Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MARYLAND IMPROPERLY CLAIMED PERSONAL CARE SERVICES PROVIDED UNDER ITS MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER FOR OLDER ADULTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General

April 2013
A-03-11-00201

Office of Inspector General

https://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Maryland, the Department of Health and Mental Hygiene (State agency) administers the Medicaid program.

Under section 1915(c) of the Act, a State may obtain a waiver that allows it to furnish an array of services to Medicaid beneficiaries so that they can live in the community and avoid institutionalization. States have broad discretion to design waiver programs to address the needs of target populations; however, CMS must approve the waiver.

Maryland's Home and Community-Based Services Waiver for Older Adults (waiver) authorizes services for individuals with low incomes who are aged 50 or older and who need the level of care provided by a nursing facility. The waiver provides for personal care services and other services that help beneficiaries avoid institutionalization.

Beneficiaries receive waiver services based on a plan of care (42 CFR § 441.301(b)(1)(i)). Beneficiaries who are inpatients of a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (42 CFR § 441.301(b)(1)(ii)) are not eligible for waiver services. A registered nurse monitors all personal care aides, supervises the beneficiary's medical condition, and must complete a home visit monthly.

The Maryland Department of Aging (Department of Aging) administers the waiver program through an interagency agreement with the State agency. The Department of Aging contracts with 19 local Area Agencies on Aging for daily management activities, including case management.

From July 1, 2008, through June 30, 2010, the State agency claimed $67,248,404 (Federal share) in personal care and nurse monitoring services under the waiver program. These claims did not include personal care service claims submitted by providers under Maryland's State plan. We audited those claims separately.

OBJECTIVE

Our objective was to determine whether the State agency complied with Federal and State requirements when it claimed Medicaid personal care and nurse monitoring services under the waiver.

SUMMARY OF FINDINGS

The State agency did not always comply with Federal and State requirements when it claimed Federal Medicaid reimbursement for personal care service claims submitted under the waiver. Of the 100 sampled claims, 80 claims complied with Federal and State requirements; however, 20 claims did not. Some claims had more than one error. We estimate that the State agency claimed at least $10,864,195 in unallowable costs.

The State agency did not ensure that the Department of Aging had sufficient controls to monitor local agencies and to submit only allowable claims for reimbursement.

RECOMMENDATIONS

We recommend that the State agency:

- refund $10,864,195 to the Federal Government and

- work with the Department of Aging to improve its controls over claims for personal care services provided under the waiver to ensure compliance with Federal and State requirements.

STATE AGENCY COMMENTS

In its written comments on our draft report, the State agency generally concurred with our findings. The State agency provided additional documentation for six claims, including the necessary credentials for one personal care aide and plans of care for five claims. The State agency requested that we adjust the questioned costs for two of the claims and reduce the number of errors for four claims that remained unallowable for other reasons. The State agency did not concur with our finding that the Department of Aging lacked a process to recoup improper payments. However, the State agency concurred with our recommendation to work with the Department of Aging to improve controls and identified corrective action it had taken or planned to take.

OFFICE OF INSPECTOR GENERAL RESPONSE

We considered the State agency's comments and revised our findings and recommendations to allow two previously questioned claims. We adjusted the number of errors in our findings to reflect that the State agency supplied additional plans of care to support four claims that were disallowed for other errors and made other revisions as needed.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

In Maryland, the Department of Health and Mental Hygiene (State agency) administers the Medicaid program. The Federal Government's share of costs is known as the Federal medical assistance percentage (FMAP). The American Recovery and Reinvestment Act of 2009, P.L. No. 111-5, enacted February 17, 2009, authorized the States to temporarily receive a higher FMAP during a specified recession adjustment period. From July 1, 2008, to June 30, 2010, Maryland's FMAP ranged from 50 percent to 61.59 percent.

