



Maximum Harm:

MAXIMUS' Medicaid Management Failures

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**GOVERNMENT CONTRACTOR
ACCOUNTABILITY PROJECT**

An initiative of the Communications Workers of America and Change to Win.

EXECUTIVE SUMMARY

MAXIMUS, Inc. bills itself as the largest provider of Medicaid administrative services.¹ Founded in 1975, the company has grown to be a giant of contracted government services. But its track record is increasingly under scrutiny from state leaders over performance failures and harm to beneficiaries.

MAXIMUS serves as the Medicaid Managed Care enrollment broker for 22 states,² and carries out Medicaid eligibility determinations in 13 states.³ The company also provides other Medicaid administrative services, including for long-term services and supports and provider screening.

Collectively, states spend hundreds of millions of dollars annually contracting with MAXIMUS to help run their Medicaid programs. The company reports that it serves 52 million Medicaid and Children Health Insurance Program beneficiaries,⁴ including 70% of the Medicaid Managed Care population in the United States.⁵

MAXIMUS' record and ongoing performance on Medicaid contracts merits scrutiny considering the large number of states that entrust the company with helping to administer these vital programs for vulnerable Americans. For this report, the Government Contracting Accountability Project reviewed information pertaining to MAXIMUS' Medicaid contracts, including state and federal audits and investigations, state legislative oversight proceedings, media reports, and documents obtained through public records requests.

KEY FINDINGS

- MAXIMUS' performance failures on a Kansas Medicaid contract resulted in harms to **Kansans** and health providers, particularly elders and senior living homes.
- Large numbers of children in **Tennessee** were improperly kicked off of Medicaid due to problems with the eligibility redetermination process that MAXIMUS helped conduct.
- Ailing seniors in **Pennsylvania** faced significant hurdles in receiving home care services due to MAXIMUS' shortfalls as enrollment broker.
- MAXIMUS failed to comply with information security protocols as the **Texas** Medicaid and CHIP enrollment broker.
- MAXIMUS' flawed testing services prior to the launch of **North Carolina's** Medicaid claims processing system put the system's readiness at risk. There were significant defects in the subsequently launched system.
- Consulting with MAXIMUS led to **Arizona, Missouri, New Jersey, and Wisconsin** submitting improper claims for Medicaid reimbursement.
- A MAXIMUS employee in **Massachusetts** siphoned off almost \$500,000 of Medicaid and other state health funds over nine years before the company discovered the fraudulent theft.
- MAXIMUS acknowledged causing the **District of Columbia** to submit undocumented Medicaid claims for foster care services, leading to a major Medicaid fraud settlement with the Department of Justice.

MAXIMUS OVERVIEW

MAXIMUS, Inc. is a publicly traded company specializing in business process outsourcing for U.S. and foreign government agencies, primarily in the fields of health and social services. The company reported \$2.4 billion in revenue in FY2018.⁶ In addition to Medicaid, MAXIMUS provides services to states related to the Children’s Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), child support, disability benefits, and Women, Infants, and Children (WIC). MAXIMUS’ state contracts account for more than 40% of the company’s total revenue.⁷

MAXIMUS’ motto is “helping government serve the people,” and its employees are responsible for Americans’ access to vital programs and services. But the company’s management capitalizes on situations where people are at their most vulnerable. MAXIMUS leadership has told investors that “when unemployment rates are higher, volumes are better, we’re doing better from an operating income margin standpoint,”⁸ and called the recent refugee crisis in Australia an “exciting situation”⁹ and “a meaningful growth opportunity” that is “good for us.”¹⁰ Investigative reporters have scrutinized whether MAXIMUS seeks to profit off the public purse at the expense of those in need.¹¹

MAXIMUS reports that its U.S. Health and Human Services segment—which includes its Medicaid and other state contracting business—is by far its most profitable, with an operating profit of 18.6% in the third quarter of 2019. This is 60% higher than its profit margins on its federal contracts and more than four times the profit margin on its business abroad.¹² **This large operating margin on state contracts raises questions about whether states are adequately negotiating with MAXIMUS to ensure that public funds intended to help the most vulnerable are being spent responsibly.**





