Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MARYLAND CLAIMED UNALLOWABLE COSTS FOR MEDICAID COMMUNICABLE DISEASE CARE SERVICES

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

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Deputy Inspector General
for Audit Services

March 2016
A-03-14-00150

Office of Inspector General

http://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

Maryland claimed at least $16 million in unallowable costs for communicable disease care services paid to nursing facilities from 2008 through 2012.

WHY WE DID THIS REVIEW

Before July 1, 2012, Maryland's Department of Health and Mental Hygiene (State agency) paid nursing facilities for communicable disease care services for Medicaid beneficiaries with a disease such as hepatitis C or HIV/AIDS that was transmitted primarily by blood, blood products, or other body fluids. For calendar years (CYs) 2008 through 2012, Medicaid paid Maryland nursing facilities $66.6 million ($37.9 million Federal share) for communicable disease care services. (The State terminated reimbursement of communicable disease care as a covered service as of July 1, 2012.)

The State agency allowed providers to claim these services only if the beneficiary required and received treatment for the communicable disease. Because beneficiaries with a covered communicable disease may not require or receive treatment, claims for such services may be at risk for error or abuse.

The objective of our review was to determine whether the State agency complied with Federal and State requirements when it claimed communicable disease care costs.

BACKGROUND

Under Maryland's State Medicaid plan, nursing facilities receive a set per diem rate for basic services provided to a beneficiary based on the required level of care. Nursing facilities may also receive a separate payment to provide ancillary services for beneficiaries who need additional nursing care, such as ventilator care, tube feeding, or intravenous care. During our audit period, communicable disease care was an ancillary service provided for beneficiaries who required treatment for a disease such as HIV/AIDS or hepatitis C that was transmitted primarily by blood, blood products, or other body fluids.

The State agency contracts with a Utilization Control Agent (utilization agent) to review nursing facility claims. The utilization agent conducts onsite reviews of each nursing facility once each quarter and reviews the documentation in the beneficiary's medical record to determine whether it supports the claimed reimbursements. The utilization agent follows the *Maryland Medicaid Assistance Program Nursing Facility Assessment and Reimbursement Handbook* (Handbook). The Handbook defined the requirements for claiming communicable disease care services:

- the beneficiary had a medical diagnosis of a communicable disease transmitted primarily by blood, blood products, or other body fluids;

- specialized services included, but were not limited to, treatment for opportunistic infections and diseases; and

- the progress notes reflected individualized treatments that were being provided.

The Handbook further clarified that "Universal Blood and Body Fluid Precautions, as defined by the Centers for Disease Control and Prevention, will be maintained for all recipients. However, these precautions in and of themselves shall not constitute grounds for reimbursement for this service."

HOW WE CONDUCTED THIS REVIEW

Our review covered 19,229 claim lines totaling $59,401,207 ($33,743,506 Federal share), representing payments to 52 nursing facilities from January 1, 2008, through December 31, 2012. We selected a stratified random sample of 124 paid claim lines totaling $373,505 ($212,703 Federal share). We reviewed the sample items to determine whether they were allowable in accordance with Federal and State Medicaid requirements.

WHAT WE FOUND

The State agency did not always comply with Federal and State requirements when it claimed costs for communicable disease care services. Of the 124 claim lines that we sampled, 49 complied with Federal and State requirements; however, 75 did not. (Three claim lines were partially unallowable. For these lines, we calculated the unallowable cost.)

- For 41 claim lines, the State agency claimed services that were not supported by documentation.

- For 16 claim lines, the State agency claimed services for which the medical record did not contain a physician's order or treatment sheets to indicate that services had been provided.

- For 18 claim lines, the State agency claimed services that were not supported by a signed physician's order.

On the basis of our sample results, we estimate that the State agency claimed at least $16,015,005 (Federal share) in unallowable costs.

The State agency claimed these unallowable costs because it did not have sufficient internal controls to ensure that nursing facilities were correctly claiming communicable disease care services. However, because the State agency no longer pays for these services, we are not recommending additional internal controls.

WHAT WE RECOMMEND

We recommend that the State agency refund $16,015,005 to the Federal Government.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency concurred with our findings for 72 of the 79 claims we originally determined were in error and concurred with our recommendation to refund the unallowable costs. The State agency did not concur with our findings for seven claims and provided new documentation to support the claims. In addition, the State agency did not concur that its internal controls were not sufficient to ensure that claims were being properly reviewed. State agency officials contended that the utilization agent reported and recovered significant monies related to undocumented claims during the audit period.