The Waiver for Older Adults Program

Under section 1915(c) of the Act, a State may obtain a waiver that allows it to furnish an array of services to Medicaid beneficiaries so that they can live in the community and avoid institutionalization. States have broad discretion to design waiver programs to address the needs of target populations; however, CMS must approve the waiver. Waiver services must comply with Federal cost principles, which establish principles and standards for determining allowable costs incurred by State and local governments under Federal awards.[1]

Maryland's Home and Community-Based Services Waiver for Older Adults (waiver) authorizes services for individuals with low incomes who are aged 50 or older and who need the level of care provided by a nursing facility. The waiver provides for personal care services and other services that help beneficiaries avoid institutionalization. The Maryland Department of Aging (Department of Aging) administers the waiver program through an interagency agreement with the State agency. The Department of Aging contracts with 19 local Area Agencies on Aging (local agencies) to manage the daily activities of the waiver program, including case management.

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

Personal Care Services

Beneficiaries receive personal care services based on a plan of care (42 CFR § 441.301(b)(1)(i)). Beneficiaries who are inpatients of a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities are not eligible for waiver services (42 CFR § 441.301(b)(1)(ii)).[2]

The waiver authorizes personal care services that assist with activities of daily living, such as feeding and bathing. Personal care services may also include assistance with self-administered medications or administration of medications by a qualified personal care aide with the required training and certification. Household services, such as bed making, dusting, and vacuuming, that are incidental to the personal care furnished and essential to the health and welfare of the beneficiary, rather than the beneficiary's family, are also covered (Code of Maryland Regulations (COMAR) 10.09.54.22(E)).

Personal care aides provide personal care services under the supervision of a registered nurse.[3] Personal care aides may be self-employed, employees of agency providers, or members of the beneficiary's family, with the exception of the spouse or children under 18 (COMAR 10.09.54.06). The registered nurse monitors all personal care aides and supervises the beneficiary's medical condition.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency complied with Federal and State requirements when it claimed Medicaid personal care and nurse monitoring services under the waiver.

Scope

Our audit period covered claims paid from July 1, 2008, through June 30, 2010. Our audit population consisted of 1,088,302 waiver claims totaling $67,248,404 (Federal share) submitted by 588 providers for personal care and nurse monitoring services to 2,334 beneficiaries. Our audit population did not include claims for services submitted by providers under Maryland's State plan. We audited those claims separately.[4] We limited our review of the State agency's internal controls to those related to the objective of our audit.

We conducted fieldwork at the offices of the State agency and the Department of Aging in Baltimore, Maryland, and at 19 local agencies throughout the State.

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[2] Changes in terminology are based on Rosa's Law (P.L. No. 111–256). For more information, see CMS Final Rule, 77 Fed. Reg. 29002, 29021, and 29028 (May 16, 2012).

[3] Registered nurse monitors are employees of personal care agency providers.

[4] See *Review of Personal Care Services Claimed Under Maryland's Medicaid State Plan* (A-03-11-00200).

Methodology

To accomplish our objective, we:

- reviewed applicable Federal statutes and regulations, the COMAR, the waiver, and the Medicaid Waiver for Older Adults Program Billing and Reimbursement Reference Guide;

- held discussions with State agency and Department of Aging officials to gain an understanding of the waiver program in Maryland;

- extracted waiver claims for personal care services and nurse monitoring services from the data provided by the State agency;

- identified 1,088,302 claims totaling $67,248,404 (Federal share) for personal care and nurse monitoring services and created a database of the paid claims;

- selected a simple random sample of 100 claims from the sampling frame of 1,088,302 claims;

- gathered the corresponding personal care services documentation maintained in files at the Department of Aging and local agency offices;

- determined whether the documentation met the required Federal and State requirements and identified unallowable claims;

- estimated unallowable Federal Medicaid reimbursement paid in the population of 1,088,302 claims; and

- discussed our findings with officials from CMS, the State agency, and the Department of Aging.

Appendix A contains the details of our sample design and methodology.

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.