KANSAS: MAXIMUS Underbids and Understaffs Medicaid Contract, Leading to Unacceptable Performance and Harm to Seniors

After more than three years of performance shortfalls by MAXIMUS on its contract to administer the new KanCare Clearinghouse, the Kansas Department of Health and Environment (KDHE) announced in April 2019 that it will insource much of the Medicaid administration work it had contracted to MAXIMUS.¹³ MAXIMUS' poor performance conducting Medicaid eligibility in Kansas resulted in harms to Medicaid applicants and enrollees, seniors, nursing homes, individuals with developmental disabilities, providers, and pharmacies.

MAXIMUS began processing applications and reviews for all Medicaid programs in Kansas in January 2016, including eligibility for Family Medical programs and for Elderly, Disabled and Long-Term Care programs.¹⁴ Complaints about problems at the Clearinghouse began almost immediately after its launch with MAXIMUS at the helm.¹⁵ In early 2016, the average answer time for KanCare calls placed to MAXIMUS peaked at 27 minutes, and the abandonment rate on calls at over 35%.¹⁶

Prospective Medicaid beneficiaries also faced significant delays in getting their applications approved. At one point, almost 11,000 Medicaid applications were pending past the 45-day limit set by the Centers for Medicare and Medicaid Services (CMS).¹⁷ The backlog was so severe that CMS ordered KDHE to develop a plan for resolving it and to report on its progress to CMS twice a month from 2016 through July 2017.¹⁸

“MAXIMUS’ performance has not met our standards. There was a tremendous backlog developed due to understaffing. Additionally, oversight and training were lacking. . . The subsequent performance has been unacceptable.”

KDHE Secretary Jeff Anderson ¹⁹

MAXIMUS’ performance failures continued into 2018. The Kansas Department of Administration sent MAXIMUS a letter of non-compliance in January 2018,²⁰ and ordered the company to come into compliance by June or face retroactive fines.²¹ A one-day examination by the Kansas Medicaid Director in February uncovered enough performance problems to merit \$250,000 in fines for that day alone.²² MAXIMUS ultimately agreed to pay Kansas up to \$10 million in concessions.²³

In February 2018, MAXIMUS was achieving 40% accuracy on financial payments, under half the contractually required 98%.²⁴ To ensure the company was improving its performance, KDHE began holding daily calls and weekly meetings with MAXIMUS’ KanCare leadership.²⁵

According to then KDHE Secretary Jeff Anderson, MAXIMUS’ “unacceptable” performance was the result of understaffing,²⁶ and the fact that MAXIMUS had underbid to win the contract.²⁷

“It’s night and day. It’s a completely different work environment on our side of the house [at KDHE] and their side of the house [at MAXIMUS] and I think that’s because we at the state value the employees that work for us.”

Kansas Medicaid Director Jon Hamdorf ²⁸

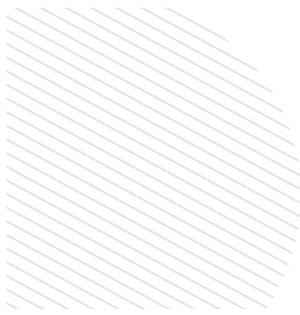
Inadequate employee training also contributed to MAXIMUS’ performance problems in Kansas. Secretary Anderson called MAXIMUS’ training “lacking,”²⁹ while KDHE’s Eligibility Director stated that the agency discovered that some staff had not been trained on basic and necessary job duties, such as how to search its imaging system for documents.³⁰ In January 2019, KDHE took over responsibility for training MAXIMUS’ employees.³¹

