA will maintain and track these cases as part of a delinquency log. ● **Case Review and Accountability:** During the monthly Program Integrity meeting, DHS will be required to report on all non-compliant cases, including outreach efforts and actions taken to secure compliance. ● **Escalation Protocol:** Cases remaining non-compliant beyond 60 days will be escalated to leadership within both MCPA and DHS through a formal monthly escalation report. ● **Advance Outreach:** MCPA will continue its existing process of issuing advance notice to individuals approximately 90 days prior to their 65th birthday, reminding them of the requirement to apply for Medicare. ● **System Analysis:** MCPA will work with Maryland Benefits to address identified system vulnerabilities and implement enhancements in the E&E system designed to strengthen verification and tracking of individuals required to apply for Medicare. This control will reduce the administrative burden

	associated with prior identified controls as the MCPA works towards this solution

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Finding 3
MCPA did not have effective processes to identify, prevent, and recover questionable Medicaid payments including $9.2 million in payments on behalf of recipients who were incarcerated or deceased at the time of service.

We recommend that MCPA establish effective processes over questionable Medicaid payments. Specifically, MCPA should establish processes to

a. identify, prevent, and recover improper fee-for-service payments related to incarcerated recipients (repeat); and

b. ensure deceased recipients are removed from Medicaid in a timely manner and investigate and pursue the recovery of improper payments after the recipients' dates of death, including those noted in our analysis (repeat).

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Agency Response	
Analysis	**Partially Agree**
Please provide additional comments as deemed necessary.	MCPA follows all regulations outlined in COMAR 10.67.02.06 to disenroll enrollees on the first day of the month following the month in which the Department verifies an enrollee is an inmate. As a result of this regulation, MCPA cannot recover funds paid for any date prior to the Department receiving and verifying the data even if payments were made after the enrollee's incarceration date. Of the $9.2 million in payments highlighted in this finding, $6.4 million is associated with the auditors' set of 2,397 recipients that OLA's match identified as being incarcerated during the current audit period. Of the 2,397 cases, only 20 were identified as enrolled in an MCO and subsequently disenrolled. If a case was not enrolled in an MCO, there is no action to be taken. MCPA properly disenrolled these individuals, according to regulation, in the immediate month following verification. MCPA is currently reviewing the remaining $2.8 million in potentially improper claims payments, with review expected to be complete by December 31, 2026, and will pursue recovery of any payments determined to be improper. 3(a) Regarding the data cited in OLA's MCPA Primary Discussion Notes, OLA independently obtains incarceration data from DPSCS that differs from the dataset MCPA receives. For the incarceration records MCPA does receive, the matching and suspension process functions as designed. MCPA uses a conservative, probability-based matching methodology on four core identifiers (first name, last name, SSN, DOB), triggering automated suspension only for 100% matches, with near-matches manually reviewed weekly. When incarceration is confirmed, managed care capitation is stopped and Medicaid coverage is maintained, consistent with federal rules that require continued Medicaid enrollment for inpatient hospital services. 3(b) Regarding the data cited in OLA's MCPA Primary Discussion Notes, MCPA currently follows established policy for completing automated disenrollment of MAGI cases through the systems of record using system matches, such as those from Maryland Vital Records. However, this automated process is only effective for cases that match with 100% accuracy and reflect deaths occurring within the State of

