

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MARYLAND CLAIMED COSTS FOR
UNALLOWABLE ROOM AND BOARD AND
OTHER RESIDENTIAL HABILITATION
COSTS UNDER ITS COMMUNITY
PATHWAYS WAIVER PROGRAM**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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Gloria L. Jarmon
Deputy Inspector General

September 2013
A-03-12-00203

Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

Maryland claimed at least \$20.6 million in unallowable costs for residential habilitation services under its Community Pathways waiver program.

WHY WE DID THIS REVIEW

From July 1, 2009, through June 30, 2012, Maryland's Department of Health and Mental Hygiene (State agency) claimed \$1.1 billion (\$648.6 million Federal share) for residential habilitation services under its Community Pathways waiver program (waiver) for individuals with developmental disabilities. The Office of Inspector General received an allegation that the State agency claimed unallowable costs for these services. This report covers allegations related to unallowable room and board costs.

The objective of our review was to determine whether the State agency complied with Federal and State requirements when it claimed room and board and some other residential habilitation costs under the waiver.

BACKGROUND

The waiver provides home and community-based services, including residential habilitation services, to individuals with developmental disabilities in group homes, alternative living units, or individual family care homes. Residential habilitation provides training for eligible beneficiaries to promote the skills necessary for maximum independence in daily activities of living. Medicaid does not cover the cost of room and board under the waiver, but providers may collect up to \$375 per month from beneficiaries to cover these costs.

WHAT WE FOUND

The State agency did not comply with Federal and State requirements when it claimed costs for residential habilitation services under the waiver. Of the 100 claim lines that we sampled, 5 complied with Federal and State requirements; however, 95 did not. The 95 claim lines had 135 errors. For 81 claim lines, the State agency included unallowable costs for room and board. For 54 claim lines, the State agency reduced provider payments to reflect amounts in excess of room and board that providers had collected from beneficiaries but did not reduce claims for Federal reimbursement accordingly. Forty claim lines included both errors. (Fourteen claim lines, with service dates after December 2011, had errors related only to excess beneficiary payments.) We estimate that, as a result of these errors, the State agency claimed at least \$20,627,705 (Federal share) in unallowable costs.

The State agency claimed these unallowable costs because it lacked internal controls to ensure that unallowable costs were not included in claims for provider per diem payments.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund \$20,627,705 to the Federal Government and
- claim only actual expenditures for allowable costs.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described some of the corrective actions it has taken to ensure they claim only actual expenditures for allowable costs.

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INTRODUCTION

WHY WE DID THIS REVIEW

From July 1, 2009, through June 30, 2012, Maryland's Department of Health and Mental Hygiene (State agency) claimed \$1.1 billion (\$648.6 million Federal share) for residential habilitation services under its Community Pathways waiver program (waiver) for individuals with developmental disabilities. In October 2011, the Office of Inspector General received an allegation that the State agency claimed unallowable costs for these services. This report covers allegations related to unallowable room and board costs.

OBJECTIVE

Our objective was to determine whether the State agency complied with Federal and State requirements when it claimed room and board and some other residential habilitation costs under the waiver.

BACKGROUND

The Social Security Act (the Act, § 1915(c)), allows States to apply for waivers to provide long-term care services in home and community settings rather than institutional settings. States generally may design their waiver programs to address the needs of specific populations; however, the Centers for Medicare & Medicaid Services (CMS) must approve the waiver. Waiver services must comply with Federal cost principles, which establish standards for determining allowable costs incurred by State and local governments under Federal awards.¹

The Community Pathways Home and Community-Based Waiver Program

The waiver provides home and community-based services, including residential habilitation services, to individuals with developmental disabilities in group homes, alternative living units, or individual family care homes. Residential habilitation provides training for eligible waiver beneficiaries to promote the skills necessary for maximum independence in daily activities of living.² Medicaid does not cover the cost of room and board under the waiver, but providers may collect up to \$375 per month from beneficiaries to cover these costs. Maryland's provider agreement states that, unless expressly authorized, providers may not seek payment from beneficiaries for services paid by the waiver.³ Within the State agency, the Developmental Disabilities Administration operates the waiver.

