



Audit Report

Maximus, Inc., Member Communications

Texas Medicaid and CHIP
Enrollment Broker



**Inspector
General**

Texas Health
and Human Services

September 2, 2022
OIG Report No. AUD-23-001



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Results in Brief

Why OIG Conducted This Audit

The Texas Health and Human Services Commission (HHSC) contracts with Maximus to perform as the sole Medicaid and Children's Health Insurance Program (CHIP) enrollment broker for Texas. Maximus has served as the state enrollment broker since 1997. In state fiscal year 2021, Maximus reported an average of 103,006 new Medicaid medical enrollments every month, 35 percent of which were based on member choice; and 6,924 new CHIP medical enrollments every month, 70 percent of which were based on member choice.

Summary of Review

The audit objective was to determine whether Maximus, accurately, timely, and in accordance with applicable requirements:

- Communicated enrollment-related information to members who were determined eligible for Medicaid and CHIP services.
- Received and processed enrollment-related information from those members.

The audit scope included Maximus's enrollment-related processes for the period from September 1, 2020, to August 31, 2021. The scope also included a review of significant information system controls related to those processes for state fiscal year 2021 through the present.

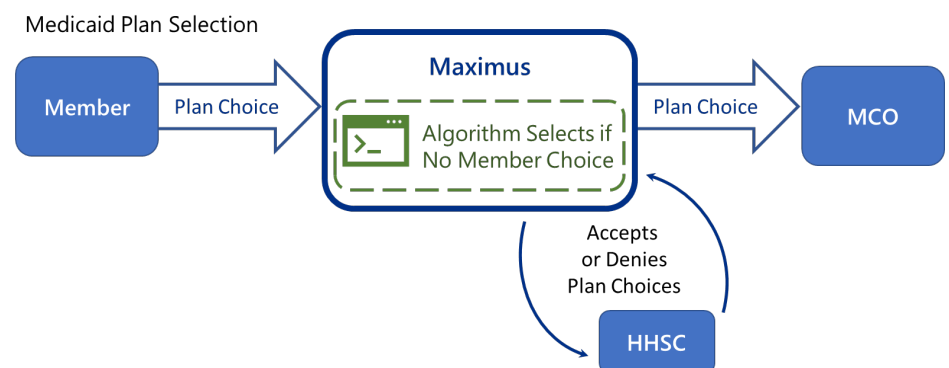
Conclusion

Maximus, Inc., (Maximus) substantially complied with applicable requirements related to communicating enrollment-related information to eligible Medicaid and Children's Health Insurance Program (CHIP) members and receiving and processing member enrollment-related information. However, it has opportunities to (a) improve its default managed care organization (MCO) selection process for CHIP members, (b) improve service to members, and (c) strengthen oversight of its mailing contractor. Additionally, while Maximus had processes and controls in place for its enrollment system, it should strengthen certain information system controls.

Key Results

Receiving and Processing Enrollment-Related Information From Members

Maximus received and processed Medicaid and CHIP enrollment-related transactions, accurately capturing members' enrollment choices and accurately communicating them to MCOs, as required. The figure below depicts the process for Medicaid. For CHIP, enrollments are processed without HHSC's approval.



Maximus did not initiate its default enrollment process for CHIP members in accordance with its documented procedures. Maximus's procedures, which it submits to HHSC quarterly for review, require Maximus to enroll CHIP members who had prior coverage one year or less from the current enrollment with their prior MCO. Maximus's default algorithm enrolled CHIP members with their previous MCO regardless of when that prior coverage occurred.

Background

For both Medicaid and CHIP enrollments, HHSC determines member eligibility and provides that information to Maximus.

Recommendations

Maximus should:

- Work with HHSC to update its process for initiating its default algorithm for CHIP members to ensure that it operates in accordance with the procedures it has submitted to HHSC.
- Continue to strengthen its process for resolving TIERS-denied transactions by developing clear procedures for the process and implementing a review of the process to ensure that all TIERS-denied transactions are captured and resolved according to its contract.
- Work with HHSC to review prior TIERS-denied transactions that were not captured in its review process to ensure that they were appropriately resolved.
- Implement a process to ensure that its enrollment packets provide accurate response deadlines.
- Implement a process to verify the accuracy of mail date information provided by its subcontractors.
- Strengthen its controls to help protect its data from unauthorized changes.

Management Response

OIG Audit presented preliminary audit results, issues, and recommendations to Maximus in a draft report dated August 5, 2022. Maximus's management responses are included in the report following each recommendation.

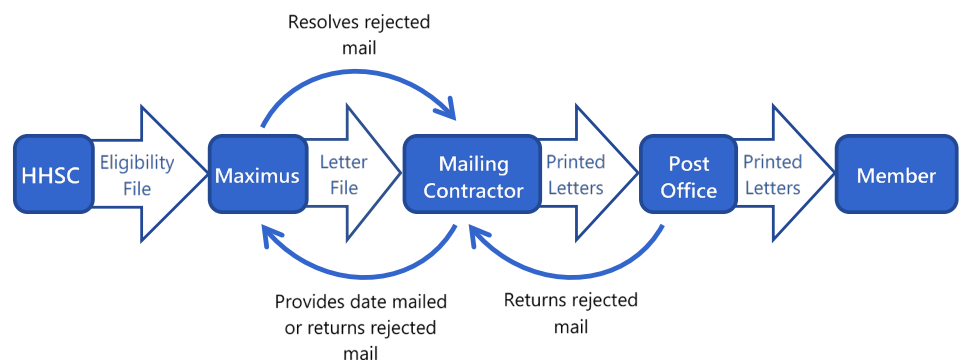
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After an enrollment selection is made, Maximus communicates Medicaid transactions to the Texas Health and Human Services Commission (HHSC) Texas Integrated Eligibility Redesign System (TIERS) and is required to resolve any transactions that TIERS denies. Its process for tracking and resolving transactions did not ensure it resolved all TIERS-denied transactions. Specifically:

- Maximus runs a daily report to capture TIERS-denied transactions, but the daily report did not include all TIERS-denied transactions.
- For TIERS-denied transactions that were included on the daily reports, Maximus did not include 68 percent of transactions in its tracking spreadsheet for the 12 daily reports tested.
- For the 25 tested transactions on its spreadsheet, all were resolved; however, 11 were not resolved timely and one did not address the member's selection of MCO.

Processing Enrollment-Related Information from HHSC and Communicating to Members

While Maximus communicated accurate enrollment-related information to Medicaid and CHIP members, it should improve its processes related to communicating enrollment deadlines and monitoring its mailing contractor. The figure below depicts the process.



