

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MARYLAND CLAIMED UNALLOWABLE  
MEDICAID COSTS FOR RESIDENTIAL  
HABILITATION ADD-ON SERVICES  
UNDER ITS COMMUNITY PATHWAYS  
WAIVER PROGRAM**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



**Daniel R. Levinson  
Inspector General**

June 2015  
A-03-13-00202

# *Office of Inspector General*

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## EXECUTIVE SUMMARY

***Maryland was paid \$34.2 million over 3 years in unallowable Medicaid costs for residential habilitation add-on services under its Community Pathways waiver program.***

### WHY WE DID THIS REVIEW

From July 1, 2010, through June 30, 2013, Maryland's Department of Health and Mental Hygiene (State agency) claimed a \$581.7 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 Medicaid costs under its waiver. This is the second report addressing those allegations. The first report addressed improper claims for room and board and other residential habilitation costs. This report addresses residential habilitation "add-on services" that are provided in addition to the services covered under the per diem rate.

Our objective was to determine whether the State agency complied with Federal requirements when it claimed add-on service 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 develop the skills necessary for maximum independence in activities of daily living in accordance with the beneficiary's plan of care, called the individual plan.

For beneficiaries who may warrant additional services not identified in the individual plan, the waiver authorized payment for these add-on services, when:

- the beneficiary had the highest level-of-need rating (level 5) on at least one standard on Maryland's Individual Indicator Rating Scale (Rating Scale), which scores the beneficiary's level of need from 1 to 5;
- the beneficiary required an extraordinary level of service or support, and the provider could show that the waiver funds it received were insufficient to cover the costs of the services; and
- the beneficiary's case manager, known as a resource coordinator, recommended the extraordinary service or support.

From July 1, 2010, through June 30, 2013 (the audit period), the State agency claimed \$329 million (\$178.7 million Federal share) for all add-on waiver services. We reviewed \$34.2 million of the \$178.7 million Federal share in add-on services.

## **WHAT WE FOUND**

The State agency did not always comply with Federal requirements when it claimed Medicaid costs for add-on services under the waiver. The State agency did not implement its waiver as approved by CMS. Rather, the State agency claimed \$62,918,678 (\$34,155,857 Federal share) for provider claims for add-on services for beneficiaries who did not meet the waiver's level-of-need requirement for those services.

The waiver allowed add-on services for beneficiaries who met three requirements, including a level of need of 5 on the Rating Scale. However, the State agency did not consider beneficiaries' level-of-need scores when approving add-on services and said that the requirement in the waiver limiting add-on services only to beneficiaries with the highest level of need was an error. The State agency said that the waiver should have allowed for add-on services based on any one of the requirements. However, Maryland's July 13, 2013, renewal application for the waiver, effective after our audit period, also required that all three conditions be met. (In March 2014, after discussions during our audit, the State agency further amended its waiver to require that two of the three conditions be met and eliminated the requirement for a level of need of 5 on the Rating Scale.)

## **WHAT WE RECOMMEND**

We recommend that the State agency:

- refund to the Federal Government \$34,155,857 and
- claim add-on service costs only for beneficiaries who meet waiver requirements.

## **STATE AGENCY COMMENTS AND OUR RESPONSE**

In its written comments on our draft report, the State agency did not concur with our recommendations. The State agency said that the waiver contained a grammatical error: the conjunction "and" was used after the second requirement instead of the conjunction "or." Accordingly, the State agency said that the provision should be interpreted to mean that meeting any one of the three criteria was sufficient to authorize add-on services and that its State regulations support its interpretation. The State agency further said that the first two requirements were essentially the same. Finally, the State agency noted that revisions in the March 2014 waiver allow for add-on services regardless of the level of need on the Rating Scale as long as two conditions are met.

After reviewing the State agency's comments, we maintain that our finding and our recommendation for a refund are valid. States must comply with the terms and conditions of their approved waivers. The State agency's interpretation of its waiver (that only one of the three requirements must be met) is not reasonable based on the plain language of the waiver, which uses the word "and" to indicate that all three conditions must be met. As stated in the waiver, meeting all three requirements was necessary.