	Maryland. Cases involving deaths that occur outside of Maryland, or those identified as partial matches, require manual caseworker validation. This process is necessary to ensure accuracy, as the State seeks to avoid erroneously terminating Medical Assistance benefits. Reinstating benefits after an individual is incorrectly marked as deceased can be administratively complex and resource-intensive.		
Recommendation 3a	**Agree**	**Estimated Completion Date:**	12/31/27
Please provide details of corrective action or explain disagreement.	MCPA will continue to collaborate with DPSCS to obtain the most conclusive data lists ensuring that the identification of incarcerated recipients is conducted accurately and promptly. MCPA has begun to investigate the full set of 2,397 recipients that OLA's match identified as being incarcerated during the current audit period. Of the 2,397 cases: ● 1,055 cases identified by OLA could not be found in our eligibility files. ● 668 cases were matched but were not enrolled in an MCO, so MCO disenrollment was not required and no capitation payments were at risk. ● 594 cases were appropriately disenrolled during the audit period ● 60 cases were present in our eligibility files as members enrolled in an MCO but they did not meet the specified match criteria, including First Name, Last Name, SSN and DOB. If we cannot match the cases, we take no further action to avoid the risk of improperly disenrolling someone from coverage. ● 20 cases were in an MCO and were disenrolled. In April 2026, MCPA completed an assessment of the feasibility of implementing new functionality within the MMIS claims subsystem to identify and prevent outpatient claims submitted for recipients with verified incarceration status. The assessment determined that the required system modifications, including development, interface creation, and end-to-end testing, represent a significant level of effort and are estimated to require approximately 12–18 months for full implementation. Due to the complexity of establishing a new inmate data interface with the MMIS claims subsystem, as well as competing Departmental priorities related to HR-1 initiatives and other critical		

	system efforts, implementation and testing activities are not expected to be completed in less than 12 months. In the interim, MCPA will implement a new Eligibility Verification System (EVS) business rule to notify providers that incarcerated recipients are eligible only for inpatient services, thereby strengthening controls intended to prevent inappropriate outpatient payments.		
Recommendation 3b	**Agree**	**Estimated Completion Date:**	12/31/26
Please provide details of corrective action or explain disagreement.	MCPA concurs with the recommendation and has processes in place to identify deceased recipients, terminate eligibility, and pursue recovery of improper payments to providers when services are paid after a recipient's date of death. MCPA utilizes automated system matches with systems of record, including Maryland Vital Records, to identify individuals reported as deceased and to automatically terminate Medicaid eligibility. This automated process is effective when records match with a high degree of certainty and when deaths occur within the State of Maryland. Cases involving deaths that occur outside of Maryland, or those that result in partial or near matches, require manual validation by eligibility caseworkers to ensure accuracy and prevent the erroneous termination of Medicaid coverage. This validation step is necessary because incorrectly coding a recipient as deceased can result in inappropriate loss of coverage and requires significant administrative effort to restore eligibility. MCPA monitors deceased case closure activity by Local Health Departments (LHDs) and Local Departments of Social Services (LDSS) for cases requiring manual review. Monitoring activities include regular reporting and notification to executive leadership when local offices do not comply with established timeliness standards, as well as follow-up actions to ensure cases are resolved. MCPA is currently reviewing approximately $2.8 million in potentially improper claims payments, representing 18,086 claims for 4,510 individuals, for services paid after the recipients' dates of death. The agency will complete its review by December 31, 2026, and will pursue recovery of any payments determined to be improper.		

	These actions will strengthen oversight of deceased recipient case processing and help ensure that eligibility is terminated promptly and that improper payments are identified and recovered when applicable.

Auditor's Comment: Although MDH agrees with the recommendations, certain comments in the response to our analysis appeared to conflict or deflect attention from the facts presented. First, MDH asserts that almost all of the population was not enrolled in MCOs and that it timely removes recipients from MCOs when they meet certain match criteria. Our analysis clearly explains that the improper payments we identified consist of fee-for-service claims (not MCO capitation payments) and therefore, the recipients' MCO enrollment status is not relevant to this finding.

Second, MDH asserts that it uses a conservative process to identify individuals that are 100 percent matched to state records. While this methodology is reasonable for an automated process, our analysis identified cases that were not identified by this match and the failure to investigate certain matches including those cited in our analysis. As noted in our finding, during our fieldwork MCPA could not readily explain why the recipients cited were not identified and/or investigated to prevent future payments.

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Finding 4
MCPA did not ensure that changes to recipient Medicaid eligibility information were processed timely and accurately.

We recommend that MCPA ensure recipient eligibility information is updated timely and accurately, and that errors to recipient eligibility information in MMIS II are corrected (repeat).