Starting in January 2020, KDHE will insource the processing of applications for the Elderly, Disabled and Long-Term Care programs. “After three years, it is clear that MAXIMUS is not willing or able to do what is necessary to fix the issues,” said one eldercare advocate before KDHE made this insourcing decision.³² KDHE’s Eligibility Director said at the time, “The goal of bringing the [Elderly, Disabled, and Long-Term Care] applications in-house to KDHE is to enhance customer service,” such as “calling individuals to obtain outstanding information rather than denying applications for failure to provide the requested information.”³³

“The eligibility processing mess is hacking away at the safety net for lower and middle-income seniors, and will have echoing effects for years to come”

Rachel Monger, LeadingAge Kansas, a state association of not-for-profit and faith-based aging service providers ³⁴

Kansas issued a request for proposals in August 2019 for the successor contract to provide Family Medical program eligibility services when MAXIMUS’ current contract ends in December 2020. As of the publication of this report, Kansas is in the process of determining what company will be awarded this contract.



THE IMPACT OF MAXIMUS’ PERFORMANCE FAILURES IN KANSAS

The harm inflicted in Kansas by MAXIMUS’ KanCare contract failures has been far-reaching. Elders and senior living homes were hit particularly hard. Some seniors reportedly gave up on seeking Medicaid coverage due to the problems at MAXIMUS.³⁵ According to

testimony provided to the legislative KanCare oversight committee, nursing homes had to pay for prescriptions upfront for some Medicaid-pending residents because pharmacies had stopped filling their prescriptions due to the risk that they would not be paid for the medications.³⁶

“Our elderly in Kansas and our nursing facilities that care for those elders are being penalized because MAXIMUS lacks the education and commitment to follow the policies in regard to Medicaid eligibility.”

Holly Noble, Attica Long Term Care, a senior living home in Kansas³⁷

As early as 2017, many nursing homes stopped accepting individuals whose Medicaid applications were still pending and began turning people away due to financial hardships caused by providing uncompensated care for those facing approval delays.³⁸ One senior living home reported having to turn away a spouse of one of its residents.³⁹ An association of non-profit and faith-based aging service providers in Kansas reported on behalf of its members:

“Three years of eligibility delays left many nursing homes in dire straits, unable to pay their bills, and under threat of losing their electricity, food, and medical supplies. They were forced to apply to banks for lines of credit to make payroll. They begged their food and other supply vendors for more grace, accepting large payment penalties in the process. Facilities who were lucky enough to have enough reserves to float through the worst of the crisis, will still take large financial hits for uncompensated care that they will never be able to recover. This is a direct result of our malfunctioning eligibility system, and represents the largest and longest lasting damage to the availability of Medicaid services to seniors.”⁴⁰

MAXIMUS’ poor services also caused problems for people with developmental disabilities and the organizations that serve them. According to InterHab, an association of organizations that serve individuals with disabilities, “Since the creation of the Clearinghouse, InterHab members have expressed frustration with

the State’s contracted vendor for eligibility determination.” These frustrations included difficulty receiving timely communication, and lack of responsiveness, competency, and transparency.⁴¹

MAXIMUS’ KANCARE CLEARINGHOUSE PERFORMANCE BY THE NUMBERS

- **Almost 11,000:** Peak number of Medicaid applications pending past the 45-day federal limit⁴²
- **27 minutes:** Peak average call-answer time at call center⁴³
- **Over 35%:** Peak call abandonment rate⁴⁴
- **40%:** Accuracy rate on financial payments despite requirement of 98% accuracy⁴⁵
- **259 days:** Application processing time reported for one senior in nursing home care⁴⁶
- **95%:** Portion of members of the state association for providers of community services to Kansans with developmental disabilities who reported difficulty receiving timely communication at Clearinghouse⁴⁷



TENNESSEE: Children Lose Health Insurance Due to “Dysfunctional” Eligibility Process

In April 2019, 25 members of the Tennessee House of Representatives called on the state Comptroller to audit MAXIMUS’ contract performance in operating the Eligibility Redetermination Processing Center, which helps to redetermine enrollee eligibility for TennCare and CoverKids, the state’s Medicaid and CHIP

programs, respectively.