After reviewing the State agency's comments, we reviewed the additional documentation provided to support the seven disputed claims. We agree that the new documentation supports four of the seven claims. We adjusted our finding to state that 75 claims were in error, and we recalculated a new estimated unallowable amount. Additionally, we acknowledge that the State agency took action in late 2010 to reeducate the utilization agent; however, we maintain that the internal controls were not sufficient during our entire audit period to ensure that the claims were supported.

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INTRODUCTION

WHY WE DID THIS REVIEW

Before July 1, 2012,[1] Maryland's Department of Health and Mental Hygiene (State agency) paid nursing facilities for communicable disease care services for Medicaid beneficiaries with a disease such as hepatitis C or HIV/AIDS that was transmitted primarily by blood, blood products, or other body fluids. For calendar years (CYs) 2008 through 2012, Medicaid paid Maryland nursing facilities $66.6 million ($37.9 million Federal share) for communicable disease care services.

The State agency allowed providers to claim these services only if the beneficiary required and received treatment for the communicable disease. Because beneficiaries with a covered communicable disease may not require or receive treatment, claims for such services may be at risk for error or abuse.

OBJECTIVE

The objective of our review was to determine whether the State agency complied with Federal and State requirements when it claimed communicable disease care costs.

BACKGROUND

The Social Security Act (the Act) authorizes State Medicaid agencies to provide nursing facility services to Medicaid beneficiaries (§ 1905(a)(4)(A)). Participating nursing facilities must meet the requirements of the Act and implementing Federal participation regulations that describe the services provided (the Act § 1919 and 42 CFR part 483 subpart B).

CMS reimburses the State Medicaid agency the Federal share of the State's claimed costs, based on the Federal medical assistance percentage (FMAP). Maryland's FMAP for our audit period ranged between 50 and 61.59 percent.[2]

Medicaid Nursing Facility Services in Maryland

Maryland's Medicaid State plan authorizes nursing facility services for individuals 21 years of age or older.[3] The Code of Maryland Regulations (COMAR) requires the program to cover

[1] The State terminated reimbursement of communicable disease care as a covered service as of July 1, 2012 (State plan amendment MD 12-08). No new claim lines were paid after this date; however, we extended our audit period to include adjustments to claim lines already paid.

[2] Maryland received an enhanced Federal share of up to 61.59 percent during the period covered by the American Recovery and Reinvestment Act of 2009.

[3] Medicaid State plan Attachment 3.1-A(4)(a).

routine care and supplies, equipment, and services, including nursing services, when appropriate to meet the needs of the beneficiary as described in 42 CFR Part 483, Subpart B.[4]

Nursing facilities receive a set per diem rate for basic services provided to a beneficiary. The per diem rate is based on the required level of care.[5] Nursing facilities may also receive a separate payment to provide ancillary services for beneficiaries who need additional nursing care, such as ventilator care, tube feeding, or intravenous care.

Communicable Disease Care Services

During our audit period, communicable disease care was an ancillary service provided for beneficiaries who received treatment for a disease such as HIV/AIDS or hepatitis C that was transmitted primarily by blood, blood products, or other body fluids. Providers who met the requirements of COMAR 10.09.10 and 10.07.02 could receive reimbursement for communicable disease care for patients who had a documented diagnosis of a covered communicable disease. For costs to be reimbursable, providers were required to maintain all clinical records, including documented assessment of the needs of the patient, an established plan of treatment, and documentation that the actual care and services were provided.[6]

The *Maryland Medicaid Assistance Program Nursing Facility Assessment and Reimbursement Handbook* (Handbook) set standards for providers under COMAR 10.09.10. The Handbook defined the requirements for claiming communicable disease care services:

- the beneficiary had a medical diagnosis of a communicable disease transmitted primarily by blood, blood products, or other body fluids;

- specialized services included, but were not limited to, treatment for opportunistic infections and diseases; and

- the progress notes reflected individualized treatments that were being provided.

The Handbook further clarified that "Universal Blood and Body Fluid Precautions, as defined by the Centers for Disease Control and Prevention, will be maintained for all recipients. However, these precautions in and of themselves shall not constitute grounds for reimbursement for this service."[7]

[4] COMAR 10.09.10.04(A).