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.			
Recommendation 4	**Agree**	**Estimated Completion Date:**	12/31/26
Please provide details of corrective action or explain disagreement.	MPCA is working to address this finding in two parts: 1. Address the backlog of changes that require correction. 2. Address the root cause of the erroneous data by making targeted system updates in MHBE's Health Benefit Exchange, E&E, and MMIS systems. **1. Address the Backlog** A Certified Turn-a-Round Document or CTAD is systematically generated when daily eligibility transactions which are transmitted from the Maryland Health Benefit Exchange (HBX) and Department of Human Services/MD Benefits' (E&E) enrollment and eligibility systems fail to successfully interface/batch with MMIS due to errors or exceptions. As mentioned, a lack of sufficient staffing coupled with a considerable rise in CTADs received following the Public Health Emergency are primary factors contributing to the backlog. Since February 2025, MCPA has implemented a multi-phase process to address the backlog: ● Phase 1: "Backlog Elimination," began on February 1, 2025 to identify challenges, and implement a comprehensive monitoring and strategic framework to track and eliminate the 2021 - 2024 backlog. To date, years 2021-2024 have been completed. ● Phase 2: "Workgroup Implementation," began April 2025 and is currently in process. The workgroup includes staff from MCPA, MHBE and DHS who are collaborating to determine the		

	underlying cause of the increase in errors and to find systematic solutions that will prevent further erroneous and duplicated CTAD requests. A comprehensive report detailing the findings and next steps was delivered by April 30, 2026. ● Phase 3: "Operational Reset and Optimization" is currently in process. On March 11, 2026, the management team initiated strategic planning to evaluate current operational processes to determine whether they remain efficient or require restructuring to meet current needs. The planning also included accessing current staffing levels to identify training opportunities to maximize the performance of existing resources. During the assessment, MCPA identified 96,199 CTADs in the queue for calendar year 2025. The goal is to clear the 2025 cases by the end of 2026. Achieving this milestone is contingent on onboarding 5 freeze-exempt PINs timely, especially considering the unit currently has 13 vacancies. ● Phase 4: "Sustainment," is scheduled to launch in 2026. This phase will establish a proactive operational model to manage ongoing workload beginning 2025. By implementing this phased strategy, MCPA aims to not only eliminate the current backlog but also to establish effective systemic processes and workflows that will prevent future backlogs. **2. Fix the Root Cause** Preliminary analysis indicates that data inconsistencies sent by the HBX and E&E remain the primary cause in the transmission of erroneous data to MMIS. By minimizing the frequency of high reporting error codes, management can reallocate resources to concentrate on addressing the backlog. Office of Eligibility Services technical leads are actively collaborating with the system's staff from MHBE and DHS to assess the manner in which specific transactions are transmitted to MMIS, as well as the purpose of these transactions, in order to identify deficiencies in the process. A comprehensive report detailing the findings to include recommendations, next steps and timeline for implementing action items is expected to be submitted by April 30, 2026.

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Third-Party Liability

Finding 5
MCPA did not ensure that all referrals of potential third-party health insurance information were investigated and recorded in MMIS II, which could result in MCPA improperly paying claims that should have been paid by a third-party.

We recommend that MCPA ensure that

a. all third-party health insurance information provided by its third-party liability vendor are interfaced with MMIS II (repeat), and

b. all MCO insurance referrals are recorded into MMIS II timely (repeat).