For 26 of 27 applicable Medicaid enrollment packets tested, Maximus included an incorrect date by which the member must respond. Medicaid beneficiaries may not be enrolled with their preferred MCO because they may not respond by the stated deadline.

Maximus also did not review the accuracy of its mailing contractor's self-reported information about the date the mailing contractor delivered letters to the postal service.

IT General Controls

Maximus should strengthen certain controls to help protect its data from unauthorized changes. To minimize security risks, OIG Audit communicated details about the identified weaknesses to Maximus's management in a separate written communication.

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Audit Overview

Overall Conclusion

Maximus, Inc., (Maximus) substantially complied with applicable requirements related to communicating enrollment-related information to eligible Medicaid and Children's Health Insurance Program (CHIP) members and receiving and processing member enrollment-related information. However, it has opportunities to (a) improve its default managed care organization (MCO) selection process for CHIP members, (b) improve service to members, and (c) strengthen oversight of its mailing contractor. Additionally, while Maximus had processes and controls in place for its enrollment system, it should strengthen certain information system controls.

Key Audit Results

Maximus received and processed Medicaid and CHIP enrollment-related transactions, accurately capturing members' enrollment choices and accurately communicating them to MCOs, as required. However, Maximus should improve its processes for (a) automatically assigning certain CHIP members to plans and (b) resolving Medicaid transactions it submitted that the Texas Integrated Eligibility Redesign System (TIERS) denied.

While Maximus communicated accurate enrollment-related information to Medicaid and CHIP members, it should improve its processes related to communicating enrollment deadlines and monitoring its mailing contractor, CSG.

Maximus should strengthen certain controls to help protect its data from unauthorized changes. To minimize security risks, OIG Audit communicated

Objective

The audit objective was to determine whether Maximus accurately, timely, and in accordance with applicable requirements:

- Communicated enrollment-related information to members who were determined eligible for Medicaid and CHIP services.
- Received and processed enrollment-related information from those members.

Scope

The audit scope included Maximus's enrollment-related processes for the period from September 1, 2020, to August 31, 2021. The scope also included a review of significant information system controls related to those processes for state fiscal year 2021 through the present.

details about the identified information system control weaknesses to Maximus's management in a separate written communication.

OIG Audit also communicated other, less significant issues to Maximus's management in a separate written communication.

OIG Audit thanks management and staff at Maximus for their cooperation and assistance during this audit.

The "Detailed Audit Results" section of this report presents additional information about the audit results. OIG Audit presented preliminary audit results, issues, and recommendations to Maximus in a draft report dated August 5, 2022. Maximus acknowledged the audit recommendations and asserted it would implement corrective actions. Maximus's management responses are included in the report following each recommendation. Audit issues identified in this report may be subject to liquidated damages or administrative enforcement measures.¹

Background

The Texas Health and Human Services Commission (HHSC) contracts with Maximus to perform as the sole Medicaid and CHIP enrollment broker for the state of Texas. HHSC provides Maximus eligibility information from TIERS, and Maximus enrolls Medicaid beneficiaries and CHIP applicants who meet the necessary requirements in plans offered by MCOs. Maximus uses its enrollment system, MAXeb, to record, track, and manage Medicaid and CHIP member information.

Auditing Standards

Generally Accepted Government Auditing Standards

We conducted this performance audit 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.

¹ 1 Tex. Admin. Code § 371.1603 (May 20, 2020).

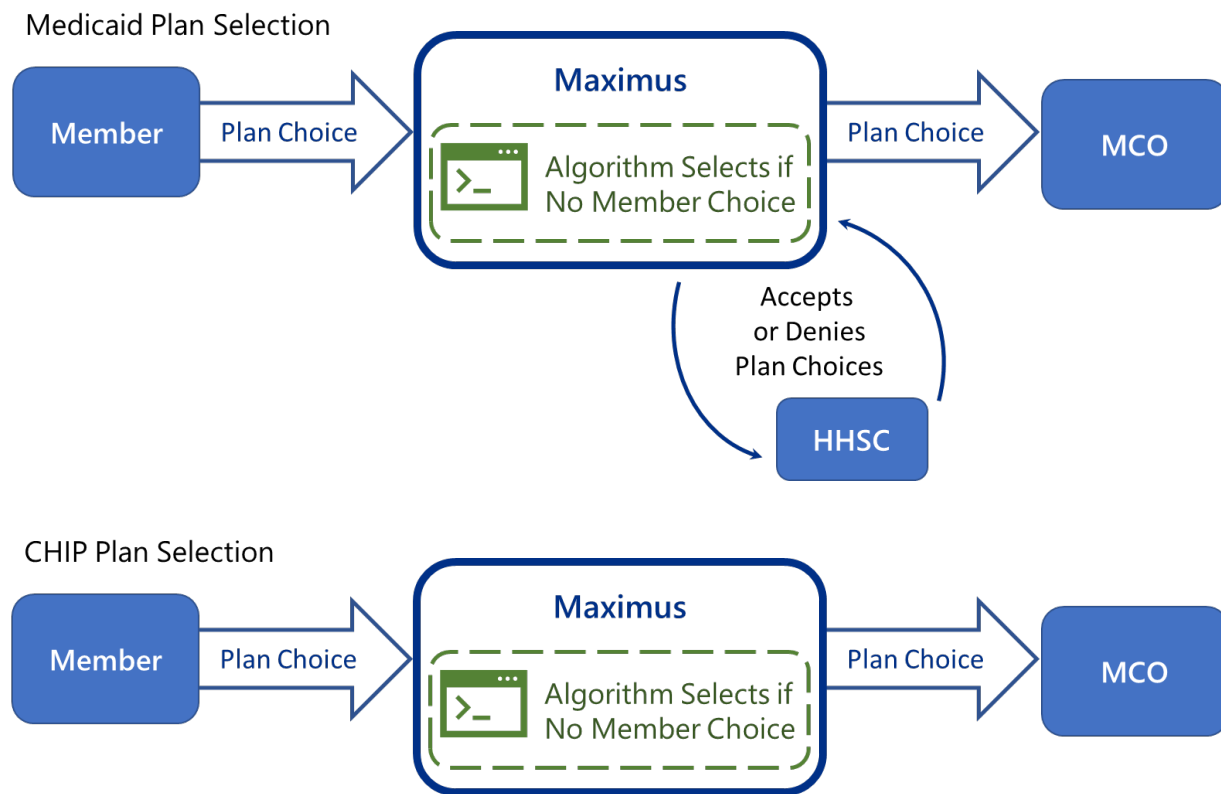
Detailed Audit Results

The following sections of this report provide additional detail about the results of the audit. Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31.