Due to “alarming numbers of children unenrolled from TennCare and CoverKids,” the legislators had “grave concerns with how exhaustively this out-of-state company [MAXIMUS], acting under contract with the State, conducted this eligibility redetermination process for the specific purpose of ensuring that Tennessee children had necessary access to health coverage.”⁴⁸ As part of the deal, MAXIMUS mailed out and processed redetermination forms for children enrolled in the state health programs. In 2016, the company began mailing out renewal packets that were as long as 98 pages (49 in English and 49 in Spanish).⁴⁹

A *Tennessean* investigation published in July 2019 found that over 220,000 children faced potential loss of TennCare or CoverKids coverage between 2016 and 2018 due to late, incomplete, or unreturned eligibility forms despite many remaining eligible.⁵⁰

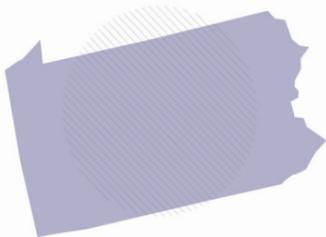
Reports began to surface in 2017 that large numbers of children were losing health coverage despite remaining eligible.⁵¹ Seniors whose Medicare premiums were paid through TennCare also faced problems due to the troubled mail-based redetermination process. When seniors were incorrectly deemed ineligible for this TennCare support, the Social Security Administration began deducting the cost of Medicare premiums from their monthly benefit checks, eating into their retirement security.⁵² A 2017 state Comptroller review of the eligibility determination process found that some individuals were being deemed ineligible for TennCare because MAXIMUS had failed to link individual documentation with family members in a timely manner.⁵³

Many families did not receive notice that their child’s insurance had been terminated, with some only finding out when visiting a doctor.⁵⁴ TennCare could not say how many kids lost coverage due to paperwork issues,⁵⁵ but a Georgetown University study found that the number of uninsured children in Tennessee increased by 22.4% in 2017 alone,⁵⁶ and *The Tennessean* reported that TennCare disenrolled

more children from its Medicaid system in 2018 than any other state.⁵⁷ The Tennessee Justice Center called the “staggering” numbers of children who lost health coverage “the predictable result of TennCare’s dysfunctional process for redetermining eligibility of its enrollees.”⁵⁸ As of the writing of this report, the Comptroller’s office was conducting the audit requested by legislators, and aimed to release the investigation’s results by the end of 2019.⁵⁹

“What we are seeing now is massive numbers of people being dropped off the rolls with no notification, and they don’t find out until they have a reason to use their insurance. They are forced to determine what the health of their child is worth to them and if they can delay whatever attention they need until they get—if they can get—their insurance back.”

-Tennessee Medical Professional quoted anonymously in *The Tennessean*⁶⁰



PENNSYLVANIA: Ailing Adults and People with Disabilities Seeking Home-Based Care Face Poor Treatment and Hurdles

In October 2016, the Pennsylvania legislature held a joint Senate and House hearing to investigate complaints about MAXIMUS’ services as the new enrollment broker for ailing seniors and people with disabilities seeking home care assistance under the Medicaid Aging Waiver.⁶¹

The House Chair of the committee called the reports of MAXIMUS’ poor performance and testimony about the resulting harms to ailing

seniors “devastating.” “Calls are not being returned, paperwork is not being processed, and seniors are being treated poorly and not receiving necessary services,” the Chair said. “Our seniors and persons with disabilities deserve far better than they have been receiving in this change to an independent enrollment broker.”⁶²

Ailing seniors and people with disabilities—many of whom required assistance eating, going to the bathroom, and bathing—faced significant hurdles and delays when trying to enroll for home-based care through MAXIMUS.⁶³ The number of completed enrollments dropped significantly after MAXIMUS became the enrollment broker, according to research by the County Commissioners Association of Pennsylvania.⁶⁴ An advocacy group for the elderly stated that MAXIMUS “seems to lack the capacity to facilitate the eligibility and enrollment process for Aging Waiver applicants.”⁶⁵ Some seniors seeking home-support were forced to go to nursing homes due to processing delays.⁶⁶

Juliann Frydrych was just one of the many seniors who went into a nursing home while waiting for MAXIMUS to process her application for home-based care. Her son had wanted her to spend her last days at his home so she could be surrounded by family.