FINDINGS AND RECOMMENDATIONS

The State agency did not always comply with Federal and State requirements when it claimed Federal Medicaid reimbursement for personal care service claims submitted under the waiver. Of the 100 sampled claims, 80 claims complied with Federal and State requirements; however,

20 claims did not. The 20 claims contained 24 errors as described in the table below. Some claims had more than one error.

Table 1: Summary of Deficiencies in Sampled Claims

Type of Deficiency	Total Errors
Unqualified Personal Care Aide	15
Unapproved or Missing Plan of Care	4
Unauthorized Services	4
Undocumented Services	1
Total	**24**

We estimate that the State agency claimed at least $10,864,195 in unallowable costs.

The State agency did not ensure that the Department of Aging had sufficient controls to monitor local agencies and to submit only allowable claims for reimbursement.

UNQUALIFIED PERSONAL CARE AIDE

The waiver must provide assurances that it has met all the health and welfare requirements of 42 CFR § 441.302(a). Specifically, the waiver must assure that providers of waiver services have met all State licensure or certification requirements (42 CFR § 441.302(a)(2)). States may not receive a Federal share when the health and welfare requirements are not met (42 CFR § 441.310(a)(1)).

Federal cost principles state that, to be allowable, costs must be authorized or not prohibited by State or local laws or regulations (2 CFR part 225, Appendix A, section C.1.c.). State regulations require that covered personal care services be "rendered by a qualified personal care aide under the supervision of a personal care nurse monitor" (COMAR 10.09.54.22(E)). State regulations for the waiver (COMAR 10.09.54.06) further state that, to be qualified, personal care aides must have:

- current first aid and cardiopulmonary resuscitation (CPR) certifications and

- a criminal background check submitted by the State of Maryland's Criminal Justice Information Services in the hiring agency's name, verifying that the employee has a clear record that contains no probation before judgment(s) or criminal conviction.

State regulations (COMAR 10.09.54.22(E)(3)) allow a personal care aide to perform delegated nursing functions, such as assistance with the administration of medications or other remedies, when ordered by a physician, provided that the personal care aide is (i) certified as a nursing assistant in accordance with COMAR 10.39.01; (ii) certified as a medicine aide in accordance with COMAR 10.39.03 or registered with the Maryland Board of Nursing as a medication assistant in accordance with COMAR 10.39.01; and (iii) supervised by a personal care nurse monitor who is a licensed registered nurse.

For 15 of the 100 sampled claims, the personal care aide did not meet at least one of the qualification requirements in COMAR 10.09.54.06 and 10.09.54.22(E)(3):

- For 11 of the sampled claims, the aide did not have a CPR certification.
- For 10 of the sampled claims, the aide did not have a first aid certification.
- For four of the sampled claims, the aide did not have a criminal background check.
- For one claim, the aide performed delegated nursing functions by administering medications but did not have a medicine aide certification.

Some of the personal care aides who performed the claimed services lacked more than one certification or a background check.

UNAPPROVED OR MISSING PLAN OF CARE

Sections 1915(c)(1) and (4) of the Act authorize the Secretary to pay for home and community-based waiver services that are provided "consistent with written plans of care, which are subject to the approval of the State."

COMAR 10.09.54.15(B) states that services must be preauthorized in the participant's plan of care and approved by the Department of Aging or its designee. Under the waiver program, the local agencies provide the required preauthorization by approving the plans of care on behalf of the Department of Aging. A case manager from the local agency prepares the plan of care and members of a multidisciplinary team sign it.[5] There is a disposition box on the plan of care that notes "final approval" when the local agency signs it. The signed plan of care is sent to the provider to preauthorize the personal care services.

For 4 of 100 sampled claims, the documentation did not include an authorized plan of care. The beneficiaries' plans of care were marked "no decision" because they had not been approved and signed by the multidisciplinary team or forwarded to the providers to preauthorize the services.

UNAUTHORIZED SERVICES

Sections 1915(c)(1) and (4) of the Act authorize the Secretary to pay for home and community-based waiver services that are provided "consistent with written plans of care, which are subject to the approval of the State."