Receiving and Processing Enrollment-Related Information From Members

Figure 1 shows Maximus's process for receiving member enrollment choices and transmitting them to the MCOs.

Figure 1: Maximus's Process for Receiving, Processing, and Communicating Member Plan Choices



Source: OIG Audit

Maximus received and processed Medicaid and CHIP enrollment-related transactions. However, Maximus should improve its (a) default enrollment process for certain CHIP members and (b) process for resolving submitted Medicaid transactions denied by TIERS.

Chapter 1: Maximus Accurately Received and Processed Member Plan Selections but Should Improve Its Default Enrollment Process for CHIP Members

Maximus accurately captured members' plan enrollment selections. However, it should improve its process for automatically assigning certain CHIP members who have not selected a plan to an MCO.

Receiving Members' Plan Selections

Maximus had processes to capture a member's selection of MCO accurately and completely. For 2021, the majority of enrollments based on member selections were recorded through Maximus's online portal or through its call center. This audit focused on Maximus's processes and controls over those two selection methods.

- For enrollment selections recorded through its online portal, Maximus ensured that the portal offered members the correct MCO options and accurately recorded the member's selection of MCO.
- For enrollment selections received through the call center, Maximus's call center representatives appropriately addressed the 53 calls tested, including enrolling members in the correct MCO when applicable.

For calls received through Maximus's call center, Maximus's contract requires it to follow its quality management plan. The plan, which it submits to HHSC every six months, includes a monthly quality assurance review of a statistical sample of recorded calls. At the start of the COVID pandemic, Maximus call center staff transitioned to a remote work environment, which initially prevented recording of calls. As a result of call recording issues related, in part, to the COVID pandemic, Maximus did not perform its quality assurance reviews for the first three months of the audit scope. Maximus restarted these reviews for calls in December 2020, although it was unable to perform a statistically valid sample of reviews until its reviews in 2021. For the reviews OIG Audit tested, covering December 2020 through August 2021, Maximus performed its quality assurance call reviews accurately and timely, in accordance with its contract and the guidance it received from HHSC related to the suspension of its quality assurance reviews during the transition to the remote environment. Maximus's quality management

plan also includes a supervisory review of a selection of each call center representative's calls. During the period when Maximus could not perform its quality assurance process, it completely and accurately performed its supervisory reviews of calls for the call center representatives OIG Audit tested.

Assigning Members to Plans

Maximus did not initiate its default enrollment process for CHIP members in accordance with its documented procedures. Maximus's default algorithm enrolled CHIP members with their previous MCO regardless of when that prior coverage occurred. Of the four default enrollments tested for CHIP members with prior coverage, all four had a break in coverage of more than one year, and all four were enrolled with their previous MCO. For default enrollments, Texas Administrative Code requires Maximus to design its default enrollment process to distribute members among MCOs,

considering one or more factors including prior MCO coverage.² Maximus's procedures, which it submits to HHSC quarterly for review, require Maximus to enroll CHIP members who had prior coverage one year or less from the current enrollment with their prior MCO. Maximus confirmed that the programming of its default algorithm caused the algorithm to perform in a way that conflicted with Maximus's procedures. Not assigning members based on the default algorithm, as communicated to HHSC, could affect the distribution of members among MCOs.

Default Enrollment Process

Maximus automatically assigned an MCO to Medicaid beneficiaries and CHIP applicants who met the necessary requirements, including the payment of an enrollment fee for certain CHIP members, and who were not yet enrolled in a plan using a pre-determined algorithm. Texas Administrative Code requires this default algorithm to consider one or more relevant factors, such as MCO performance or other enrollments in the same household.

Source: OIG Audit

² 1 Tex. Admin. Code § 370.303 (Oct. 9, 2016).

Recommendation 1

Maximus should work with HHSC to update its process for initiating its default algorithm for CHIP members to ensure that it operates in accordance with the procedures it has submitted to HHSC.

Management Response

Maximus acknowledges that for this specific scenario, the default enrollment process for CHIP members was not initiated according to its documented procedures. Maximus prioritized this fix, and it was deployed in the May 2022 Systems Release. Maximus made the dental default change for CHIP to align with updated HHSC policy in May 2022. HHSC approved the CHIP default methodology document via Response #6 of the Dental Default Updates SAR# 08272021J001. As a result of these changes, Maximus is initiating the default process for CHIP members in accordance with its documented procedures.

Action Plan

Maximus updated the default algorithm to only assign CHIP clients to prior plans within the last 12 months and deployed the change in the May 2022 Systems Release.

Responsible Manager

Director, Support Services

Implementation Date

May 2022

Chapter 2: Maximus Accurately Communicated Enrollment-Related Transactions to HHSC and MCOs but It Should Improve Its Process for Resolving Transactions Denied by TIERS

Maximus's processing of enrollment-related transactions includes

(a) communicating Medicaid transactions to HHSC's eligibility system, TIERS; (b) resolving any transactions that TIERS denies; and (c) communicating Medicaid and CHIP transactions to MCOs. Maximus effectively communicated enrollment-related transactions to HHSC and MCOs, but it did not always resolve TIERS-denied transactions that it submitted, as required.

Communicating Enrollment-Related Transactions to HHSC and MCOs

Maximus accurately communicated all Medicaid enrollment-related transactions tested to TIERS within one day, as required by its contract. Additionally, Maximus appropriately updated its enrollment system based on the response from TIERS.

Maximus also accurately communicated all Medicaid and CHIP enrollment-related transactions tested to MCOs through its daily and monthly communications, as required by its contract. Maximus must communicate certain enrollment-related transactions to MCOs on daily files, such as retroactive enrollments for CHIP perinatal members. Maximus communicates all other enrollment-related transactions as part of its monthly enrollment files to MCOs.

Processing Medicaid and CHIP Enrollments

For both Medicaid and CHIP enrollments, HHSC determines member eligibility and provides that information to Maximus.

Medicaid – Maximus creates and processes enrollment transactions, transmitting them to TIERS, which determines enrollment dates and sends enrollment outcomes back to Maximus. Maximus processes those HHSC-determined enrollments and transmits them to MCOs daily and monthly, as appropriate.