The March 2014 waiver, amended after discussions during our audit, requires providers to document both medical necessity and financial need to receive add-on payments. The amended provision allows add-on payments regardless of the level of need on the Rating Scale. During our audit period, the waiver allowed for only one condition to represent the beneficiary's need: a level of need of 5 on the Rating Scale. We have amended our second recommendation to reflect the current waiver requirements.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

From July 1, 2010, through June 30, 2013, Maryland's Department of Health and Mental Hygiene (State agency) claimed a \$581.7 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 Medicaid costs under its waiver. This is the second report addressing those allegations. The first report addressed improper claims for room and board and other residential habilitation costs.<sup>1</sup> This report addresses residential habilitation "add-on services" that are provided in addition to the services covered under the per diem rate. The State agency's claims included \$178.7 million in Federal share for these services. We reviewed \$34.2 million of the \$178.7 million in add-on services.

### OBJECTIVE

Our objective was to determine whether the State agency complied with Federal requirements when it claimed costs for add-on services under the waiver.

### BACKGROUND

#### Home and Community-Based Waivers

The Medicaid Home and Community-Based Services waiver program allows States to apply for waivers to provide long-term care services in home and community settings rather than institutional settings (the Social Security Act, § 1915(c)). 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.<sup>2</sup>

#### The Community Pathways Home and Community-Based Waiver Program

The State agency covers community-based waiver services to individuals with developmental disabilities under its waiver.<sup>3</sup> The waiver's services include residential habilitation services for individuals with developmental disabilities in group homes, alternative living units, or individual family care homes. Residential habilitation provides training for eligible waiver beneficiaries to

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<sup>1</sup> *Maryland Claimed Costs for Unallowable Room and Board and Other Residential Habilitation Costs Under Its Community Pathways Waiver Program* (A-03-12-00203, issued September 9, 2013).

<sup>2</sup> Office of Management and Budget (OMB) Circular No. A-87, *Cost Principles for State, Local, and Tribal Governments*, was relocated to 2 CFR part 225. After our audit period, OMB consolidated and streamlined its guidance, which is now located at 2 CFR part 200.

<sup>3</sup> Waiver Amendment MD.0023.R05.04 (the waiver) (approved effective July 1, 2009).

develop the skills necessary for maximum independence in activities of daily living.<sup>4</sup> Within the State agency, the Developmental Disabilities Administration operates the waiver.

Beneficiaries receive residential habilitation services in accordance with an individualized plan of care, known as the individual plan, on the basis of the beneficiary's level of need. The waiver requires that the individual plan be reviewed and revised at least annually or when an individual's health status or circumstances change.<sup>5</sup>

The State agency uses the Individual Indicator Rating Scale (Rating Scale) to determine the beneficiary's level of need in the areas of health and supervision (both are scored). The beneficiary's level of need is scored from 1 to 5. A rating of 5 indicates the highest level of need. A State contractor charged with the independent assessment of the beneficiary's level of need determines the ratings.<sup>6</sup>

### **Residential Habilitation 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 beneficiary's individual plan and the level of need identified on the Rating Scale. These rates also reflect slight differences in the cost for services in different geographical areas of the State. During our audit period, the service component ranged from \$16.23 to \$148.27 per day and the administrative fee was a flat rate of \$56.27 per day.

For some beneficiaries, the daily rate may also include a third component for add-on services available under the waiver. Add-on services ranged from \$16.26 to \$30.27 per day, depending on the type of support provided.

### **Add-on Services**

Beneficiaries may be eligible for add-on services when the service component of the daily rate is insufficient to meet the requirements of the plan of care or when the condition of the patient changes, requiring additional care. To be approved for add-on services, the beneficiary was required to have a level of need of 5 on at least one of two standards on the Rating Scale: the "health/medical" needs standard or "supervision/assistance" needs standard.<sup>7</sup> To receive payment for add-on services, the provider must demonstrate that the cost of the current services

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<sup>4</sup> Code of Maryland Regulations (COMAR) 10.09.26.01(B)(30).