But unable to care for his mother, who had advancing dementia, he placed her in a nursing home two months after submitting an enrollment application through MAXIMUS and hearing no response.

When Juliann passed away another month later, her son still had heard nothing from MAXIMUS. **“I could have taken her home if we could have gotten some help,”** her son said. “I put my faith in our government, and I’m just disappointed and out of gas.”⁶⁷

Prior to the hearing, DHS had already placed MAXIMUS on a corrective action due to the severity of its performance problems.⁶⁸ DHS Secretary Ted Dallas also sent MAXIMUS a letter notifying the company that payments were being withheld until it resolved its problems

handling applications and enrollments. The letter highlighted “unacceptable call abandonment rates” at its call center, failure to meet contractual requirements for call-answer times, large backlogs, and concerns about MAXIMUS’ ability to meet the 60-day timeframe that CMS requires for application processing.⁶⁹ To resolve these problems, DHS required MAXIMUS to increase its call center staffing, improve its call center technology, implement overflow call center capacity for busy times with high call volume, and improve its collaboration and communication with agencies and stakeholders.⁷⁰



TEXAS: IG Finds 11 Areas in which MAXIMUS did not Fully Comply with Information Security Standards as Texas’ Sole Medicaid and CHIP Enrollment Broker

A 2018 audit of MAXIMUS’ Medicaid and CHIP enrollment broker services by the Inspector General for the Texas Health and Human Services (HHS) Commission concluded that MAXIMUS was not in compliance with contractually-required Information Security Standards and Guidelines of Texas HHS. Under its contract, MAXIMUS used, stored, and transmitted confidential HHS System information, including personally identifiable information for Medicaid and CHIP enrollees and applicants.⁷¹

In its audit, the Inspector General identified 11 “[a]reas in which MAXIMUS’ existing IT controls did not fully comply with [Texas HHS’ Information Security Standards and Guidelines].”⁷² It found that:

“MAXIMUS did not (a) adequately manage access to systems that store and transmit confidential HHS System information, (b) configure password parameters to meet applicable standards, (c) timely remediate identified vulnerabilities, or

(d) maintain and execute system maintenance processes.”⁷³

According to the audit, MAXIMUS’ month-long delay in remediation after it was notified of one identified vulnerability “plac[ed] confidential HHS System information at continued risk of unauthorized access, loss, or modification,”⁷⁴ while inadequate system maintenance processes “limit[ed] MAXIMUS’ ability to appropriately monitor and protect confidential data.”⁷⁵ To address these problems, the Inspector General recommended that HHS conduct timely reviews of MAXIMUS’ system security plans. It also recommended HHS require MAXIMUS to improve and strengthen its security protocols, and to improve its timeliness in fixing newly identified security weaknesses.⁷⁶



NORTH CAROLINA: MAXIMUS Implicated in Troubled Rollout of Medicaid Billing System

In 2013, the North Carolina State Auditor conducted pre- and post-launch audits of the State’s new Medicaid claims processing and payment system, NCTracks. MAXIMUS came under scrutiny because, as the independent verification and validation (IV&V) vendor for the NCTracks project, MAXIMUS was hired to provide unbiased oversight of the user assessment testing and product simulation testing of NCTracks to facilitate its successful launch. With less than two months to go before the scheduled July 1, 2013 go-live date, the State Auditor “expressed serious concerns about MAXIMUS” and “found that MAXIMUS did not provide independent oversight of the NCTracks testing process.”⁷⁷