[5] State Plan Attachment 4.19D.

[6] COMAR 10.07.02.20(B).

[7] The Handbook, page 20. The State agency revised the Handbook effective February 17, 2010, during our audit period; however, the requirements for claiming communicable disease care remained substantially the same. Effective July 1, 2012, the State agency further revised the Handbook to eliminate communicable disease care as a covered service.

The State agency paid nursing facilities for one unit of communicable disease care for each day of services provided.[8] In this report, a claim line includes all units claimed for services provided to one beneficiary in a calendar month. The number of units in a claim line varied because some beneficiaries with communicable diseases were not residents of the nursing facility for the full month or did not receive individualized services every day that they were residents.

Utilization Control Agent

The State agency contracts with a Utilization Control Agent (utilization agent) to review nursing facility claims. The utilization agent conducts onsite reviews of each nursing facility once each quarter and reviews the documentation in the beneficiary's medical record to determine whether it supports the claimed reimbursements. The results of these reviews are entered into the State's Medicaid Management Information System and compared with each facility's paid claims. If the documentation does not support the reimbursements, the nursing facilities' payments are adjusted. At the beginning of our review period, the State agency's utilization agent was Keystone Peer Review Organization, Inc. (Keystone). In February 2011, the State agency did not renew its contract with Keystone and instead contracted with a new utilization agent, Delmarva Foundation for Medical Care, Inc.

HOW WE CONDUCTED THIS REVIEW

Our review covered 19,229 claim lines totaling $59,401,207 ($33,743,506 Federal share), representing payments to 52 nursing facilities from January 1, 2008, through December 31, 2012. We selected a stratified random sample of 124 paid claim lines totaling $373,505 ($212,703 Federal share). We reviewed the sample items to determine whether they were allowable in accordance with Federal and State Medicaid requirements.

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, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

The State agency did not always comply with Federal and State requirements when it claimed costs for communicable disease care services. Of the 124 claim lines that we sampled, 49 complied with Federal and State requirements; however, 75 did not.[9]

[8] The State agency paid from $92.38 to $110.84 per day for communicable disease care services in our sample. The rate varied based on the costs to provide services in the county in which the nursing facility was located.

[9] Three claim lines were partially unallowable. For these lines, we calculated the unallowable cost.

- For 41 claim lines, the State agency claimed services that were not supported by documentation that the services had been provided.

- For 16 claim lines, the State agency claimed services for which the medical record did not contain a physician's order or treatment sheets to indicate that services had been provided.

- For 18 claim lines, the State agency claimed services that were not supported by a signed physician's order.

On the basis of our sample results, we estimated that the State agency claimed at least $16,015,005 (Federal share) in unallowable costs.[10]

The State agency claimed these unallowable costs because it did not have sufficient internal controls to ensure that nursing facilities were correctly claiming communicable disease care services.

FEDERAL AND STATE REQUIREMENTS

The State plan must provide for agreements with nursing facilities under which the facility agrees to keep records necessary to fully disclose the extent of the services provided to Medicaid beneficiaries and to agree to furnish the State agency with such information when requested (the Act § 1902(a)(27)).

Federal regulations state that nursing facility services are eligible for reimbursement under Medicaid only when the services are provided under the care and supervision of a physician. The physician must (1) review the resident's total program of care, including medications and treatments, at each visit; (2) write, sign, and date progress notes at each visit; and (3) sign and date all orders with the exception of certain vaccines, which may be administered according to physician-approved facility policy after an assessment for contraindications (42 CFR § 483.40).

The State agency requires that patient records include documented evidence of assessment of the patient's needs, of establishment of an appropriate plan of initial and ongoing treatment, and of the care and services provided; of diagnostic and therapeutic orders; and of observations and progress notes (COMAR 10.07.02.20).

THE STATE AGENCY CLAIMED UNALLOWABLE COSTS

Documentation Did Not Support the Claimed Services

The State agency requires that patient records include documented evidence of assessment of the patient's needs, of establishment of an appropriate plan of initial and ongoing treatment, and of

[10] To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total at least 95 percent of the time.

the care and services provided (COMAR 10.07.02.20). The Handbook specified key documentation for communicable disease services, including treatment sheets showing that the treatments were provided.[11]

For 41 of the sample claim lines, the State agency claimed Federal reimbursement for which there was insufficient supporting documentation that the services had been provided. The medical records did not contain treatment sheets to support that the nursing facilities had provided treatment of the communicable diseases during the months covered by our sample claim lines.[12] For example, the State agency paid one nursing facility $3,248 ($1,909 Federal share) for one claim line for 31 units (days) of communicable disease care services for hepatitis C treatment. However, the records did not include documentation to support that any medication or treatment had been provided for the period covered by the claim line.