Agency Response			
Analysis	**Partially Agree**		
Please provide additional comments as deemed necessary.	For the five MCOs using the MDH interface to send automatic third-party liability (TPL) file transmissions, the TPL data is loaded into MMIS, where the following benefits have been achieved for both MDH and the MCOs: 1) Elimination of the paper Lead Letters; the creation and keying into MMIS 2) Increased timeliness of TPL data in MMIS 3) Reduced keying errors		
Recommendation 5a	**Agree**	**Estimated Completion Date:**	8/1/26
Please provide details of corrective action or explain disagreement.	MCPA has addressed the Corrective action we proposed in 2023 "to understand why the carrier text file is not interfacing and also requested a master file of codes that the vendor utilizes and are in contact with the vendor to have them added to the system." As a result, our TPL Vendor is already properly interfaced with MMIS. What MCPA discovered is that TPL Vendor carrier codes are different from our carrier codes in MMIS. The cases OLA found were not a result of improper interface but this carrier code mismatch. MCPA identified this issue in August of 2023, since then MCPA made a master list of carrier codes and presented them to them to reconcile the error report that is delivered from the MMIS system. MCPA submits the error listing to our third party vendor on a monthly basis. Our third party		

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	vendor corrects the information on the file and resubmits it to MMIS within the 90 days timeline.		
Recommendation 5b	**Agree**	**Estimated Completion Date:**	8/1/26
Please provide details of corrective action or explain disagreement.	Five MCOs are already transmitting the TPL/insurance referrals into MMIS II. Once the final 4 MCOs have completed testing with the MDH interface and have been migrated to production, all subsequent monthly TPL files from all MCOs will be loaded into MMIS upon receipt of their TPL file, thereby satisfying 5b for timeliness to record insurance referrals into MMIS II.		

Auditor's Comment: Although MDH indicates that it partially agrees with our analysis, the response does not contradict the facts presented in the finding.

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Program Oversight

Finding 6
MCPA did not ensure that the UCA contractor performed continued stay reviews (CSRs) of Medicaid recipients in nursing facilities.

We recommend that MCPA monitor the UCA contractor to ensure CSRs are performed and assess related liquidated damages as permitted by the contract (repeat).

Agency Response			
Analysis	**Partially Accurate**		
Please provide additional comments as deemed necessary.	MCPA disputes that it did not apply any liquidated damages related to CSRs. As shared with the OLA auditors, MCPA applied for liquidated damages based on the UCA's contractual obligations to provide an annual census. MCPA agrees with the recommendation that the UCA must ensure that nursing facilities complete and submit CSRs and that MCPA will continue to assess related liquidated damages as permitted by the contract.		
Recommendation 6	**Partially Agree**	**Estimated Completion Date:**	5/1/27
Please provide details of corrective action or explain disagreement.	MCPA disputes that it did not apply any liquidated damages related to CSRs. As shared with the OLA auditors, MCPA applied for liquidated damages based on the UCA's contractual obligations to provide an annual census. In March 2025, the UCA was expected to provide an annual census used to ensure all CSRs are completed by nursing facilities. As required by the contract, the first census report was due in March 2025. It was not received and MCPA applied a liquidated damage of $105,688.99. It is also important to note that the liquidated damage associated with the census is an annual assessment as written in the contract, and this would have been the first opportunity to assess the damage since the contract started in September 2024. The annual census is important because it identifies nursing facility residents that are due for a CSR. The UCA contract has a liquidated damage of $75 per occurrence when the UCA fails to identify the need for and conduct a CSR. The UCA began using claims data with the initiation of the September 2024 contract to identify missing CSRs and is working closely with nursing facilities to complete those CSRs that are missing or past due. This reconciliation will ensure that no CSRs are missing for claims paid to		

	nursing facilities. Because the UCA is utilizing this claims data and completing CSRs in partnership with nursing facilities upon identification of a missing or late CSR, the $75 liquidated damage per occurrence was not applied. The claims reconciliation is expected to be completed by April 30, 2026, as such, MCPA will begin applying the $75 liquidated damage beginning May 1, 2026. To resolve this finding, MCPA is in the process of moving the CSR process into the State's data management system, LTSSMaryland. LTSSMaryland is a participant based system as opposed to the provider based system run by the UCA, and is better suited to manage the CSR process. Scoping has begun to move the CSR process into the State's data management system, LTSSMaryland. MCPA expects full implementation to take 12 to 18 months with an anticipated effective date of May 1, 2027. As of May 4, 2026, MCPA completed the initial scoping and the project plan was submitted to the software developer, FEi, for a cost estimate and confirmation of the project timeline. In the meantime, MCPA continues to work with the UCA on identifying residents who require CSRs. A combination of claims data, initial level of care requests, and facility censuses are being used to create the UCA's CSR census. The UCA's next annual census report was due to MCPA by 3/2/2026. The census was not provided by the deadline, as such, a liquidated damage of 10% of the March 2026 invoice will be applied. As the UCA identifies facilities that are non-compliant with completion of past due CSRs, they are working individually with the facilities to get them caught up. The UCA is notifying MCPA of providers who continue to be non-compliant in spite of UCA outreach and education.