<sup>5</sup> Waiver, Appendix D, section 1(g), "Participant-Centered Planning and Service Delivery."

<sup>6</sup> During our audit period (July 1, 2010, through June 30, 2013), APS Healthcare, Inc., was the State contractor for assessing the level of need for beneficiaries.

<sup>7</sup> State regulations (COMAR 10.22.17.08(E)) also allow add-on services under some circumstances for beneficiaries whose level of need is less than 5; however, the waiver requires beneficiaries to have the highest level of need (level 5) on the Rating Scale for either the health/medical standard or supervision/assistance standard.

and any add-on services exceed the payments the waiver provider receives for the beneficiary's care and the resource coordinator, the beneficiary's case manager, must recommend an "extraordinary service or level of support."<sup>8</sup>

The three types of add-on services are:

- direct one-on-one support services, including any habilitation services deemed necessary to carry out the individual plan, provided by the residential staff;
- professional support services (e.g., occupational therapy and physical therapy) provided by authorized health professionals directly to the beneficiary; and
- direct overnight services, which include services of an aide who must stay awake during the overnight hours to provide medications or to monitor the beneficiary for potentially violent behavior.

During our audit period, the State agency claimed \$329 million (\$178.7 million Federal share) for all add-on waiver services.

## **HOW WE CONDUCTED THIS REVIEW**

Our review covered a database of 776,771 claims totaling \$62,918,678 (\$34,155,857 Federal share) paid to 115 providers during the audit period (July 1, 2010, through June 30, 2013) for add-on waiver services for beneficiaries identified with a level of need of less than 5 on the Rating Scale. Our scope did not require us to determine the medical necessity of the add-on services. To confirm that the State agency claimed add-on services paid for beneficiaries who did not meet the level-of-need requirement, we reviewed documentation supporting the level of need for a random sample of 45 add-on claims for waiver beneficiaries.

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 A contains the details of our audit scope and methodology.

## **FINDING**

The State agency did not always comply with Federal requirements when it claimed Medicaid costs for add-on services under the waiver. The State agency did not implement its waiver as approved by CMS. Rather, the State agency claimed \$62,918,678 (\$34,155,857 Federal share)

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<sup>8</sup> Waiver, Appendix I, section 2(a), "Financial Accountability—Rates, Billing, and Claims."

for provider claims for add-on services for beneficiaries who did not meet the waiver's level-of-need requirement for those services.

The waiver allowed add-on services for beneficiaries who met three requirements, including a level of need of 5 on the Rating Scale. However, the State agency did not consider the beneficiary's level-of-need score when approving add-on services. The State agency said that the requirement in the waiver limiting add-on services only to beneficiaries with the highest level of need was an error. The State agency said that the waiver should have allowed for add-on services based on any one of the requirements. However, Maryland's July 13, 2013, renewal application for the waiver, effective after our audit period, also required that the same three conditions be met.<sup>9</sup>

## **STATE AND FEDERAL REQUIREMENTS**

In its waiver, the State agency specified that providers could make a request in writing for additional add-on funding when the following conditions were met:

- the beneficiary had the highest level of need (level 5) on the Rating Scale for either the health/medical standard or supervision/assistance standard;
- an extraordinary service or level of support was required to safely maintain the beneficiary in the community, and the provider could show that the waiver funds it received were insufficient to cover the costs of the services; and
- the extraordinary service or support was recommended by the resource coordinator.<sup>10</sup>

In its instructions for an application for a section 1915(c) waiver,<sup>11</sup> CMS states: "The approved waiver application specifies the operational features of the waiver. A state must implement the waiver as specified in the approved application. If the state wants to change the waiver while it is in effect, it must submit an amendment to CMS for its review and approval."