CHIP – Maximus creates and processes enrollment transactions, determines enrollment dates, and transmits them to MCOs daily and monthly, as appropriate.

Source: Maximus

Resolving TIERS-Denied Transactions

Maximus's process for resolving submitted Medicaid transactions³ denied by TIERS does not consistently ensure that enrollments are corrected or communicated to HHSC as required. Maximus's contract requires it to research enrollment transactions failed or rejected by TIERS and resolve them within four business days by:

- Correcting the transactions, or
- Reporting to HHSC that Maximus cannot correct the failure or rejection.^{4,5}

Prior to April 2021, Maximus did not maintain documentation that it consistently resolved TIERS-denied transactions. While Maximus did not maintain this documentation prior to April 2021, auditors determined that Maximus resolved 4 of 18 TIERS-denied transactions tested within the required timeframe and resolved a total of 10 of the 18 transactions tested. Table 1 shows the results of testing 18 sampled TIERS-denied transactions from before April 2021.

Table 1: Results of Testing 18 Sampled TIERS-Denied Transactions Prior to April 2021

Testing Result	Transactions	Percentage
Maximus did not provide support that it resolved the transaction	8	44%
Resolved, but not within four days	6	33%
Resolved timely	4	22%
Total	18	

Source: OIG Audit

Additionally, auditors identified one member whose enrollment had been denied due to a system error in MAXeb, Maximus's enrollment system. That member's enrollment was denied in October 2020 and the member was not covered under a Medicaid plan at the time of the audit. After the auditors notified Maximus of

³ Maximus submits daily files to TIERS with medical and dental enrollment updates from recipient enrollments, default enrollments, and primary care physician changes from the medical or dental plans.




⁴ HHSC contract HHS000061300001, Exhibit C, "Agreed Modifications Chart," Requirement EB 266 (Aug. 6, 2020).

⁵ For the purposes of this report, the term "resolve" means Maximus's performance of either of these required activities.

this issue, Maximus contacted and enrolled the member. Maximus corrected the system error in March 2021.

In April 2021, Maximus implemented a process for tracking and resolving TIERS-denied transactions. Maximus did not have documented policies and procedures for this process; Figure 2 shows the process as it was designed and the observed results of the process in practice.

Figure 2: Maximus's Process for Resolving TIERS-Denied Transactions

	Maximus Design	OIG Audit Result
 1. Query	Maximus runs a daily report to capture TIERS-denied transactions.	Not all transactions were captured.
 2. Spreadsheet	Maximus records the transactions from its daily report to a tracking spreadsheet.	Not all the daily report results were recorded on the tracking spreadsheet.
 3. Resolution	Maximus researches and resolves the transactions on the spreadsheet timely.	The transactions were resolved but not always resolved as required by the contract.

Source: OIG Audit

This process did not ensure that Maximus resolved all TIERS-denied transactions as required by its contract. Specifically:

- The daily report did not include all TIERS-denied transactions, including certain TIERS-denied transaction types. For example, the daily reports did not include transfers of primary care physicians in addition to other types of transactions.
- For TIERS-denied transactions that were included on the daily reports, Maximus did not include 288 of the 426 (68 percent) TIERS-denied transactions in its tracking spreadsheet for the 12 daily reports tested.
- For the transactions included on its tracking spreadsheet, Maximus documented its research and either corrected the error or communicated the transaction to HHSC for all transactions tested, as required.

- For the 25 tested transactions on its spreadsheet needing a resolution:
 - 11 were resolved more than four days after Maximus received the denial from TIERS.
 - One resolution did not address the member's selection of MCO. For this member, Maximus's resolution relied on its default algorithm to assign the member to a plan.

By not resolving TIERS-denied transactions accurately and timely members may not receive the correct MCO coverage or may not receive coverage under any MCO.

Recommendation 2a

Maximus should continue to strengthen its process for resolving TIERS-denied transactions by developing clear procedures for the process and implementing a review of the process to ensure that all TIERS-denied transactions are captured and resolved according to its contract.

Management Response

Implementation of the process was delayed due to factors outside of Maximus' control. The process for reviewing failed transactions did not identify and include all transactions rejected by TIERS because Maximus was not provided with a complete list of denial codes; the transactions were sent with unknown denial codes which caused the process to fail. Maximus is dependent upon Deloitte and HHSC to provide and update the complete list of TIERS denial codes so that all transactions can be resolved. Maximus began working with HHSC to finalize the process for resolving TIERS-denied transactions in July 2020 during the KPR 10 Workgroup Transition meeting, before the September 1, 2020, contract start date. The original plan for resolving denied transactions relied on Maximus having an explanation of all denial reasons as communicated by the TIERS reason codes. Having the TIERS denial reasons would allow Maximus staff to respond to and resolve a larger number of transactions thus limiting the work that is sent to HHSC staff for handling. Implementation of the process to review and resolve denied transactions could not start until the process was approved by HHSC since the process is dependent on understanding the inputs from TIERS.

This request to receive all TIERS denial code reasons was tracked in the General Transition meetings via the Action Items log until it was closed in January 2021 due to a lack of response from Deloitte. At that point, Maximus developed a process without the denial reason information and deployed the process with HHSC's approval in April 2021. Due to this delay, Maximus did not maintain documentation that it resolved TIERS-denied transactions prior to April 2021. Accordingly, Maximus collaborated with HHSC to implement this requirement, and Maximus and HHSC Medicaid CHIP Services (MCS) leadership were able to agree to and implement a process that began in April 2021.

Maximus acknowledges that not all denied transactions available to the report were included in the tracking spreadsheet used by staff. There was a defect in the process whereby the output used by Operations staff excluded certain TIERS-denied transactions that were available to the report query. Maximus corrected this defect in August 2022 and staff have been able to track all denied transactions available in the report.

Maximus reviewed all 288 transactions that were tested to determine impacts to client MCO enrollment. Of these 288 transactions,

- 84 clients were enrolled with the MCO in the transaction;
- 97 clients lost eligibility;
- 106 clients remain eligible but not enrolled;
- 1 client was enrolled within 4 months.

For the 106 clients that remain eligible but not enrolled, Maximus continues to send enrollment to TIERS on a monthly basis and these enrollments continue to be denied. Now that the defect has been fixed, these 106 clients have been included in the output for the tracking spreadsheet. Some of these transactions have already been escalated to HHSC using the denied transaction process and all transactions will be escalated by the end of August 2022.