Auditor's Comment: MDH partially agrees with the analysis and recommendation but asserts that it assessed liquidated damages against the UCA contractor for not providing an annual census that was to be used to ensure all CSRs are completed. However, the focus of this finding was not on the liquidated damages associated with the annual census. Rather, the finding relates to MDH not ensuring the UCA contractor completed CSRs and not pursuing liquidated damages when CSRs are not completed, as provided for in the contract. As explained in our analysis and acknowledged by MDH in its response, MDH did not assess these additional liquidated damages for each missing CSR as provided for in the contract.

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Finding 7
MCPA did not approve HCBS plans of service timely, resulting in numerous recipients not receiving required services and payments for services that were no longer medically necessary.

We recommend that MCPA ensure initial and updated HCBS plans are approved timely and any additional services are added and unnecessary services are discontinued, including those noted above.

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.	The analysis is correct but we would like to further clarify that our definition of approving HCBS "timely" is 15 days now that the Utilization Control Agent (UCA) took over in October 2024. This finding references plans of service for the Community Options Waiver, Community First Choice (CFC), Community Personal Assistance Services (CPAS), and Increased Community Services (ICS) programs. Prior to October 2024, MCPA's Office of Long Term Services & Supports rendered plan of service determinations. In light of the long standing plan of service backlog, in 2018, the plan of service review and determination process was added to the request for proposals for the Utilization Control Agent (UCA) to assume this work. The UCA contract with the plan of service review/determination process began in September 2024, and the UCA fully assumed responsibility for rending determinations in October 2024.		
Recommendation 7	**Agree**	**Estimated Completion Date:**	Complete
Please provide details of corrective action or explain disagreement.	This audit finding references the plan of service backlog that was fully resolved in December 2025, ahead of the anticipated April 2026 resolution plan. The UCA contract monitor reviews a monthly report to ensure plan of service determinations are made within contractual timeframes. Liquidated damages are applied to plan of service determinations that fall outside of those contractual obligations.		

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Finding 8
MCPA did not establish adequate oversight to ensure that all CFC program recipients received personal assistance services in accordance with their individual plans of service.

We recommend that MCPA

a. **implement a process to ensure that all CFC recipients are monitored by nurses (repeat), and**
b. **develop a plan to address the longstanding instances of non-compliance for the aforementioned LHD (repeat).**

Agency Response			
Analysis			
Please provide additional comments as deemed necessary.	It is important to note the significant progress on this issue that is not reflected in the analysis. MCPA executed Nurse Monitoring Agreements with each Local Health Department (LHD) performing nursing monitoring services on May 15, 2024. The purpose of these agreements were to establish clear standards for the nurse monitoring service, its delivery, and its continuous monitoring by both the LHDs and the Office of Long Term Services and Supports (OLTSS). LHDs were required to begin adhering to the timelines for specific activities as of July 1, 2024 pursuant to the agreement. In October 2024, OLTSS evaluated the degree to which each LHD was meeting the required timelines for specific activities based on a random sample. The results were provided to each LHD by 12/31/2024 to assist the LHD in making changes, if necessary, before the annual evaluation. The first annual evaluation period was July 1, 2024 - June 30, 2025, which began in July 2025 and ended on 10/31/2025.		
Recommendation 8a	**Agree**	**Estimated Completion Date:**	Complete
Please provide details of corrective action or explain disagreement.	The last annual nurse monitoring audit/evaluation occurred 10/31/2025. OLA acknowledged OLTSS' progress and indicated that this finding was still noted because the resolution date was not final until 10/31/2025, which is after the conclusion of their audit period. Improved compliance is anticipated going forward based on feedback from this first formal evaluation. As a result of the annual evaluation ending 10/31/2025, OLTSS required 11 Quality Improvement Plans (QIPs) from LHDs that did not meet the compliance threshold for specific performance measures. Since the last update OLTSS has approved 10 of 11 QIPs and received the initial		