No Physician's Order

The State agency requires that patient records include diagnostic and therapeutic orders (COMAR 10.07.02.20). The Handbook specified key documentation for communicable disease services, including a physician's order for treatment, and treatment sheets showing that the treatments were provided.

For 16 claim lines, the medical records did not contain a physician's order to support the claim lines.[13] For example, the State agency paid a nursing facility $3,325 ($2,048 Federal share) for one claim line for 30 units (days) of hepatitis C treatment; however, the nursing facility provided no physician's order or treatment sheets to support that services had been ordered or provided for the period covered by the claim line.

Physician's Order Not Signed

Nursing facility services are eligible for reimbursement when care is medically necessary, adequately described in progress notes in the resident's medical record, and there is a physician's order signed and dated by the individual providing care (COMAR 10.09.07.05(B)).

For 18 claim lines, the State agency paid nursing facilities for services although the order lacked a physician's signature. For example, the State agency paid a nursing facility $3,325 ($1,663) for 30 units (days) of HIV/AIDS treatment; however, the physician's order that the nursing facility provided was not signed.

[11] State agency and utilization agent officials said that, for claiming communicable disease care services, individualized treatment meant the administration of drugs to treat the communicable disease.

[12] For 2 of these claim lines, the records included treatment sheets for part of the month (5 of 31 units on 1 claim line and 17 of 18 units claimed for the other). We allowed those units of service and calculated the unallowable portion of the claim line accordingly.

[13] For 1 claim line, the physician's order and treatment sheets covered 29 of the 31 units claimed. We allowed the 29 units (29 days of service) and calculated the unallowable portion of the claim line accordingly.

LACK OF INTERNAL CONTROLS

The State agency's internal controls were not sufficient to ensure that claims were being properly reviewed. The State agency contracts with a utilization agent to conduct onsite postpayment reviews of claimed services at nursing facilities. However, during our audit period the utilization agent did not report errors in the claimed communicable disease care services to the State agency. The State agency did not have procedures in place to ensure that the utilization agent properly reviewed the claims. However, because the State agency no longer pays for these services, we are not recommending additional internal controls.

ESTIMATE OF UNALLOWABLE COSTS

On the basis of our sample results, we estimated that the State agency improperly claimed at least $16,015,005 (Federal share) for unallowable costs for communicable disease care services. Appendix C contains our sample results and estimates.

RECOMMENDATION

We recommend that the State agency refund $16,015,005 to the Federal Government.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings for 72 of the 79 claims we originally determined were in error and concurred with our recommendation to refund the unallowable costs. The State agency did not concur with our findings for seven claims and provided new documentation to support the claims. In addition, the State agency did not concur that its internal controls were not sufficient to ensure that claims were being properly reviewed. State agency officials contended that the utilization agent reported and recovered significant monies related to undocumented claims during the audit period.

The State agency's comments are included as Appendix D. The attachments and additional documentation were not included because they contained personally identifiable information.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we reviewed the additional documentation provided to support the seven disputed claims. We agree that the new documentation supports four of the seven claims. We adjusted our finding to state that 75 claims were in error, and we recalculated a new estimated unallowable amount.

Additionally, we acknowledge that the State agency took action in late 2010 to reeducate the utilization agent; however, we maintain that the internal controls were not sufficient during our entire audit period to ensure that the claims were supported.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 19,229 claim lines totaling $59,401,207 ($33,743,506 Federal share), representing payments to 52 nursing facilities from January 1, 2008, through December 31, 2012. We selected a stratified random sample of 124 paid claim lines totaling $373,505 ($212,703 Federal share). We reviewed the sample items to determine whether they were allowable in accordance with Federal and State Medicaid requirements.

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 internal control review to those controls related directly to processing and monitoring nursing facility claims. Our review did not assess the quality of the services or whether the services provided to the beneficiaries were medically necessary.