¹ Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Tribal Governments*, was relocated to 2 CFR part 225.

² Code of Maryland Regulations (COMAR) 10.09.26.01(B)(30).

³ State of Maryland Provider Agreement for Delivery of Services Regulated by the Developmental Disabilities Administration: Provider Responsibilities 10. C. (October 10, 2007).

The State Agency's Rate-Setting Methodology

The State agency pays providers a daily rate for each beneficiary that includes a component for the habilitation services and a fee for administrative costs related to these services. The service component of the daily rates varies according to the required level of care identified in the beneficiary's needs assessment. These rates also reflect slight differences in the cost for services in different geographical areas of the State. During our review period, the service component ranged from \$16.23 to \$145.36 per day.

In addition to the service component, the State agency paid providers \$56.27 per day for administrative costs, including a portion to cover the daily cost of room and board for the beneficiary. Although Medicaid does not pay waiver costs for room and board, the waiver allows providers to collect up to \$375 per month from beneficiaries to cover these costs. The State agency calculated the daily portion of the room and board as \$12.29⁴ and included it in the providers' daily rate as an advance against providers' collections from beneficiaries. Providers reported to the State agency the amounts collected from beneficiaries, and the State agency reduced its payment to the providers accordingly. However, the State agency must deduct all room and board payments from its per diem rate before submitting its claim for Federal reimbursement. If providers cannot collect the full room and board amount from beneficiaries, the State agency is responsible for the difference and may not claim Federal reimbursement for the uncollected portion.

The daily rate may also include a third component for additional services available under the waiver. We will cover allegations related to these services in a future audit.

HOW WE CONDUCTED THIS REVIEW

Our review covered 5,435,940 claim lines totaling \$1,121,368,823 (\$648,553,838 Federal share), representing payments to 116 providers from July 1, 2009, through June 30, 2012. (A claim line represented 1 day of residential habilitation service.) Our review was based on a random sample of 100 claim lines paid to 53 providers. We limited our review to determining whether the State agency properly reduced its claims to exclude unallowable costs for room and board and to reflect reduced payments that it made to providers. Our scope did not require us to determine the medical necessity of the claimed services or the allowability of beneficiary payments in excess of the prescribed room and board amount.

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.

⁴ The daily amount of \$12.29 is 1/366th of the annualized total of the monthly room and board amount.

Appendix A contains the details of our audit scope and methodology, Appendix B contains the details of our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

The State agency did not comply with Federal and State requirements when it claimed costs for residential habilitation services under the waiver. Of the 100 claim lines that we sampled, 5 complied with Federal and State requirements;⁵ however, 95 did not. The 95 claim lines had 135 errors:

- For 81 claim lines, the State agency included unallowable costs for room and board.
- For 54 claim lines, the State agency reduced provider payments to reflect amounts in excess of room and board that providers had collected from beneficiaries but did not reduce claims for Federal reimbursement accordingly.

Forty claim lines included both errors.⁶ We estimate that, as a result of these errors, the State agency claimed at least \$20,627,705 (Federal share) in unallowable costs.

The State agency claimed these unallowable costs because it lacked internal controls to ensure that unallowable costs were not included in claims for provider per diem payments.

FEDERAL AND STATE REQUIREMENTS

Federal regulations prohibit Federal reimbursement for room and board under a home and community-based waiver except when (1) provided as part of respite services in a facility approved by the State that is not a private residence or (2) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the beneficiary (42 CFR § 441.310(a)(2)).⁷ In its waiver, the State agency assured CMS that it would comply with this Federal regulation.⁸ Federal cost principles state that, to be allowable, costs must be necessary and reasonable, and be authorized or not prohibited by State or local laws or regulations (2 CFR part 225, Appendix A, § C.1).

Appendix D contains Federal and State requirements related to the waiver.

⁵ All five allowable claim lines were submitted after December 2011.

⁶ Fourteen claim lines, with service dates after December 2011, had errors related only to excess beneficiary payments.

⁷ Federal reimbursement is not available if the beneficiary lives in the caregiver's home or in a residence owned or leased by the caregiver (42 CFR § 441.310(a)(2)(ii)).