## **THE STATE AGENCY CLAIMED UNALLOWABLE ADD-ON COSTS**

The State agency claimed \$62,918,678 (\$34,155,857 Federal share) for add-on services that were unallowable because the beneficiaries did not have a level of need of 5 on either the health/medical needs or the supervision/assistance needs standard on the Rating Scale.

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<sup>9</sup> Waiver, Appendix I-2(a) and Appendix E, section 2(b)(ii), "Opportunities for Participant Direction" (CMS approval effective July 1, 2013). In March 2014, after discussions during our audit, the State agency further amended its waiver.

<sup>10</sup> Waiver, Appendix I, section 2(a).

<sup>11</sup> *Application for a § 1915(c) Home and Community-Based Waiver: Instructions, Technical Guide, and Review Guide*, page 6 (released January 2008).

The State agency identified a database of claims paid for add-on services provided to beneficiaries who did not meet the standard of need in the waiver requirements. To confirm that the State agency claimed add-on services for beneficiaries who did not have a level of need of 5, we reviewed supporting documentation for a random sample of 45 claims. All of the 45 paid claims included the error.

The State agency said that the waiver was not intended to restrict add-on services on the basis of the level of need on the Rating Scale and that the waiver had an error in the requirement for additional services. The State agency said that State regulations allow for add-on services for beneficiaries provided that the proper officials request the services and the add-on services would be more cost effective than an increase in the service component of the per diem rate.<sup>12</sup>

However, the approved waiver stated that all of the listed conditions must be met, including a Rating Scale score of 5 on either the health/medical standard or the supervision/assistance standard.<sup>13</sup> Maryland's July 2013 renewal application for the waiver, effective after our audit period, also contained this same requirement. (The State agency revised this provision in its waiver in March 2014, after discussions during our audit.) CMS guidance states that "a state must implement the waiver as specified in the approved application."

The State agency did not comply with the requirements for add-on services in its approved waiver. Accordingly, the State agency's claims of \$62,918,678 (\$34,155,857 Federal share) for these services were unallowable.

## **RECOMMENDATIONS**

We recommend that the State agency:

- refund to the Federal Government \$34,155,857 and
- claim add-on service costs only for beneficiaries who meet waiver requirements.

## **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

### **STATE AGENCY COMMENTS**

In its written comments on our draft report, the State agency did not concur with our recommendations. The State agency said that the waiver application that was approved and in effect during our audit period contained a grammatical error. Specifically, the conjunction "and" instead of the conjunction "or" was used after the second of the three requirements for eligibility for add-on funding.<sup>14</sup> The State agency further said that the first two requirements were

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<sup>12</sup> COMAR 10.22.17.08(E).

<sup>13</sup> Waiver, Appendix I, section 2(a).

<sup>14</sup> The three requirements are listed on page 4 of this report.

essentially the same. The State agency said that the add-on provision should be interpreted to mean that meeting any one of the three criteria was sufficient to authorize add-on services and that its State regulations support its interpretation.

The State agency also noted that revisions in the March 2014 waiver, amended after discussions during our audit, allow for add-on services regardless of the level of need as long as two conditions are met:

- that the individual’s particular circumstances warrant add-on services and
- that the individual requires more services than the provider can provide for the per diem payment.<sup>15</sup>

The State agency’s comments appear in their entirety as Appendix B.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing the State agency’s comments, we maintain that our finding and recommendation for a refund are valid. States are required to comply with the terms and conditions of their CMS-approved waivers. The State agency’s argued interpretation of its waiver (that only one of the three requirements must be met) is not reasonable based on the plain language of the waiver, which uses the word “and” to indicate that all three conditions must be met. Moreover, the State failed to provide compelling evidence to support its position that the use of the word “and” in the waiver was a mistake. While the State agency argued that its State regulations provide such evidence, the State regulations and the approved waiver contain different requirements for the program. CMS guidance is clear that a “state must implement the waiver as specified in the approved application.”<sup>16</sup> As a result, the waiver provisions are the applicable criteria and not the State regulations. In Maryland’s approved waiver application, the waiver provides that all three requirements must be met. Thus, all three requirements were necessary to receive additional benefits for add-on services.