Specifically, in its pre-launch audit, the State Auditor concluded that NCTracks’ “independent assessments are flawed and put system readiness

at risk.”⁷⁸ The audit found that MAXIMUS “did not minimize system implementation risks” because it had relied exclusively on the test result reports of other vendors and had not monitored user test case details using a key test repository tool called SILK.⁷⁹ The State Auditor also noted that “Maximus was not aware of key issues regarding the testing environment.”⁸⁰

MAXIMUS was not solely at fault for these shortfalls. The audit found that the state had not requested or provided funding for MAXIMUS to conduct an independent test case analysis, and that the state’s contract with MAXIMUS did not specify test cases that the company was to conduct.⁸¹ The company did promise to “conduct IV&V monitoring and high-level auditing of test management activities” in its IV&V plan.⁸² The State Auditor described these activities by MAXIMUS as “questionable, especially considering that they were not aware of key details and issues” relating to tests intended to ensure the system would be operational for users.⁸³

Despite these warnings, the state’s Department of Health and Human Services opted to go-live with the NCTracks system on July 1, 2013 based in part on MAXIMUS’ “favorable opinion” about the system’s readiness.⁸⁴ “For the Department to consider MAXIMUS as a source for its go-live decision is questionable,” concluded the State Auditor in its response to comments from the state Department of Health and Human Services on the second audit.⁸⁵

The State Auditor’s concerns about NCTracks’ readiness proved well-founded. The post-launch audit determined that in the first four months of its operation, NCTracks had over 3,200 defects, including 203 that were critical system-wide failures.⁸⁶ Many doctors reported that they were not getting properly reimbursed for services provided to Medicaid patients after the rollout.⁸⁷ The North Carolina Medical Society stated that “NCTracks has inflicted real damage on Medicaid patients and providers across the state.” A group of doctors filed a class action suit against the state after the troubled launch of NCTracks, alleging unpaid and delayed benefit claims.⁸⁸ (In 2018, the North Carolina Supreme Court held that the plaintiffs needed to exhaust their administrative remedies prior to filing suit.⁸⁹)



ARIZONA, MISSOURI, NEW JERSEY, AND WISCONSIN:

Consulting with MAXIMUS Led to Compliance Failures

A series of investigations by the Office of the Inspector General of the U.S. Department of Health and Human Services (HHS OIG) between 2006 and 2013 found that Arizona,⁹⁰ Missouri,⁹¹ New Jersey,⁹² and Wisconsin⁹³ had each improperly claimed federal Medicaid reimbursements they had submitted with the aid of MAXIMUS.

The 2013 HHS OIG audit in Wisconsin, for example, found that the state had improperly billed Health Check, a Medicaid psychiatric services program, for residential care center (RCC) payments after taking on Maximus as a revenue maximization consultant.⁹⁴ Under the revenue maximization contract, MAXIMUS was paid contingency fees based on the amount of federal reimbursements it helped Wisconsin garner, creating an incentive for MAXIMUS to encourage the state to increase its billing.⁹⁵ Of the \$41.4 million that Wisconsin claimed for RCC payments from October 2004 to September 2006, the audit found that \$39.4 million, or 95%, was unallowable.⁹⁶

According to HHS OIG, Wisconsin “used a cost allocation methodology that did not comply with Federal requirements. . . In addition, the State claimed unsupported administrative costs as an add-on to the RCC service costs.” The audit called for Wisconsin to refund \$22.8 million to the federal government.⁹⁷

In New Jersey, the HHS OIG concluded that Maximus submitted claims for school-based health services on behalf of New Jersey to CMS that failed to comply with federal and state requirements 51% of the time. About 32% of all claims were for services that were not provided or supported. The OIG concluded that MAXIMUS “was not effective” in monitoring school-based health providers, and also found deficiencies in the documentation from MAXIMUS’ monitoring visits. OIG called on New Jersey to reimburse the CMS about \$8 million of the \$32.2 million the State had received for the school-based health claims from July 2003 to October 2006.⁹⁸



MASSACHUSETTS: MAXIMUS Employee Steals Medical Transportation Funds over Almost Nine Years