⁸ Waiver, Amendment MD.0023.R05.04, 6. C. Additional Requirements: Room and Board (CMS approval effective July 1, 2009).

THE STATE AGENCY CLAIMED UNALLOWABLE COSTS

Room and Board

For 81 of the sampled claim lines, the State agency claimed Federal reimbursement of \$5.30 per day for room and board.

Except as described in the regulations above, room and board is unallowable under the waiver; however, providers may collect up to \$375 per month from beneficiaries for these costs (COMAR 10.09.26.12(F)(2)(a)). The State agency included \$12.29 in its per diem payments to providers as an advance on provider collections of these beneficiary room and board payments. The State agency must deduct these advances from its claim for Federal reimbursement. However, for 81 claim lines in our sample, the State agency deducted only \$6.99 from the per diem rate before submitting its claim to Medicaid for Federal reimbursement. As a result, each of these claims included \$5.30 of unallowable room and board costs ($\$12.29 - \$6.99 = \$5.30$).

State agency officials said that they did not know how they arrived at the \$6.99 figure. However, in December 2011, the State agency began deducting the full per diem room and board amount of \$12.29 from its claims.

Excess Beneficiary Payments

For 54 claim lines, the State agency reduced provider payments to reflect amounts in excess of room and board that providers had collected from beneficiaries but did not reduce claims for Federal reimbursement accordingly.

The State agency pays providers prospectively. Providers report any payments that they received from beneficiaries on a monthly claim form that they submit to the State agency. For 54 claim lines in our sample, providers reported monthly beneficiary payments that exceeded room and board costs by amounts that ranged from \$0.47 to \$881.77. The State agency reduced the prospective payment to providers by the amount of excess beneficiary payments reported; however, the State agency did not reduce its claim for Federal reimbursement to reflect its actual costs. Rather, the State agency claimed more than it paid the providers for these claim lines.

For example, for one claim line, the provider reported a monthly beneficiary payment of \$600, which included \$375 for room and board and an excess amount of \$225. The State agency reduced the provider's prospective payment but did not reflect the reduction for the excess amount as an adjustment on the claim for Federal reimbursement. Because our estimate was based on sample claim lines for 1 day of service, we calculated the unallowable portion of the per diem rate attributable to the excess beneficiary payment ($\$225 \div 31$ [days in the month of our sample claim line] = \$7.26).

We found similar errors in 53 other claims.

FLAWED INTERNAL CONTROLS

The Developmental Disabilities Administration's Provider Consumer Information System tracked beneficiary payments to providers but did not report the payment information to the State agency's Medicaid Management Information System (MMIS). The MMIS automatically deducted a predetermined portion of the daily per diem rate for room and board but did not record any of the beneficiary payments reported by providers and did not deduct the payments from the claim for Federal reimbursement. The State agency lacked internal controls to identify the errors in the claims or correct the flawed communication between the two systems.

ESTIMATE OF UNALLOWABLE COSTS

Using the results of our sample, we estimate that the State agency improperly claimed at least \$20,627,705 (Federal share) for unallowable costs for room and board and other costs for which providers reported beneficiary payments. Appendix C contains our sample results and estimates.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$20,627,705 to the Federal Government and
- claim only actual expenditures for allowable costs.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described some of the corrective actions it has taken to ensure they claim only actual expenditures for allowable costs. The State agency's comments are included in their entirety as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From July 1, 2009, through June 30, 2012, the State agency claimed \$1,121,815,374 (\$648,808,371 Federal share), representing 5,455,767 claim lines for residential habilitation services provided to beneficiaries under the waiver program. A claim line represented 1 day of residential habilitation. We removed all 19,827 claim lines under \$72.50, which was the minimum per diem rate a provider could receive for rehabilitative services under the waiver. Our review covered 5,435,940 claim lines totaling \$1,121,368,823 (\$648,553,838 Federal share), representing payments to 116 providers. We based our review on a random sample of 100 claim lines paid to 53 providers.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only those internal controls related to our objective. We limited our review to determining whether the State agency properly reduced its claims to exclude unallowable costs for room and board and to reflect reduced payments that it made to providers. We did not determine whether the beneficiaries met the eligibility requirements of the waiver program. Our review did not assess the quality of the services or whether the services provided to the beneficiaries were medically necessary. Our scope did not require us to determine the allowability of beneficiary payments in excess of the prescribed room and board amount.