COMAR 10.09.54.15 states that covered services must be preauthorized in the beneficiary's plan of care. A beneficiary's plan of care must include the type and frequency of services that the individual requires (COMAR 10.09.30.01(B)(11)(d)).

[5] Individuals signing the plan of care include: a licensed registered nurse or social worker from the local health department; the beneficiary's case manager; the beneficiary or authorized representative; and, as appropriate, the beneficiary's physician, dietitian, or other service providers.

For 4 of the 100 sampled claims, providers billed for services that were not authorized under the plan of care. In the four sampled claims, the provider billed for service hours in excess of the daily limit. For example, the plan of care for one beneficiary authorized 8 hours of service for 7 days per week; however, the claim that we reviewed for a single day of service reflected 11 hours of service.

UNDOCUMENTED SERVICES

Section 1902(a)(27) of the Act requires providers to keep records necessary to fully disclose the extent of the services provided to Medicaid beneficiaries under the waiver and to agree to furnish the State agency with such information when requested. Federal cost principles state that to be allowable, costs must be adequately documented (2 CFR part 225, Appendix A, section C.1.j). In addition, Federal regulations (42 CFR § 455.1(a)(2)) require States to have a method to verify whether services reimbursed by Medicaid were actually furnished to beneficiaries.

COMAR 10.09.36.04 requires that providers submit requests for payment according to procedures established by the State agency. The State agency requires caregivers to complete Form DHMH 4659, Caregiver Timesheet/Caregiver Service Record Form (timesheet), during each visit. The timesheet documents the date and time the caregiver rendered services and is reviewed and signed by the caregiver and by the beneficiary or their representative at the end of the week. The timesheet must be submitted with the request for payment (Form DHMH 4659, Instructions and Process for Caregivers (7-01-2006)).

For 1 of the 100 claims that we sampled, the services were not supported by a timesheet.

INADEQUATE INTERNAL CONTROLS

The State agency did not ensure that the Department of Aging had adequate controls to monitor local agencies and to submit only allowable claims for reimbursement. The Department of Aging administers the waiver program, including oversight, through an interagency agreement with the State agency. Department of Aging officials said that they perform audits of providers and that those audits have uncovered results similar to ours. These officials said that the Department of Aging cites providers for unallowable claims. However, the Department of Aging did not recoup the improper payments or determine whether the providers had taken corrective action.

RECOMMENDATIONS

We recommend that the State agency:

- refund $10,864,195 to the Federal Government and

- work with the Department of Aging to improve its controls over claims for personal care services provided under the waiver to ensure compliance with Federal and State requirements.

STATE AGENCY COMMENTS

In its written comments on our draft report, the State agency generally concurred with our findings. The State agency provided additional documentation for six claims, including the necessary credentials for one personal care aide and plans of care for five claims. The State agency requested that we adjust the questioned costs for two of the claims and reduce the number of errors for four claims that remained unallowable for other reasons. The State agency did not concur with our finding that the Department of Aging lacked a process to recoup improper payments. However, the State agency concurred with our recommendation to work with the Department of Aging to improve controls and identified corrective action it had taken or planned to take.

OFFICE OF INSPECTOR GENERAL RESPONSE

We considered the State agency's comments and revised our findings and recommendations to allow two previously questioned claims. We adjusted the number of errors in our findings to reflect that the State agency supplied additional plans of care to support four claims that were disallowed for other errors and made other revisions as needed.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of Medicaid claims paid from July 1, 2008, through June 30, 2010, (audit period) for personal care and nurse monitoring services that the providers rendered under the Home and Community-Based Services Waiver for Older Adults.

SAMPLING FRAME

The sampling frame was a Microsoft Access database that contained 1,088,302 claims, paid during the audit period, for personal care and nurse monitoring services submitted by 588 providers in Maryland. The total Medicaid reimbursement for the 1,088,302 claims was $113,204,363, of which the Federal share was $67,248,404.