In 2013, MAXIMUS agreed to pay Massachusetts restitution after a MAXIMUS employee pled guilty to stealing from MassHealth—the state’s Medicaid and CHIP program—by fraudulently obtaining transportation reimbursements between October 2003 and July 2012 from a pool of funds earmarked to assist MassHealth enrollees with travel to medical appointments. The employee siphoned off \$490,000 over nine years before MAXIMUS finally found evidence of the fraudulent practices, which led the company to refer the matter to the Massachusetts Attorney General’s Office and the Executive Office of Health and Human Services.⁹⁹



WASHINGTON, D.C.: Whistleblower on Fraudulent Claims leads to \$30.5 Million Medicaid False Claims Act Settlement

In 2007, MAXIMUS accepted responsibility for causing the District of Columbia’s Child and Family Services Agency (CFSA) to submit 26,863 undocumented claims for foster care services for Medicaid reimbursement.¹⁰⁰ The company entered into a criminal deferred prosecution agreement with the U.S. Department of Justice, a corporate integrity agreement with the Office of the Inspector General of the U.S. Department of Health and Human Services, and a civil False Claims Act settlement to resolve the investigation of its activities on a foster care contract with CFSA.¹⁰¹

According to the U.S. Attorney’s Office that prosecuted the case, “MAXIMUS acknowledged its responsibility for causing scarce Medicaid dollars to be spent for undocumented services that likely were never provided to some of the neediest citizens of the District of Columbia.”¹⁰² The settlement required MAXIMUS to pay the DOJ \$30.5 million and to pay the whistleblower \$460,000 for his employment-related claims.¹⁰³

CONCLUSIONS & RECOMMENDATIONS: THE NEED FOR RESPONSIBLE CONTRACTING AND ROBUST CONTRACT OVERSIGHT

In MAXIMUS' Code of Conduct, its Basic Principles of Ethical Conduct states that “[w]e follow all applicable laws, regulations and contractual obligations when conducting business.”¹⁰⁴ Based on the record of evidence summarized in this report, MAXIMUS has not met its own standards of ethical conduct in its provision of Medicaid-related services.

Problems at MAXIMUS have at times directly impeded vulnerable Americans from accessing the health services that they desperately needed:

- MAXIMUS' botched takeover of Medicaid eligibility services in Kansas resulted in nursing homes refusing admittance to seniors in need of care.
- MAXIMUS played a central role in Tennessee's Medicaid redetermination process, which put thousands of children at risk of being removed from the rolls without notice even though they remained eligible.
- MAXIMUS' performance problems in Pennsylvania delayed seniors and people with disabilities from getting home-based care to help them eat, bathe, and use the toilet.

MAXIMUS has also been implicated in performance failures that affect the security of health system information, health care provider payments, and stewardship of public dollars.

This record highlights the need for state governments to be vigilant when choosing to outsource critical functions and when making award decisions for Medicaid contracts. Contracting with companies with a record of irresponsible practices and performance problems can carry risks for agencies and the public they serve, and can result in harm to state health systems and states' most vulnerable populations.

Furthermore, states should hold companies like MAXIMUS accountable after awarding a Medicaid contract. Oversight should include:

- Robust contract monitoring to ensure compliance with all applicable laws and adherence to all contract requirements.
- Inclusion of contract provisions that enable the state to institute penalties when obligations are not being met.
- Cooperation with oversight agencies and other relevant state officials to support audits and independent assessment of Medicaid contracts.

Public stewardship is the bedrock principle of taxpayer-funded health programs. As state lawmakers continue to face budget pressures, there is a temptation to outsource ever more agency functions to cut costs. But as lawmakers in Kansas and elsewhere have seen, certain functions are better safeguarded by maintaining state employee staffing. In cases where contracting is necessary, states should carefully assess contractor responsibility on the front end and ensure robust oversight throughout the term of the contract.