We conducted our audit from July to December 2012 and performed our fieldwork at the State agency's office in Baltimore, Maryland, and at provider locations throughout Maryland.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidelines and the waiver application;
- held discussions with State agency officials and Developmental Disabilities Administration officials to gain an understanding of the operation of the waiver program;
- reconciled claimed residential habilitation waiver costs to the State agency's accounting records;
- obtained a database of residential habilitation service claims from the State agency's MMIS for the audit period, representing 5,455,767 claim lines totaling \$1,121,815,374 (\$648,808,371 Federal share);
- removed 19,827 claims under \$72.50 to set our sampling frame at 5,435,940 claims totaling \$1,121,368,823 (\$648,553,838 Federal share);
- selected a simple random sample of 100 claim lines from our sampling frame;

- reviewed provider records and Developmental Disabilities Administration records to determine the amount of beneficiary payments reported;
- divided the monthly beneficiary payment by the number of days reflected on the monthly provider claim to determine the daily amount attributable to our sampled claim line;
- calculated the overpayments for each sampled claim line;
- estimated, based on the sample results, the unallowable costs; and
- discussed our findings with CMS and State agency officials.

See Appendix B for the details of our statistical sampling methodology and Appendix C for our sample results and estimates.

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.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of Medicaid claim lines paid during the period July 1, 2009, through June 30, 2012, for residential habilitation services under the waiver.

SAMPLING FRAME

From the population of claim lines, we removed 19,827 claim lines under \$72.50, the minimum per diem rate for rehabilitative services. After we removed these claim lines, the sampling frame consisted of a Microsoft Access database that contained 5,435,940 claim lines for residential habilitation services submitted by 116 providers that Maryland paid during the audit period. The total Medicaid reimbursement for the 5,435,940 claim lines was \$1,121,368,823 (\$648,553,838 Federal share).

SAMPLE UNIT

The sample unit was a claim line for 1 day of residential habilitation services for one beneficiary for which the State agency claimed Federal Medicaid reimbursement.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a total sample of 100 paid claim lines.

SOURCE OF RANDOM NUMBERS

We used the Office of Inspector General, Office of Audit Services (OAS), statistical software to generate the random numbers.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the sample units in the frame from 1 to 5,435,940. After generating 100 random numbers, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount and Federal share of the overpayments.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Results

Frame Size	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Claim Lines With Overpayments	Value of Overpayments (Federal Share)
5,435,940	\$648,553,838	100	\$12,399	95	\$438

Estimated Value of Overpayments

(Limits Calculated for a 90-Percent Confidence Interval)

	Federal Share
Point estimate	\$23,818,658
Lower limit	20,627,705
Upper limit	27,009,611

APPENDIX D: FEDERAL AND STATE REQUIREMENTS

Federal cost principles state that, to be allowable, costs must be necessary and reasonable and be authorized or not prohibited by State or local laws or regulations (2 CFR part 225, Appendix A, § C.1).

The Act authorizes medical assistance for part or all of the cost of home and community-based services (the Act, § 1915(c)(1)). However, Federal regulations prohibit Federal reimbursement for room and board provided under the waiver except when (1) provided as part of respite services in a facility approved by the State that is not a private residence or (2) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the beneficiary. Federal reimbursement is not available if the beneficiary lives in the caregiver's home or in a residence owned or leased by the caregiver (42 CFR § 441.310(a)(2)).