SAMPLE UNIT

The sample unit was a claim for 1 day of service for which the State agency claimed Federal Medicaid reimbursement.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 paid claims.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services, statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the frame from 1 to 1,088,302. After generating 100 random numbers, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the Office of Inspector General, Office of Audit Services, statistical software to appraise the sample results.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Frame Size	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Items	Value of Unallowable Items (Federal Share)
1,088,302	$67,248,404	100	$6,436	20	$1,534

Estimated Value of Unallowable Items (Federal Share)

(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	$16,693,272
Lower Limit	$10,864,195
Upper Limit	$22,522,348

APPENDIX C: 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

January 28, 2013

Stephen Virbitsky
Regional Inspector General for Audit Services
Office of Audit Services, Region III
150 S, Independence Mall West
Philadelphia, PA 19106

Report Number: A-03-11-00201

Dear Mr, Virbitsky:

This letter is in response to the draft report issued by your office entitled *Maryland Improperly Claimed Personal Care Services Provided under Its Medicaid Home and Community-Based Services Waiver for Older Adults.* Your letter indicated this draft report is subject to further review and revision; therefore we are providing information for your consideration that is in addition to what the Department sent to Mr. Baiocco on May 17, 2012.

Specifically, we are providing five plans of care and seven additional documents which demonstrate proof of qualifications for one personal care worker. Four of the five plans of care were not submitted in May due to an oversight. The fifth plan of care being submitted will replace a plan previously submitted in error. The additional information for consideration is enclosed. We believe the documentation provided demonstrates compliance and addresses the audit findings.

Thank you for this opportunity to review the draft audit report and submit additional documentation. We appreciate the assistance of your staff in this audit process. If you have any questions, please contact me at 410-767-4639 or Thomas V. Russell, Inspector General at 410-767-5862.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosures

cc: Robert Baiocco, HHS OIG
Elwood Hall, DHMD, Asst. Inspector General
Charles J. Milligan, Jr., DHMH, Deputy Secretary for Health Care Financing
Warren Sraver, Department of Aging
Susan Tucker, DHMH, Executive Director, Office of Health Services
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Response to Preliminary Federal Audit Report – A-03-11-00201

Auditor's Finding:

Unqualified Personal Care Aide (p.4)

Department's Response:

The Department concurs with the finding, however, the credentials for one of the personal care aides has been located. (See attachment for Sample # 12)

The program enrolls both self-employed personal care providers and agency personal care providers. The audit reported 16 unqualified aides. Five were self-employed aides and 11 were employed by agencies.

Agency Personal Care Providers:

In 2005, a policy was implemented requiring the principals of enrolled personal care agencies to send Maryland Department of Aging (MDoA) a monthly list of the aides they assigned to provide personal care to enrolled participants and to attest by signature that these individuals meet the requirements to be aides including all certifications.

During the audit period, 178 agencies were enrolled in the Waiver for Older Adults and their employees were providing personal care services. Those agencies that were part of the Audit did submit the monthly list attesting to the certifications and qualifications of their staff. The on-going monitoring of aide credentials does not prevent providers from inaccurately or fraudulently attesting to the qualifications of their aides.

MDoA monitored 11 of the 16 agencies identified with deficiencies during the audit period and addressed any deficiencies in writing instructing the agencies to stop using the unqualified aides immediately and to submit a corrective action plan. MDoA provided technical assistance to the agency to improve their ability to monitor staff qualifications. In some cases a recommendation was made to DHMH for recovery and disenrollment of the agency.

Self Employed Personal Care Aides:

All self-employed personal care aides are required to have current first aid, CPR and Criminal Justice Information System (CJIS) criminal history background reports as a condition for enrollment. Providers are expected to send MDoA updated credentials as appropriate. MDoA monitors and contacts aides by letter when they have found that

Page two

their credentials have expired.

The credentials for one aide have been located since the Department's initial response to the HHS OIG in May 2012 and are enclosed for consideration. (See attachment for Sample # 12.)