The March 2014 waiver, amended after discussions during our audit, requires providers to document both medical necessity and financial need to receive add-on payments. The amended provision allows add-on payments regardless of the level of need on the Rating Scale. During our audit period, the waiver allowed for only one condition to represent the beneficiary’s need: a level of need of 5 on the Rating Scale. We have amended our second recommendation to reflect the current waiver requirements.

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<sup>15</sup> The State agency amended its waiver in March 2014 in an effort to reflect the language in its State regulations. The revised 2014 waiver cites COMAR 10.22.17.08 and appears to mirror the language from the regulation section. However, the regulation and the revisions to its waiver do not align. The regulation contains an “and” in the list of five conditions that represent the need for add-on components, whereas the amended waiver contains an “or.”

<sup>16</sup> Application for § 1915(c) Home and Community-Based Waiver: Instructions, Technical Guide, and Review Guide, page 6 (released January 2008).

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

During our audit period (July 1, 2010, through June 30, 2013), the State agency claimed \$328,769,706 for all add-on residential habilitation services under the waiver. Our review covered \$62,918,678 (\$34,155,857 Federal share) for 776,771 claims paid to 115 providers for add-on services for beneficiaries who did not have a level of need of 5 on either the health/medical or supervision/assistance standard of the Rating Scale.

We did not review the overall internal control structure of the waiver program. Rather, we reviewed only those internal controls related to our objective. We limited our review to determining whether the State agency properly claimed add-on services under the waiver. 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.

We performed our fieldwork at the State agency's Developmental Disabilities Administration in Baltimore, Maryland, from May through September 2013 and in July 2014.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidelines and the waiver application;
- held discussions with officials from the State agency and the Developmental Disabilities Administration to gain an understanding of the operation of the waiver program;
- obtained from the Developmental Disabilities Administration a database of add-on residential habilitation claims for services provided to beneficiaries who did not have the highest level of need (5) (the database had 776,771 add-on claims totaling \$62,918,678 (\$34,155,857 Federal share) paid during our audit period);
- confirmed that the State agency claimed add-on services paid for beneficiaries who did not have a level of need of 5 by:
  - randomly selecting 45 claims for beneficiaries who had needs levels of less than 5 identified in the database of add-on services, using the Office of Inspector General, Office of Audit Services, statistical software and
  - obtaining and reviewing State agency documentation supporting the Rating Scale scores; and
- discussed our findings with CMS and State agency officials.

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: STATE AGENCY COMMENTS



STATE OF MARYLAND

# DHMH

Maryland Department of Health and Mental Hygiene

Lawrence J. Hager, Jr., Governor – Boyd K. Rutherford, Lt. Governor – Van T. Mitchell, Secretary

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January 23, 2015

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

SUBJECT - Report Number: A-03-13-00202

Dear Mr. Virbitsky:

This letter is submitted on behalf of The Maryland Developmental Disabilities Administration (DDA), a division of the Maryland Department of Health and Mental Hygiene (Department), in response to the draft report prepared by the Department of Health and Human Services' Office of Inspector General (OIG), entitled *Maryland Claimed Unallowable Medicaid Costs for Residential Habilitation Add-on Services Under Its Community Pathways Waiver Program*, dated December 23, 2014 ("draft OIG report"). The Department does not concur with either of the two recommendations contained in the report and shown below.

- **Recommendation #1:** refund to the Federal Government \$34,155,857
- **Recommendation #2:** discontinue claiming add-on service costs for beneficiaries whose level of need does not comply with waiver requirements

The draft OIG report both misstates DDA's position regarding the correct interpretation of the relevant provisions of the *Community Pathways* waiver application as it existed at the time of the audit and mischaracterizes the relevant provisions of the current *Community Pathways* waiver application, which was approved in March 2014. This letter explains the errors in the draft report that lead to the erroneous conclusion that DDA has not complied with the provisions of its waiver and therefore should refund to the Federal Government the sum of \$34,155,857. DDA believes that it has consistently provided needed services to waiver recipients, including add-on services, in accordance with its approved waiver applications, regulations, and policies, and consistent with protecting the health, safety and welfare of the individuals in the *Community Pathways Waiver*.