Maximus would like to note that managed care organization (MCO) choice is not a requirement for the process. Maximus contacts the client as part of the resolution process; however, Maximus must resolve both default and choice transactions. If a client cannot be contacted and the enrollment information

must be communicated to TIERS, the process proceeds with the default enrollment selection.

Action Plan

To ensure contractual compliance, Maximus has proposed modifications to the contract requirement to align it with the process as agreed to by Maximus and HHSC. These modifications were submitted to HHSC via MIM-SAR#01252022A Texas Enrollment Broker HS00006130001 - Amendment 2 MIM Follow-up. The request to amend the contract with these modifications was submitted on May 25, 2022, and is currently with HHSC for review and incorporation into a formal amendment. Maximus has identified additional updates to the contract requirement language and will be proposing them to HHSC. These updates include specifying that PCP transfer transactions are excluded from this scope of work and identifying that the work is dependent upon having a complete list of enrollment transaction denial codes from HHSC.

Additionally, going forward, Maximus will work with HHSC and TIERS to create a process for TIERS to update Maximus when new codes are created by the eligibility system. Maximus also intends to propose additional modifications to the contract requirement to address the known denial codes as provided by HHSC.

Responsible Managers

- Director, Support Services
- Director, Operations
- Director, Project Management Office

Target Implementation Date

Upon HHSC's approval of changes to EB 266 submitted in contract Amendment 2, Maximus will work with HHSC to implement the second element of changes EB 266. Maximus will work with HHSC to specify the changes necessary to align the requirement with the agreed upon process and will complete that work by November 2022.

Recommendation 2b

Maximus should work with HHSC to review prior TIERS-denied transactions that were not captured in its review process to ensure that they were appropriately resolved.

Management Response

Maximus agrees that resolving TIERS denied transactions that were not evaluated in the current process is an important piece of completing the work on Recommendation 2. Once the actions in recommendation 2a have been completed, Maximus will work with HHSC to identify which transactions that have already been denied need to be reviewed for resolution. Current client eligibility and enrollment status must be considered to identify actionable transactions only so that no EB or HHSC follow up impacts or changes a client's current managed care enrollment.

Action Plan

Once the actions in recommendation 2a have been completed, a timeline for completing this work will be established and Maximus will confirm when all historic transactions have been reviewed and sent for resolution.

Responsible Managers

- Director, Support Services
- Director, Operations
- Director, Project Management Office

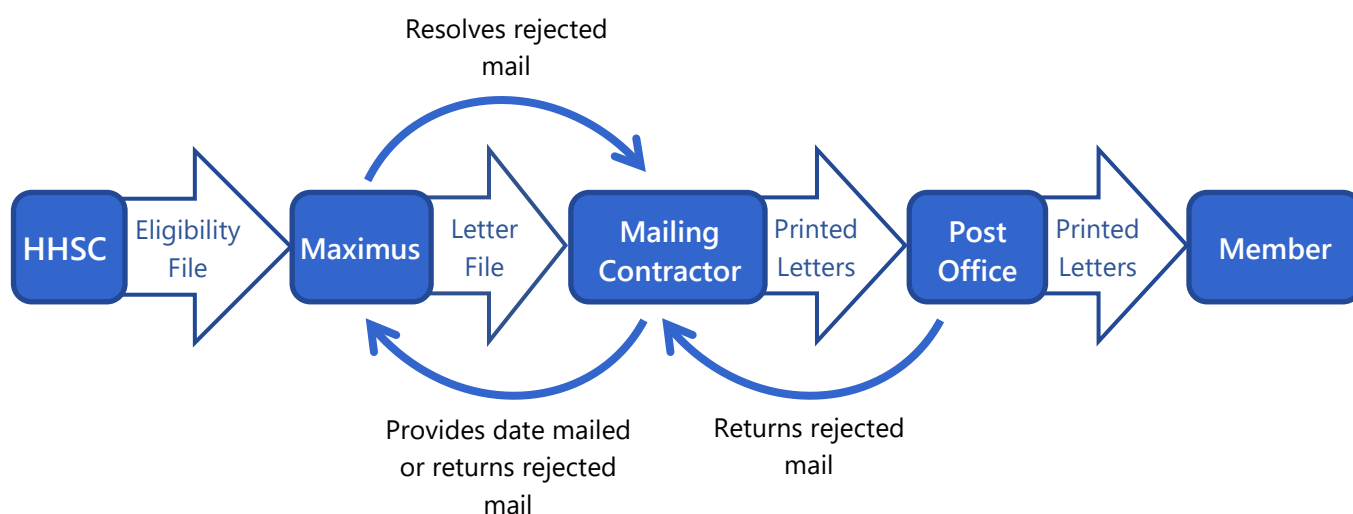
Target Implementation Date

Upon resolution of the process to receive updated denial codes from HHSC and Deloitte, Maximus and HHSC will establish the timeline to complete the review of historic denied transactions.

Processing Enrollment-Related Information from HHSC

Figure 3 shows Maximus's process for communicating enrollment-related information to members who were determined eligible for Medicaid and CHIP services.

Figure 3: Maximus's Process for Receiving Enrollment-Related Information from HHSC and Communicating It to Members



Source: OIG Audit

Maximus had processes to ensure that it communicated accurate enrollment-related information to Medicaid and CHIP members. However, it should improve its processes related to communicating enrollment deadlines and monitoring its mailing contractor, CSG.

Chapter 3: Maximus Communicated Enrollment-Related Information to Members, but Should Identify Accurate Enrollment Deadlines

Maximus had processes to ensure it communicated enrollment-related information to members, but it did not always include accurate information in its mailed enrollment packets. Maximus's process for receiving enrollment-related information from HHSC and communicating it to members includes:

- Uploading information from HHSC into its enrollment system, MAXeb.
- Generating and sending enrollment packet information to its mailing contractor, CSG.
- Resolving letters rejected by CSG.

Receiving and Processing Information from HHSC

Maximus accurately and completely uploaded information from HHSC into MAXeb. Maximus's contract requires that it maintain an accurate file transfer process and an accurate record of member information in MAXeb. For the Medicaid and CHIP transactions tested, MAXeb accurately reflected the members' personal and mailing information.

Resolving Rejected Letters

If the initial letter cannot be sent or is undeliverable, CSG provides Maximus with information about those rejected letters. Maximus's contract requires it to (a) process and capture rejected letters in its enrollment system, (b) use tools available from the postal service to minimize rejected letters, and (c) deliver enrollment letters to the postal service within four days of receiving an eligibility file. For all rejected letters tested, Maximus took the appropriate action, including (a) updating the address in its enrollment system when the postal service identified that it was undeliverable, (b) cancelling letters when members were no longer eligible, or (c) correcting and resending letter files to CSG when the original file sent to CSG omitted address information. When the letters required correction, Maximus corrected the letters and provided them to CSG, which reported that they were mailed within four days, as required.