Corrective Action

1. Onsite Agency Monitoring: These monitoring visits provide a retrospective review through which inappropriate attestations can be identified.

New provider orientation and annual provider training sessions, required Plans of Corrections to address deficiencies, recommendations to Medicaid for recovery of funds or provider disenrollment remain the primary methods of addressing credentialing problems. There has been significant improvement in compliance over the last year.

2. Self-employed Personal Care Providers: MDoA will continue to review the provider database for records to determine the status of credentials and will contact providers for updates and follow-up as necessary when credentials are not received.

While these are not new actions, compliance has improved over time as providers receive technical assistance and training from MDoA.

Auditors Finding:

Unapproved or Missing Plan of Care (p. 5)

For 9 of 100 sampled claims the documentation did not include an authorized Plan of Care.

Department's Response:

The Department concurs that for 4 of the 9 cases the documentation did not either include the Plan of Care that was authorized or one that was authorized prior to the service being provided.

1. Sample #53: Plan of Care (POC) finalized after the date the services were provided.

Page three

2. Sample #9: Missing provider signature on POC authorizing the service as provided on the dates of service identified by the auditor.
3. Sample #11: An electronic POC that would cover the services in question is not in the tracking system and the file copy while containing all the required signatures to authorize the services has a disposition that reads "Not Finalized". **Note**: The electronic POC became available for use in November 2007, less than a month prior to the creation of this POC. Initially, there were technical and user problems which might explain this documentation problem.
4. Sample #18: The POC for this sampled claim was finalized in the Waiver Tracking system after the service was provided.

However, for the remaining 5 cases noted:

1. Sample # 21: The auditor reported that for one of the sampled claims, the services were provided in August 2008 before the effective date of the POC; however, there is an authorizing POC for services provided in August 2008. (See attachment)
2. Sample numbers #22, #87, #91 and #94: An approved POC was obtained but not sent with the initial documentation because these sampled claims were also denied for additional errors. The approved POCs for each of these sampled claims are being submitted now since they are referenced as a finding in the auditor's report. (See attachment)

Corrective Action

MDoA monitors POC development for compliance with program regulations, policies and procedures by annually auditing each Area Agency on Aging (AAA). The POCs maintained in the AAA files are reviewed and compared to the Plans in the Electronic Waiver Tracking System. If the POC in the participant paper record does not read finalized or should signatures not be available as indicated in the Tracking System and required by policy, the AAA is cited and they must correct the record to include missing items. MDoA also maintains a list of unapproved POCs identified by either our claims department or by other specialists randomly checking POCs. The responsible Case Managers are then contacted to make certain the approval process is completed and documented in both the tracking system and in the participant files.

Page four

Personal care providers are informed during pre-enrollment training sessions that they must have an authorized POC from the AAA before services can be provided. This requirement is then reinforced in annual provider trainings. Providers are aware that should they provide services without an authorized POC in their records, they may not be paid, or if paid, they will be subject to recovery of funds and disenrollment if necessary based on significant and/or continued non-compliance.

Auditor's Finding:

Unauthorized Services (p. 6)

For 4 of the 100 sampled claims, providers billed for services that were not authorized in the Plan of Care. The providers billed in excess of the daily limit.

Department's response:

The Department concurs with the finding.

Personal care claims are submitted on paper and manually entered into a billing software program. This information is then electronically transmitted to the Maryland Medicaid Information System for processing and payment. Information on services and units of service contained in a participant's POC must also be manually entered into the billing software. The billing software program is not directly linked to participant POCs in the Waiver Tracking System.

In December 2007, the ability to view participant POCs was added to a web-based participant tracking system. This allows billing specialists to view POCs. When claims are initially received for a participant, a claims specialists reviews the POC and enters information into the billing software based on units in the participant's POC up to the maximum number of units listed in the POC. POCs have an annual renewal date. When units run out in the billing software, the specialist is required to review the POC before adding new units. Should the unit run out before the end of the plan year, the specialist reports the problem to a supervisor before adding more units.