In its waiver, the State agency assured CMS that it would comply with this Federal regulation.⁹ Maryland defines room and board as rent or mortgage, utilities, and food (COMAR 10.09.26.01(B)(33)]. The waiver states:

The cost of room and board is excluded from Community Pathways waiver service rates. Waiver providers are expected to bill waiver participants for room and board expenses. Upon enrollment in the program, waiver providers sign an agreement that states that room and board costs are not included in Community Pathways waiver rates and waiver participants will be billed for room and board costs. The charge cannot exceed \$375 monthly. Additionally, DDA [the Developmental Disabilities Administration] sends a letter to waiver providers indicating the waiver services that are authorized for each waiver participant as they are enrolled in the program and as services change or are re-authorized thereafter. This letter also states that the waiver provider will charge room and board costs to the waiver participant.¹⁰

States claim Medicaid current expenditures and any prior-period adjustments on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). The State agency must also report on the Form CMS-64 any adjustments for overpayments, underpayments, and refunds. Federal regulations (42 CFR § 430.30(c)(2)) and the CMS *State Medicaid Manual*, sections 2500 A.1 and 2500.2 A., require the amounts reported on Form CMS-64 to represent actual expenditures.

⁹ Waiver Amendment MD.0023.R05.04, 6. C. Additional Requirements: Room and Board (CMS approval effective July 1, 2009).

¹⁰ Waiver Amendment MD.0023.R05.04, Appendix I-5: Exclusion of Medicaid Payment for Room and Board (CMS approval effective July 1, 2009).

APPENDIX E: STATE AGENCY COMMENTS



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

July 18, 2013

Mr. Stephen Virbitsky
Regional Inspector General
United States Department of Health and Human Services
Public Ledger Building, Room 316
150 S. Independence Mall West
Philadelphia, PA 19106

Report Number: A-03-12-00203

Dear Mr. Virbitsky,

This letter is in response to a draft report from the Department of Health and Human Services' Office of the Inspector General entitled *Maryland Claimed Costs for Unallowable Room and Board and Other Residential Habilitation Costs Under Its Community Pathways Waiver Program*. The Department of Health and Mental Hygiene (Department) has no additional evidence to submit and no comments regarding the content of the report.

Prior to December 2011, the Department was incorrectly calculating the cost for room and board for individuals served by the Department's Developmental Disabilities Administration (DDA) and, due to inadequate controls between the Maryland Medicaid Information System (MMIS) and DDA's Provider Consumer Information System II (PCIS II), the costs removed prior to submission for federal reimbursement were insufficient as noted in the draft report. DDA identified this issue and took appropriate steps to correct it.

Below are the Department's responses to the specific recommendations in the report.

Recommendation 1 – The State Agency should refund \$20,627,705 to the Federal Government

The State concurs with this recommendation.

Recommendation 2 – The State Agency should claim only actual expenditures for allowable costs

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The State concurs with this recommendation and has taken the following steps in order to address this issue:

1. Beginning with residential services rendered in December 2011, the DDA has deducted a daily rate for room and board in PCIS II from claims submitted to MMIS for federal reimbursement. This daily reduction for room and board equates to an average monthly deduction of \$375.
2. Edits were also completed in the MMIS system on 5/18/2012 to further reduce claims for federal reimbursement by the Medicaid calculated Contribution to Cost of Care. With this edit, claims are reduced until the full Contribution to Cost of Care is met for a given month. These edits were effective for services rendered in and after December 2011 and once the edit was implemented, the DDA submitted claims for the period of December 2011 through April 2012.
3. To further address issues identified in the audit, the DDA will be issuing additional guidance to providers on how to calculate the correct contribution to care for individuals. In conjunction with this guidance, the DDA will also make adjustments to its PCIS II system to ensure that providers are collecting the correct amount and that their payments are adjusted in accordance with the reductions to federal claims for both Room and Board and Contribution to Cost of Care. This additional guidance will be issued by August 1, 2013.
3. The Department will actively monitor and review the effectiveness of these additional changes and guidance in order to ensure the ongoing appropriateness of claims submitted for federal reimbursement.

We appreciate the assistance of your staff in this audit process. If you have any additional questions for the Department, please feel free to contact me or the Department's Inspector General, Thomas V. Russell, at (410) 767-5862.

Sincerely,



Joshua M. Sharfstein, M.D.
Secretary

cc:

Patrick Dooley, Acting Director, DDA, DHMH
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