Mailing Enrollment Packets

Maximus ensured that its mailing contractor, CSG, mailed enrollment packets to new members within the four days required by its contract.⁶ For the packets tested, those packets also included accurate member and available plan information.

Maximus's contract requires it to perform an onsite quality assurance review of printed materials. Due in part to the COVID pandemic, Maximus did not perform these onsite reviews for the first three months of the audit scope. Starting in December 2020, Maximus's onsite quality assurance reviews of printed materials effectively ensured that mailings were accurately printed and included the appropriate materials for the reviews OIG Audit tested.

While the enrollment packets were mailed timely, and the reviews were effective, enrollment deadlines included in the packets for Medicaid members were often incorrect. Specifically, for 26 of 27 applicable Medicaid enrollment packets tested, Maximus included an incorrect date by which the member must respond. Medicaid beneficiaries have 15 days from the date the packet is mailed to choose an MCO.⁷ Maximus used the date printed on the letters to calculate the 15-day deadline instead of the date CSG mailed the packet. Because CSG did not always mail the letter on the same day as the date Maximus included on the letter, the 26 letters included response deadlines of as little as 10 days from the date that CSG mailed the letters. Since the letters indicate that Maximus will select an MCO for members who do not respond before the deadline, including a shorter response deadline increases the risk that members may not respond with, and be enrolled with, their preferred MCO.

Mailing Process

Maximus generates daily letter files and transmits them to its mailing contractor, CSG. CSG prints the packets and delivers them to the postal service. Once the mail is delivered to the postal service, CSG provides Maximus with summary reports of successfully sent, rejected, and returned mail.

Source: OIG Audit

⁶ See chapter 4 for information regarding the accuracy of the mailed dates used to determine compliance with this requirement.

⁷ 1 Tex. Admin. Code § 353.403 (Sept. 1, 2014).

Recommendation 3

Maximus should implement a process to ensure that its enrollment packets provide accurate response deadlines.

Management Response

Maximus worked with HHSC to establish the due dates printed on the enrollment packets in accordance with contract requirements EB 293 and EB 383. Historically, HHSC and Maximus have been challenged with identifying a successful solution for encouraging clients to respond quickly with enrollment selections. Specific due dates or text-based deadlines have both been considered. Currently due dates for Medicaid enrollment packets are set using a calculation of letter request date plus 17 days. This was selected to provide clients a 15-day timeline while allowing for (2) two days for letter processing by the print vendor. Medicaid clients who are defaulted faster to limit fee for service gaps will have a text-based deadline instead of a specific due date.

Currently, information on letters is only reviewed as it relates to a specific project that HHSC or Maximus initiates, so some pieces of letter information can go many years without being updated or reviewed. Maximus will work with HHSC to establish a separate process to audit correspondence, including letter text and the data that is populated in letters.

Maximus disagrees with the risk in the OIG report that the current methodology increases the risk that members may not respond with, and be enrolled with, their preferred MCO. Maximus has not received complaints from clients not receiving their plan selection. Data from January 2022 – September 2022 enrollment selections shows that seventy-one (71) percent of clients respond with 15 days of eligibility being received from TIERS and the Welcome Packet being sent. The other twenty-nine (29) percent of clients that make a plan selection do so after day 15.⁸ Clients make a choice based on receiving outreach and responding to it at the time they open the mail.

⁸ In its response, Maximus referred the reader to the table titled, "Choice Enrollments Breakdown," which is provided in Appendix D as Table D.1.

Of the clients that were defaulted between January and September 2022, only 13% are defaulted on day sixteen (16). Over half of the population had between 16 and 31 days from the day eligibility was received from TIERS and the Welcome Packet being sent.⁹ Maximus' conclusion is the current methodology is the best to encourage client choice while providing guidance on deadlines.

Action Plan

Maximus established the due date on enrollment forms in accordance with contract requirements EB 293 and EB 383 based on HHSC direction. Therefore, to verify HHSC is still in agreement with the current established due dates on the enrollment forms, Maximus will conduct a review of all Medicaid and CHIP correspondence that include due dates with HHSC to confirm their approval.

Responsible Managers

- Director, Support Services
- Director, Project Management Office

Target Implementation Date

December 2022

Refer to Appendix D

Maximus's Enrollment Breakdown Reports

Auditor Comment

OIG Audit appreciates the feedback provided by Maximus in its management response and acknowledges Maximus's position that including a shorter response deadline does not create a risk. OIG Audit notes that Maximus's contract, in requirement EB 383, specifically requires the inclusion of an accurate deadline:

Provide identified eligible CHIP and Medicaid Managed Care clients an enrollment packet within HHSC-specified timelines per each Managed Care Program. The Enrollment Broker must provide information in the

⁹ In its response, Maximus referred the reader to the table titled, "Default Enrollments Breakdown by Duration," which is provided in Appendix D as Table D.2.

enrollment packet explaining deadlines to select an MCO before the client is auto assigned to an MCO.

OIG Audit stands by the risk it identified and its related recommendation.

Chapter 4: Maximus Should Strengthen Its Mailing Contractor Monitoring

Maximus did not review the accuracy of CSG's self-reported information about the date CSG delivered letters to the postal service. Maximus has a process for monitoring its subcontractors, including assessing their internal controls. However, that process did not include reviewing the accuracy of information that CSG provides to Maximus about the date the letters were mailed. Maximus used that information to calculate and report on its compliance with its requirement to deliver all enrollment packets to the post office no later than four business days after receipt of the eligibility file from HHSC, a key performance requirement of its contract with HHSC.¹⁰ Without verifying the accuracy of this mail date information, Maximus cannot ensure that it is meeting its contractual requirements and providing members an opportunity to enroll with a plan that best suits their needs.

Recommendation 4

Maximus should implement a process to verify the accuracy of mail date information provided by its subcontractors.

Management Response

Maximus acknowledges that a process was not in place to audit mail date information from CSG. Creating and implementing such a process will verify the accuracy of data and allow Maximus to identify and respond to any issues identified by the audit process.