Page five

While these procedures are intended to reduce the chance that claims will be entered for hours of service not unauthorized by the POC, it is dependent on people, is not electronically sophisticated enough to monitor units entered for a day of service against units authorized per day in a POC and it is currently not possible to get the billing software directly linked to read a participant's POC in the Waiver Tracking System.

Corrective Action

1. In July 2013, the Department is implementing a new program designed to ensure greater accountability by providers of personal care services. The In-Home Supports and Assurance System (ISAS) is an automated voice monitoring authorization system used to validate the provision of personal care services.

This system provides documented evidence of the time spent in the home by the personal care aide through a call-in system utilizing a Biometric Voice Recognition System.

Providers will call in to the system on arrival at a participant's home and again upon leaving. The hours of service provided will be compared in this automated system to hours authorized in the POC. Discrepancies will be recorded by the system for administrative review by program staff.

ISAS will generate electronic invoices, thereby doing away with claims submission by the provider. The provider will be paid only for services provided in accordance with the participant's POC and will cut down on fraud and abuse of Medicaid funds.

2. When discrepancies are found between services authorized in the POC and those claimed, there is a recommendation by MDoA to Medicaid for recovery of payments.

3. Annual provider training sessions and individualized technical assistance will continue to reinforce the requirement to provide the service as authorized in the POC. Providers are instructed to attach copies of revised POCs to their claims to support the change in authorized number of hours to be provided.

Page six

Auditor's Finding:

Undocumented Services (p. 6)

For 1 of the 100 claims sampled, the services were not supported by a time sheet.

Department's Response:

The Department concurs with the finding.

Sample #9: The agency involved has been disenrolled from the program and the payments made for services not supported by a time sheet have been recovered.

Currently, personal care service providers submit their completed claims on paper along with an attached time sheet and the claim is processed manually for payment. Processed claims and copies of claims submitted by the provider are required to be kept for six years. Generally, MDoA and the provider work together to identify appropriate documentation to support paid claims.

In this instance, claims were processed and paid for dates of service that were not supported by appropriate documentation and the paper claims could not be located. MDoA worked with the provider who could not provide any evidence to support payment of these claims. The payments for the dates of service were recovered from the provider.

Corrective Action

These claims were entered by one of six AAAs authorized by MDoA to enter provider claims. In July 2012, MDoA withdrew the authorization that allowed the six AAAs to enter claims and now MDoA enters all Waiver provider claims for payment statewide. This change should reduce the likelihood that the documentation used to support the payments made to providers cannot not be located when needed since claims will be centrally stored by MDoA.

Page seven

Auditor's Finding:

Inadequate Internal Control (p.6)

A Department of Aging official stated that MDoA cites providers for unallowable claims but does not have a process to recoup the improper payments or to determine whether the providers have taken corrective action.

Department's Response:

The Department does not concur with the statement that MDoA lacks a process to recoup an improper payment or to determine whether a provider has taken corrective action.

Follow-up visits are conducted by MDoA when corrective action plans are required to determine compliance. If recovery of funds is indicated, a recommendation to Medicaid for recovery of waiver funds is the method used by MDoA for recoupment of improper payments.

Page eight

Auditor's Recommendation:

Refund $12,148,943 to the Federal Government

Department's Response:

We concur that a refund will be due to the Federal Government, however, based on the subsequent documentation submitted with this response, the recommended refund amount should be revised.

Auditor's Recommendation:

Work with the Department of Aging to improve its controls over claims for personal care services provided under the waiver to ensure compliance with Federal and State requirements

Department's Response:

We concur with the recommendation and as stated in the Corrective Actions of this response the Department will work with MDoA to improve its controls for personal care services under the Waiver for Older Adults. Additionally, effective in late 2012, the Medicaid Division of Waiver Services has begun to accompany the MDoA monitors on visits to the largest and/or most problematic providers.