We conducted our fieldwork at the State agency's office in Baltimore, Maryland, and at nursing facility locations throughout Maryland from April through December 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidelines;
- held discussions with State agency officials and nursing facility officials to gain an understanding of communicable disease care services;
- obtained FMAP rates applicable to our audit period;
- held discussions with the current utilization agent to better understand the documentation requirements;
- obtained a database of communicable disease care claims from the State agency's Medicaid Management Information System for the audit period, containing 22,731 claim lines totaling $66,595,274 ($37,949,463 Federal share);
- included all final action claim lines above $1,000 for the top 52 providers to set our sampling frame at 19,229 claim lines totaling $59,401,207 ($33,743,506 Federal share);
- selected a stratified random sample of 124 claim lines from our sampling frame;
- reviewed the supporting documentation for communicable disease care services in each claim line to determine their allowability;

- calculated the overpayments for partially unallowable sampled claim lines;
- estimated the unallowable costs; and
- discussed our findings with State agency and nursing facility officials.

See Appendix B for 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 to the State agency for communicable disease care services provided to nursing facility beneficiaries during the period January 1, 2008, through December 31, 2012.

SAMPLING FRAME

The sampling frame consisted of a Microsoft Excel worksheet that contained 19,229 claim lines for communicable disease care submitted by 52 nursing facilities that Maryland paid during the audit period. The total Medicaid reimbursement for the 19,229 claim lines was $59,401,207 ($33,743,506 Federal share).

SAMPLE UNIT

The sample unit was a claim line for 1 month of communicable disease care services for one beneficiary for which the State agency claimed Federal Medicaid reimbursement.

SAMPLE DESIGN

We used a stratified random sample.

Stratum	Dollar Range of Frame Units	Number of Frame Units	Dollar Value of Frame Units
1	$1,006.20–3,436.04	19,205	$59,337,368
2	Probe sample $1,108.10–3,436.04	24	63,839
Total		**19,229**	**59,401,207**

SAMPLE SIZE

We selected a sample of 124 claim lines: 100 from stratum 1 and all 24 from stratum 2.

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

For our probe sample, we selected 24 sample units for review. The 24 claim lines were selected to represent high-volume and low-volume nursing facilities as well as nursing facilities in urban and rural locations. We removed the 24 audited sample units from the sampling frame and

consecutively numbered the sample units in stratum 1 from 1 to 19,205. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to appraise our sample results. We estimated the total amount and Federal share of the overpayments at the lower limit of the 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Results

Stratum	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)
1	19,205	$33,708,106	100	$177,303	57	$98,372
2	24	35,400	24	35,400	18	27,248
Total	**19,229**	**$33,743,506**	**124**	**$212,703**	**75**	**$125,620**

Estimated Value of Overpayments
(Limits Calculated for a 90-Percent Confidence Interval)

	Federal Share
Point estimate	$18,919,619
Lower limit	16,015,005
Upper limit	21,824,233

APPENDIX D: STATE AGENCY COMMENTS

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

October 30, 2015

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

RE: Report Number A-03-14-00150

Dear Mr. Virbitsky:

The Maryland Department of Health and Mental Hygiene (DHMH/the Department) has carefully reviewed the draft report of the Department of Health and Human Services Office of Inspector General (HHS-OIG) entitled *Maryland Claimed Unallowable Costs for Medicaid Communicable Disease Care Services*. We have conducted a review of the individual claims for which the HHS-OIG states that there was insufficient supporting documentation. We have also assembled data from both internal sources and cost settlement data provided by our audit contractor, in response to one of the report's findings. The OIG's findings/recommendation and the Department's responses are summarized below.

OIG FINDING – Unallowable Costs

The State agency did not always comply with Federal and State requirements when it claimed costs for communicable disease care services. Of the 124 claim lines that we sampled, 45 complied with Federal and State requirements; however, 79 did not.

- For 41 claim lines, the State agency claimed services that were not supported by documentation that the services had been provided.

- For 19 claim lines, the State agency claimed services for which the medical record did not contain a physician's order or treatment sheets to indicate that services had been provided.
- For 19 claim lines, the State agency claimed services that were not supported by a signed physician's order.

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DHMH RESPONSE

The Department does not concur that 79 claim lines did not comply with Federal and State requirements, but rather 72 of the claim lines reviewed by the auditors were unsupported by the required documentation or signatures.