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	monthly report in February 2026 from 10 of 11 affected jurisdictions. Following OLTSS feedback, revised documentation has been submitted for the outstanding QIP, pending OLTSS review. OLTSS continues to provide technical assistance (recurring or on demand) to noncompliant jurisdictions to support data analysis and to make recommendations to improve compliance		
Recommendation 8b	**Agree**	**Estimated Completion Date:**	5/31/26
Please provide details of corrective action or explain disagreement.	OLTSS is evaluating LHD compliance with the timeliness of nurse monitoring visits monthly using reports from LTSSMaryland, and communicating with each LHDs on the outstanding visits that must occur. This process occurs in addition to the annual audit mentioned in recommendation A, which is the formal process in which LHDs are monitored annually. Additionally, OLTSS is currently building multiple enhancements into the LTSSMaryland system to support LHD data needs related to nurse monitoring such as expanded access in different sections of the system, enhancing existing reports with additional data points, and updates to the nurse monitoring module for increased visibility of critical information. These system enhancements are anticipated to launch in May 2026.		

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Finding 9
MCPA did not conduct the required audits of MDC and Supports Planning providers in accordance with its policy.

We recommend that MCPA

a. **audit MDC providers in accordance with its policy (repeat), ensure that audits include the minimum number of recipients and claims, and expand audit testing when significant deficiencies are identified (repeat); and**
b. **properly assess whether the Supports Planning providers met program requirements and provided satisfactory services to CFC recipients.**

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.	The finding is correct for the majority of the audit period. In January 2025, the MDC audit schedule was revised (e.g., audit every three years instead of two years) to better align with staffing resources. The finding for the OLTSS SPA audit process is factually accurate.		
Recommendation 9a	**Agree**	**Estimated Completion Date:**	Complete
Please provide details of corrective action or explain disagreement.	The MDC audit process and procedures have been updated to align with staffing resources to ensure that audits are conducted for each MDC every three years. To enhance audit procedures, a minimum claims testing standard (e.g., defined number of claims per participant) has been established, and each audit must require documentation of selection methodology and claims tested. Additionally, triggers for further testing should expand beyond just recoverable findings to include systemic or high-risk deficiencies, while basic audit coverage monitoring is implemented to ensure all providers are audited within required timeframes. The revised Standard Operating Procedure was already implemented to address the audit findings. OLA acknowledged that this update occurred, however this change occurred during the audit period. As such, OLA still cited this finding.		
Recommendation 9b	**Agree**	**Estimated Completion Date:**	Complete
Please provide details of corrective action or explain disagreement.	All Supports Planning Agencies were audited for 2019-2023 activities by end of calendar year 2024. OLTSS completed all audits of 2024 activities in calendar year 2025 on schedule, and as of March 2026 is beginning the next audit cycle of 2025 activities. The audit tool has been		

	improved to capture additional detail on "n/a" responses to clarify for future reviewers why a given performance metric was not applicable for that particular sample. Additionally, staff training has occurred for all SPA auditors to ensure relevant responses are captured instead of “n/a” responses.

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Information System Security and Controls

The Office of Legislative Audits (OLA) has determined that Finding 10 related to "cybersecurity," as defined by the State Finance and Procurement Article, Section 3.5-301(c) of the Annotated Code of Maryland, and therefore is subject to redaction from the publicly available audit report in accordance with the State Government Article 2-1224(i). Consequently, the specifics of the following finding, including the analysis, related recommendations, along with MDH's response, have been redacted from this report copy.