201 W. Frazier Street • Baltimore, Maryland 21201  
Toll Free: 1-877-AMLE-DHMH • TTY: Maryland Relay Service 1-800-735-2258  
Web Site: [www.dhmh.maryland.gov](http://www.dhmh.maryland.gov)

**Subject: Matter of the Audit:**

Prior to March, 2014, Appendix I to Maryland's Community Pathways Waiver application, Financial Accountability 1.2: Rates, Billing, and Claims (1 of 3), paragraph a ("add-on provision"), set out below, states the criteria that must be met in order for an individual receiving services under the *Community Pathways* waiver to be eligible for additional ("add-on") services. Licensed providers serving individuals with extraordinary needs may make a request in writing for additional funding on behalf of that individual when the following conditions are met:

1. The individual has the highest HRS rating of five (5) on either the HRS health/medical needs scale or supervision/assistance needs scale;
2. When an extraordinary service or level of supports is required to safely maintain the individual in the community beyond what the base budget can support, and;
3. When the extraordinary service or support (i.e. awake overnight services) is recommended by their Resource Coordinator.

(emphasis added.) The OIG auditors erroneously concluded that individuals whose HRS rating (sometimes referred to as "the Matrix score") of less than five did not satisfy the waiver criteria for add-on services, and those services should not have been provided to those individuals. However, as demonstrated below and in DDA's September 20, 2013, letter on this subject, the use of the conjunction "and" was a grammatical error, and the waiver provision at issue should be interpreted to mean that any one of these three criteria authorized add-on services.

**Summary of DDA's Position:**

The *Community Pathways* waiver application that was approved and in effect during the audit time period contained a grammatical error, in that the conjunction "and" was used after the second criteria for add-on services, rather than the word, "or." That this was a grammatical error is demonstrated by the following facts:

1. Under the OIG auditors' literal interpretation of the add-on provision, an individual would need to prove each of the three criteria in order to be eligible for an add-on service. However, the language of the provision itself demonstrates that this is an incorrect interpretation, because it would make the second criterion superfluous. Rules of construction do not permit that conclusion.

The first criterion actually includes the second criterion. In order to have an HRS score of five, an individual must need an extraordinary service or level of services, because that is an element of the HRS score. The reverse, however, is not true: a person needing an extraordinary service does not necessarily have an HRS score of five. Therefore, if a person meets criterion one, criterion two is unnecessary. Under the OIG auditors' interpretation – that all three elements must be met – the second criterion becomes superfluous. However, when the provision is read correctly, an individual who needs an extraordinary service or level of services but does not have an HRS score of five is nonetheless eligible for add-on services. Under that interpretation, the second criterion is not superfluous, and must be correct under rules of construction.

2. The OIG auditors' interpretation of the add-on provision would result in a policy that only individuals with an IRS score of five may be provided with add-on services. However, DDA has consistently interpreted the add-on provision to mean that an individual need not have a score of five but, rather, need only meet one of the three criteria in order to be eligible for add-on services. With its September 20, 2013, letter, DDA produced a July 8, 2002 memorandum from the then director of DDA, explaining how individuals with IRS scores of less than five could be offered add-on services. If all three criteria must be met for add-on services, no one with an IRS score of less than five would have been able to get add-on services. Thus, the OIG auditors' findings contradict long-standing DDA policy.

Further, throughout several iterations, DDA's regulations have set out the requirements for add-on services as DDA explains them here. One of the auditors enclosed in a discussion at DDA headquarters that DDA's regulations and policy have consistently matched DDA's interpretation of the add-on provision. As demonstrated in DDA's September 20, 2013, letter, DDA has never taken the position, in any regulation, guidance, policy, or decision, that an individual seeking add-on services must have an IRS rating of five (thus meeting criterion one) in order to obtain such services.