In the course of a "look-behind" review conducted by a Program nurse consultant of all of the claims reviewed by the auditors, DHMH determined that seven of the 79 claims were properly supported by signed physician orders, treatment sheets, and other documentation. A listing of the disputed claims is enclosed as **Attachment 1**, and the supporting medical documentation will be forwarded separately. As such, the Department requests that the HHS-OIG recalculate the unallowable costs to consider the claims for which the Department has determined that appropriate documentation exists.

Because the ancillary payment for communicable disease care ended for dates of service after June 30, 2012, six months before the end of the OIG's audit period, the payment and related documentation is no longer an issue.

OIG FINDING – Lack of Internal Controls

The State agency's internal controls were not sufficient to ensure that claims were being properly reviewed.

DHMH RESPONSE

The Department does not concur with the finding and takes issue with the statement that it "did not have procedures in place to ensure that the utilization agent properly reviewed the claims." The Program contends that both UCA contractors reported, and the Program recovered, significant monies related to undocumented claims during the audit period. DHMH took three separate actions to scrutinize the claims made by Maryland nursing facilities for CDC payments; two of these control measures were well-established, ongoing internal auditing procedures.

First, as documents provided to the OIG auditors demonstrate, in late 2010 the Program became aware (through a new project manager's self-report) that the nurses employed by the then-UCA were not strictly enforcing the documentation requirements of the Reimbursement Manual. The documents supplied show that the Program took the matter to a monthly meeting of providers, and re-educated the UCA's nurses in the application of the Handbook's requirements.

Second, CDC payments were disallowed by both UCAs, across all nursing homes during the audit period. The total adjusted amount of these claims over the five calendar

years audited was over $6.4 million; the federal share of these funds was returned to the Federal Government via the CMS 64 quarterly reporting process.

Third, because Maryland Medicaid reimbursement for nursing facility services has been, until this year, a system in which facilities received an interim payment, which was then retrospectively cost-settled using audited reports of actual incurred costs, DHMH knows precisely how much in unexpended nursing costs was returned to the Department, and the federal share remitted through the CMS 64 process as above.

Attachment 2 shows the amount of each year's cost settlements for the facilities whose claims OIG sampled. Compared to the total CDC payment for the same year (far-right column), the recoveries related to unspent direct care payments are frequently considerable, in several cases more than the entire year's CDC payment. While the amount of the unexpended nursing costs cannot be claimed as identical to the unexpended funds paid for the CDC claims, the Program's annual wage surveys have shown year after year that the incremental increase in nursing costs incurred by the care of residents with blood-borne diseases in an era of universal precautions were negligible. This, in part, led to the Department's determination that these payments were unnecessary and, in July 2012, to the end of these ancillary payments.

OIG RECOMMENDATION

We recommend that the State agency refund $17,425,202 to the Federal Government.

DHMH RESPONSE

While the Department concurs with the recommendation to refund unallowable costs, we take exception to the amount of the recommended refund based on the documentation for the 7 claims as noted above. The Department requests that the additional documentation be considered in the calculation of the error rate and revise the refund amount accordingly.

In summary, the Department has demonstrated that it brought several levels of control to bear in monitoring the utilization control agents' reviews of claimed services, including those for Communicable Disease Care. The results of these reviews are tracked and reported monthly. According to these reports, DHMH recovered over $6.4 million related to undocumented CDC claims between November 2009 and July 2013, as a result of the agents' reviews.

During the same period, significant amounts of unexpended costs for direct nursing care were recovered through the Maryland Medicaid Program's retrospective cost settlement audits. The Department requests that the final report recognize the control measures that have been in place, and the unexpended costs that have been recovered, as noted above.

Stephen Virbitsky
October 30, 2015

Thank you for the opportunity to review and comment on the HHS-OIG's draft audit report. If you have any questions, please contact me or Susan Steinberg, Acting Inspector General at 410-767-5784.

Sincerely,

/Van T. Mitchell/

Secretary

Attachments

cc: Leonard Piccari, Audit Manager, DHHS
Shannon McMahon, Deputy Secretary for Health Care Financing, DHMH
Susan Tucker, Executive Director, Office of Health Services, DHMH
Susan Steinberg, Acting Inspector General, DHMH
Elizabeth Morgan, Assistant Inspector General, DHMH
Mark Leeds, Director, Long Term Services and Supports Administration, DHMH
Susan Panek, Deputy Director, Nursing Homes & Community Long Term Care, DHMH
Shawn Cain, Chief of Staff, Office of the Secretary, DHMH