Finding 10
Redacted cybersecurity-related finding.

Agency Response has been redacted by OLA.

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Criminal Background Checks

Finding 11
MCPA did not ensure that vendor employees obtained criminal background checks, as required by the contracts.

We recommend that MCPA

a. **ensure that all required criminal background checks are obtained and reviewed, including those noted above; and**
b. **take appropriate action for any individual identified as having a criminal conviction.**

Agency Response			
Analysis			
Please provide additional comments as deemed necessary.	MCPA is operating in compliance with the Contract requirements around background checks. According to the contract, provision 3.3.2 Criminal Background Check requires **the contractor** to obtain from each prospective employee a signed statement permitting a criminal background check. The contract monitor is only responsible for reviewing disclosed criminal background findings and providing written approval prior to assignment of contractor personnel with criminal records, which has not yet happened but a process has been established to handle.		
Recommendation 11a	**Agree**	**Estimated Completion Date:**	Complete
Please provide details of corrective action or explain disagreement.	MCPA has taken corrective action to ensure full compliance with contractual screening requirements. MCPA worked directly with vendors to reinforce the requirement that all employees assigned to Medicaid projects undergo the required criminal background checks prior to onboarding. The vendor is now required to submit background check documentation to MCPA for review before any staff begin work. MCPA will review all identified criminal convictions, assess associated risks, and determine appropriate next steps in accordance with established.		
Recommendation 11b	**Agree**	**Estimated Completion Date:**	Complete
Please provide details of corrective action or explain disagreement.	There has been no individual identified with a criminal conviction. If there were to ever be an individual identified with a criminal conviction, that individual would be ineligible for work that requires access to PII and PHI.		

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Reconciliation of MMIS II to State Accounting Records

Finding 12
MCPA did not have procedures to reconcile Medicaid expenditures recorded in MMIS II with the State's accounting records and could not readily explain $200.9 million in expenditures that were not recorded in MMIS II.

We recommend that MCPA establish procedures to periodically (at least annually) reconcile financial activity recorded in MMIS II and the State's accounting records and resolve any variances, including those noted above.

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.	We agree with the finding related to the results of our initial Medicaid Management Information System (MMIS) - Financial Management Information Systems (FMIS) reconciliation. The previously submitted reconciliation was at the program level. We have subsequently developed an enhanced reconciliation at the transaction level which allows us to capture and identify all transactions. Further, 99% of the $200 million has been accounted for and reconciled.		
Recommendation 12	**Agree**	**Estimated Completion Date:**	Complete
Please provide details of corrective action or explain disagreement.	The previously submitted reconciliation was performed at the program level. We have implemented and documented a new methodology that utilizes transaction-level matching across the MMIS and FMIS systems. Using this methodology, the FY23 and FY24 reconciliation results show a 99.80% ($13.3B) and 99.96% ($15.1B) match. The remaining amounts for FY23 (.20% and $27M) and FY24 (.04% and $6M) represent: • Transactions that could not be processed in the Financial Management Information System (FMIS) due to provider data entry issues (e.g., provider name and address updates). MCPA is actively correcting these records and resubmitting the transactions for payment. • Transactions which were withheld in MMIS to offset provider liabilities (i.e. balances owed to Maryland Department of Health (MDH). As a result, these payments were correctly not transmitted to FMIS because a provider liability remained.		

AUDIT TEAM

Robert J. Smith, CPA
Audit Manager

Edwin L. Paul, CPA, CISA
Information Systems Audit Manager

David R. Fahnestock, CPA
Data Analytics Manager

Abdullah I. Adam, CFE
Sporthi J. Carnelio
Senior Auditors

Malcolm J. Woodard
Information Systems Senior Auditor

Charles H. Hinds, IV, CPA
Data Analytics Senior Auditor

Charlotte M.S. Chamberlin
Chau D. Mai
John E. Rooney
Zoe D. Smith
Garrett A. White
Staff Auditors

Neha S. Tirkey
Information Systems Staff Auditor