APPENDIX: MAXIMUS' Medicaid-Related Contracts by State

	Enrollment	Medicaid/CHIP Eligibility	Provider Services	Long Term Services & Supports	PASSR
California	Y	Y		Y	Y
Colorado	Y				
Connecticut				Y	Y
District of Columbia	Y		Y		
Florida		Y			
Georgia	Y	Y			
Illinois	Y				
Indiana	Y			Y	Y
Iowa	Y	Y	Y	Y	Y
Kansas		Y			
Louisiana	Y	Y		Y	
Maine				Y	Y
Maryland	Y				
Massachusetts	Y	Y	Y		
Michigan	Y	Y	Y		
Mississippi				Y	Y
Nebraska			Y	Y	Y
New Hampshire	Y				
New Jersey			Y		
New York	Y	Y	Y	Y	Y
North Carolina	Y				
North Dakota				Y	Y
Ohio					Y
Oklahoma			Y		
Oregon				Y	
Pennsylvania	Y			Y	
South Carolina	Y				
Tennessee		Y	Y	Y	Y
Texas	Y	Y			
Vermont	Y	Y			
Virginia	Y			Y	Y
West Virginia	Y				
Wisconsin	Y			Y	Y
Wyoming		Y			

Sources: State government websites and public procurement databases, media reports, MAXIMUS' website, and documents obtained through public records requests.

ENDNOTES

- 1 MAXIMUS, “White Paper: The importance of delivering independent, conflict-free services to citizens” (March 21, 2019). <https://maximus.com/white-paper/importance-delivering-independent-conflict-free-services-citizens>
- 2 MAXIMUS Presentation at Barclays Global Healthcare Conference, at 5 (March 15, 2018). Accessed via S&P Capital IQ.
- 3 MAXIMUS, “Eligibility and Enrollment.” <https://maximus.com/capability/eligibility-and-enrollment>
- 4 MAXIMUS, “Health and Wellness.” <https://maximus.com/health-and-wellness>. MAXIMUS does not break this number down by program. CHIP provides health coverage to eligible children through both Medicaid and separate CHIP programs.
- 5 MAXIMUS Presentation at Barclays Global Healthcare Conference, at 5 (March 15, 2018).
- 6 U.S. SEC, Form 10-K: MAXIMUS, Inc. (Nov. 20, 2018).
- 7 U.S. SEC, Form 10-Q; MAXIMUS, Inc., at 14 (Aug. 8, 2019).
- 8 MAXIMUS, 2018 2nd Quarter Earnings Call (May 10, 2018). Accessed via S&P Capital IQ.
- 9 MAXIMUS Presentation at Merrill Lynch Health Care Conference, at 7 (May, 16, 2013). Accessed via S&P Capital IQ.
- 10 MAXIMUS Presentation at Deutsche Bank Health Care Conference, at 7 (May 29, 2013). Accessed via S&P Capital IQ.
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- 12 U.S. SEC, Form 10-Q; MAXIMUS, Inc., at 11 (Aug. 8, 2019).
- 13 Kansas Legislative Research Department (KLRD), Minutes from meeting of the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight, at 7 (April 29, 2019). http://www.kslegislature.org/li/b2019_20/committees/ctte_jt_robert_g_bob_bethell_joint_committee_1/documents/minutes/20190429.pdf
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- 15 Andrew Marso, “KanCare Changes Leave Seniors Struggling to Get, Keep Medicaid Coverage,” *Kansas City Star* (Feb. 22, 2018).
- 16 MAXIMUS, “KanCare Clearinghouse Meeting With Legislative Oversight Committee,” at slide 16 (Aug. 4, 2016). http://www.kslegislature.org/li_2016/b2015_16/committees/ctte_jt_robert_g_bob_bethell_joint_committee_1/documents/testimony/20160804_11.pdf
- 17 Andy Marso, “Medicaid Application Delays Are Forcing Kansas Nursing Homes to Turn People Away,” *Kansas City Star* (Dec. 15, 2017). <https://www.kansascity.com/news/business/health-care/article189892269.html>
- 18 *Ibid.*
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