Action Plan

In March 2022, Maximus developed and implemented a semi-monthly QC process to validate the data used to ensure we are meeting contractual requirements to mail letters in 4 business days from receipt of the eligibility information. The Correspondence Materials Development (CMD) specialist

¹⁰ HHSC Contract HHS000061300001, Exhibit O, Key Performance Requirement 8 (Aug. 6, 2020).

validates the dates that the print vendor, CSG, reports are the same as the post office date. The specialist reviews the file data and the post office data. No errors have been discovered since this QC process was implemented. This process has identified no issues with mail date information.

In October 2021, Maximus implemented additional monitoring efforts to strengthen and enhance contract oversight activities of Maximus' print vendor, CSG as follows:

- Maximus TX EB Contracts team initiated quarterly audits beginning in January 2022. The scope of the audit covers a review of the subcontractor's adherence to contractual requirements related to but not limited to the following:
 - Subcontractor's scope of work,
 - Adherence to key performance requirements,
 - Review of the subcontractor's quality control and quality assurance processes
 - Compliance with Disaster Recovery and Physical Security requirements,
 - Compliance with the accuracy, completeness, and submission of deliverables, reports, etc.
 - Identification and outcome of HIPAA related incidents
 - The outcome results are documented and submitted via formal correspondence to the subcontractor.
- Maximus TX EB Contracts team initiated on-site physical security audits in January 2022. The scope of the audit assesses CSG's physical controls, hardware, processes, and technology to ensure the protection of Maximus physical assets (client data). The frequency of this audit occurs on a biannual basis. The outcome results are documented and submitted via formal correspondence to the subcontractor.
- TX EB increased the review, monitoring, and oversight of CSG's monthly and quarterly reports and deliverables beginning in October 2021. TX EB

Contracts, Correspondence Materials Development, and State Reporting teams conduct a thorough review of the reports and deliverables submitted by CSG. This oversight provides increased confidence and insurability that contractual requirements and performance is met and helps to identify continuous improvement opportunities.

- Modified key performance requirements (KPR) and Deliverable Requirements

Responsible Managers

- Director, Support Services
- Director, Project Management Office

Implementation Date

TX EB implemented the QA process and strengthened its contract oversight processes beginning in October 2021. TX EB implemented the Correspondence Materials Development QC process in March 2022.

IT General Controls

Maximus had processes and controls in place for its enrollment system, MAXeb, including user access, password requirements, and change management. Maximus's password settings for MAXeb were configured in accordance with applicable requirements, and Maximus's information systems security policies and procedures addressed significant information technology functions, including user access, password requirements, and change management. However, Maximus should strengthen certain controls to help protect its data from unauthorized changes.

Chapter 5: Maximus Should Strengthen Certain Information System Controls

To minimize security risks, auditors communicated details about the identified weaknesses separately to Maximus's management, in writing. Pursuant to Standard 9.61 of the U.S. Government Accountability Office's *Government Auditing Standards*, certain information was omitted from this report because that information was deemed to present potential risks related to public safety, security, or the disclosure of private or confidential data. Under the provisions of Texas Government Code, Section 552.139, the omitted information is also exempt from the requirements of the Texas Public Information Act.

Recommendation 5

Maximus should strengthen its controls to help protect its data from unauthorized changes.

Management Response

Action Plan

Maximus has provided a detailed confidential Management Response separately in writing to the auditors in connection to Chapter 5; however, Maximus will continue to work with HHSC to adapt and improve its processes.

Responsible Managers

- Director, TX EB Systems
- Director, Project Management Office

Target Implementation Date

December 2022

Appendix A: Objective, Scope, and Criteria

Objective and Scope

The audit objective was to determine whether Maximus accurately, timely, and in accordance with applicable requirements:

- Communicated enrollment-related information to members who were determined eligible for Medicaid and CHIP services.
- Received and processed enrollment-related information from those members.

The audit scope covered Maximus's enrollment-related processes for the period from September 1, 2020, to August 31, 2021. The scope also included a review of significant information system controls related to those processes for 2021 through present.

Criteria

OIG Audit used the following criteria to evaluate the information provided:

- 1 Tex. Admin. Code Chapters 353 (2014) and 370 (2016)
- HHSC Contract HHS000061300001 (2020)
- National Institute of Security and Technology Special Publication 800-53, rev. 4 (2015) through rev. 5 (2020)
- Maximus's policies and procedures (2013 through 2021)

Appendix B: Methodology and Data Reliability

OIG Audit conducted fieldwork from November 15, 2021, through July 11, 2022. To address the audit objective, auditors conducted interviews with Maximus management and staff and reviewed supporting documentation, including:

- Internal controls, including components of internal control significant within the context of the audit objective.¹¹
- Maximus's enrollment broker contract with HHSC and its policies and procedures relevant to its operations and information security.
- Medicaid and CHIP member information and enrollment information within MAXeb.
- Information related to Maximus's oversight of its contractors.
- Documentation of Maximus's communications with HHSC, including eligibility files Maximus receives from HHSC for Medicaid and CHIP.
- Documentation of Maximus's communications with members, including enrollment packets communicating new eligibility and enrollment plan choices.
- Documentation of Maximus's communications with MCOs related to enrollments.
- Evidence of key security controls related to passwords, information system access, and change management.

Sampling Methodology

Auditors selected non-statistical samples, primarily through risk-based selections. These sample selections were chosen to address specific risk factors identified in the populations. The sample items were generally not representative of the

¹¹ For more information on the components of internal control, see the United States Government Accountability Office's Standards for Internal Control in the Federal Government, (Sept. 2014), <https://www.gao.gov/assets/gao-14-704g.pdf> (accessed Jul. 26, 2022).

populations; therefore, it would not be appropriate to project the test results to the populations. The results of testing are described throughout the report in relation to the items sampled, as appropriate.

Data Reliability

To assess the reliability of significant data used to select samples, auditors performed some or all of the following for each of the populations: (a) analyzed the data for reasonableness and completeness, (b) reviewed the extraction methodology, (c) observed the extraction process, and (d) interviewed Maximus staff who were knowledgeable about the data.

With the exception of the population of quality assurance reviews for call center activities, OIG Audit determined that the data was sufficiently reliable for the purposes of this audit. As discussed in Chapter 1, Maximus was unable to perform a complete sample of quality assurance reviews for call center activities for December 2020 due to issues outside its control. For that month, auditors could not determine the completeness of the quality assurance reviews; however, the available quality assurance reviews were the best source of data available for the purposes of the audit.