3. Contrary to the statements in the draft OIG report, the *Community Pathways* waiver application that was approved in March of 2014 ("2014 Waiver") does not require that an individual have a rating of five (thus meeting criterion one), and also need extraordinary services at support level, and also have the add-on service be recommended by the resource coordinator, in order to be eligible for the add-on service. After the OIG auditors brought the grammatical error in the former waiver's add-on provision to the attention of DDA, DDA revised the relevant provision in the 2014 Waiver to clarify that the decision of whether an individual may receive add-on services is decided on a case-by-case basis, considering – but not requiring all of – several factors. These factors expand on the old waiver provisions in order to clarify them. See 2014 Waiver, Appendix B: Financial Accountability (-2: Rates, Billing and Claims (1 of 3) a., p. 236.<sup>1</sup> Thus, the current waiver comports with DDA's interpretation of the former waiver provision.

4. The purpose of the add-on policy is to permit DDA to respond flexibly and appropriately when a significant need arises suddenly, such as a person needing a higher staffing ratio in order to safely return home after a hospital stay or to manage serious, unexpected behavioral outbursts.

<sup>1</sup> "In accordance with COMAR 10.22.17.09, in order to pseudo-ize and approve one or more units of add-on components for an individual, the DDA shall determine that the  
(1) Individual's particular circumstances warrant units of add-on components to implement the IP; and  
(2) Individual requires more services than the provider can provide with the sum of the provider and individual components.

Any of the following conditions represent the need for add-on components:

- (1) Additional support for an individual whose individual component is less than level 3 and for whom approval of an add-on component would be more cost effective than an increase in the individual component;
- (2) Ongoing, intensive support, such as one-to-one support, for an individual whose individual component is level 3;
- (3) Ongoing support in a residential program for an individual who does not attend day activities;
- (4) Awake overnight support for an individual; or
- (5) Professional services not covered by Medicare or other payers."

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As explained in the September 30, 2013, letter, interpreting the criteria for add-on services in the way that the auditors have, would undermine that policy.

5. The interpretation argued by the OIG auditors would place the State at risk of being out of compliance with federal requirements. For example, under required waiver assurances, service plans must "address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means." CMS Guide, January 2008, p. 179 (emphasis added). If the add-on services were available only to persons with an IIRS score of five, many waiver participants' assessed needs would go unmet. Conversely, DDA's interpretation of the provision at issue would permit add-on services when the individual requires the services. Please see DDA's September 20, 2013 letter for further discussion of this point.

Further, failing to provide the services that are necessary to the health and safety of individuals who do not have an IIRS rating of five would jeopardize their well-being, and could result in them being placed in State facilities rather than in community placements.

It has never been the State's intent to fail to comply with these federal requirements to provide for the health and safety of participants. DDA has consistently interpreted the waiver provision, the relevant regulations, and DDA policies in a manner that ensures that the State remains in compliance with federal requirements, including providing add-on services for persons in any of the three categories of the provision who need them.

Given the facts that even the OIG auditors concede that DDA's regulations and policy have consistently matched its interpretation of the Appendix I provision, that the provision makes no sense under the OIG interpretation, that it obviously contains grammatical and punctuation errors, and that the OIG interpretation threatens to place Maryland out of compliance with federal waiver requirements, the Appendix I provision must be interpreted to mean that any one of the three circumstances permits granting add-on services.

Thank you for the opportunity to provide additional information. If you have any questions, please contact me or Thomas V. Russell, Inspector General at 410-767-5784.

Sincerely,



Van T. Mitchell  
Secretary

cc: Bernard Simons, Deputy Secretary, DDA, DHME  
Valerie Roddy, Deputy Director, DDA, DHMH  
Shawn Cain, Chief of Staff  
Kathleen Morse, Assistant AG, DHMH  
Charles Lehman, Acting Deputy Secretary, MCPA, DHMH  
Thomas V. Russell, Inspector General, DHMH  
Elizabeth Morgan, Acting Assistant Inspector General, DHMH