Appendix C: Summary of Recommendations

Table C.1: Summary of Recommendations to Maximus

No.	Recommendation	Responsible Managers	Target Implementation Date
1	Maximus should work with HHSC to update its process for initiating its default algorithm for CHIP members to ensure that it operates in accordance with the procedures it has submitted to HHSC.	<ul style="list-style-type: none"> • Director, Support Services 	May 2022
2a	Maximus should continue to strengthen its process for resolving TIERS-denied transactions by developing clear procedures for the process and implementing a review of the process to ensure that all TIERS-denied transactions are captured and resolved according to its contract.	<ul style="list-style-type: none"> • Director, Support Services • Director, Operations • Director, Project Management Office 	November 2022
2b	Maximus should work with HHSC to review prior TIERS-denied transactions that were not captured in its review process to ensure that they were appropriately resolved.	<ul style="list-style-type: none"> • Director, Support Services • Director, Operations • Director, Project Management Office 	Ongoing
3	Maximus should implement a process to ensure that its enrollment packets provide accurate response deadlines.	<ul style="list-style-type: none"> • Director, Support Services • Director, Project Management Office 	December 2022
4	Maximus should implement a process to verify the accuracy of mail date information provided by its subcontractors.	<ul style="list-style-type: none"> • Director, Support Services • Director, Project Management Office 	March 2022
5	Maximus should strengthen its controls to help protect its data from unauthorized changes.	<ul style="list-style-type: none"> • Director, TX EB Systems • Director, Project Management Office 	December 2022

Source: OIG Audit

Appendix D: Maximus's Management Response

Attachment: Enrollment Breakdown Reports

Maximus provided the tables in this appendix as part of its response to Recommendation 3. They are presented here unaltered, as Maximus provided them.

Table D.1: Choice Enrollments Breakdown

Month	Within 15 Days	Over 15 Days	Within 15 Days%	Over 15 Days%
Jan-22	18,508	8,941	67.4%	32.6%
Feb-22	25,157	10,582	70.4%	29.6%
Mar-22	22,243	7,640	74.4%	25.6%
Apr-22	26,590	11,823	69.2%	30.8%
May-22	22,267	8,455	72.5%	27.5%
Jun-22	23,648	9,127	72.2%	27.8%
Jul-22	19,343	8,376	69.8%	30.2%
Aug-22	15,781	6,898	69.6%	30.4%
Sep-22	24,381	9,386	72.2%	27.8%
Average	21,991	9,025	70.9%	29.1%

Source: Maximus

Table D.2: Default Enrollments Breakdown by Duration

Duration	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Average	% Defaulted per duration
16	3,104	10,751	7,916	4,577	4,589	6,702	2,777	3,800	4,144	5,373	13.29
17	0	0	7,651	1,873	2,169	2,280	1,705	1,558	1,847	2120.33	5.24
18	2,155	0	0	2,111	2,261	2,468	1,873	1,535	2,167	1618.89	4.00
19	2,234	0	0	2,071	1,889	0	1,843	1,706	1,851	1288.22	3.19
20	6,570	1,757	60	8,870	2,880	0	1,914	1,582	2,035	2852	7.05
21	0	1,722	50	0	3,486	1,884	7,385	3,220	1,989	2192.89	5.42
22	0	2,080	0	0	0	1,962	0	0	0	449.111	1.11
23	2	5,795	2,304	0	0	2,022	0	0	0	1124.78	2.78
24	134	0	0	0	0	1,889	0	0	1,617	404.444	1.00
25	2,199	0	0	82	2,924	3,572	54	1,442	1,879	1350.22	3.34
26	2,414	10	0	0	1,831	0	0	1,830	1,873	884.222	2.19
27	2,348	87	2,002	1,681	1,928	0	1,753	1,529	1,671	1444.33	3.57
28	1	1,670	1,919	2,779	2,537	0	2,147	1,690	2,985	1747.56	4.32
29	0	2,191	1,797	0	0	1,833	0	1	0	646.889	1.60
30	2,538	2,453	2,070	0	0	1,931	0	0	0	999.111	2.47
31	0	0	2,546	2,007	1,957	1,890	1,677	1,429	2	1278.67	3.16
32	2,050	0	0	2,387	1,947	2,641	1,621	1,323	1,889	1539.78	3.81
33	1,768	1,960	0	1,862	2,117	0	1,593	1,301	1,648	1361	3.37
34	1,887	1,981	1,622	1,790	1,793	0	1,517	1,398	1,533	1502.33	3.71
35	0	2,030	1,796	9,780	2,072	1,627	1,231	1,732	1,661	2436.56	6.02
36	0	2,140	1,529	0	0	1,627	0	0	0	588.444	1.46
37	1,793	1,928	1,511	0	0	1,609	0	0	0	760.111	1.88
38	2,088	0	1,853	1,377	1,730	1,551	1,360	1,304	1,242	1389.44	3.44
39	1,991	0	0	1,519	1,834	1,929	1,427	1,873	1,416	1332.11	3.29
40	2,427	1,935	0	2,024	1,940	0	1,386	1,329	1,171	1356.89	3.36
41	0	2,348	0	1,941	0	0	1,720	2	2,137	905.333	2.24
42	0	1,978	0	1,849	1	1,601	1,812	0	0	804.556	1.99
43	0	1,688	1	0	0	1,652	0	0	0	371.222	0.92
44	0	1	0	0	0	1,709	0	0	0	190	0.47
45	0	0	0	0	0	0	1	2	1,168	130.111	0.32
Total	37,703	46,505	36,627	50,580	41,885	44,379	36,796	31,586	37,925	40,443	100

Source: Maximus

Appendix E: Related Reports

- Security Controls Over Confidential HHS System Information: MAXIMUS Enrollment Broker, [AUD-18-011](#), February 28, 2018

Appendix F: Resources for Additional Information

The following resources provide additional information about the topics covered in this report.

For more information on Medicaid and CHIP enrollment:

"Choosing a Health Plan" <https://www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/choosing-a-health-plan> (accessed July 27, 2022)

For more information on Maximus:

"Medicaid, CHIP, and Insurance Marketplaces"
<https://maximus.com/capability/state-health-eligibility-enrollment> (accessed July 27, 2022)

Appendix G: Report Team and Distribution

Report Team

OIG staff members who contributed to this audit report include:

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Appendix H: OIG Mission, Leadership, and Contact Information

The mission of OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

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- Audrey O'Neill, Principal Deputy Inspector General, Chief of Audit and Inspections
- Susan Biles, Chief of Staff, Chief of Policy and Performance
- Erik Cary, Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Steve Johnson, Chief of Investigations and Reviews

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