DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Washington, D.C. 20201

August 24, 2011

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Review of Medicaid Residential Rehabilitation Services for Children in Maryland (A-03-08-00209)

Attached, for your information, is an advance copy of our final report on our review of Medicaid residential rehabilitation services for children in Maryland. We will issue this report to the Maryland Department of Health and Mental Hygiene within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or Stephen Virbitsky, Regional Inspector General for Audit Services, Region III, at (215) 861-4470 or through email at Stephen.Virbitsky@oig.hhs.gov. Please refer to report number A-03-08-00209.

Attachment

Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106-3499

August 29, 2011

Report Number: A-03-08-00209

Joshua M. Sharfstein, M.D.
Secretary
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201-2399

Dear Dr. Sharfstein:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid Residential Rehabilitation Services for Children in Maryland.* We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Robert Baiocco, Audit Manager, at (215) 861-4486 or through email at Robert.Baiocco@oig.hhs.gov. Please refer to report number A-03-08-00209 in all correspondence.

Sincerely,

/Stephen Virbitsky/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID RESIDENTIAL REHABILITATION SERVICES FOR CHILDREN IN MARYLAND

Daniel R. Levinson
Inspector General

August 2011
A-03-08-00209

Office of Inspector General

http://oig.hhs.gov

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

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 (the State agency) administers the Medicaid program.

Section 1905(a)(4)(B) of the Act authorizes early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals who are eligible under a Medicaid State plan and are under the age of 21. Section 1905(r)(5) of the Act allows States to include in their EPSDT programs any necessary services described in section 1905(a), including optional rehabilitative services specified in section 1905(a)(13). Federal regulations (42 CFR § 440.130(d)) define rehabilitative services as "… any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level."

As part of Maryland's EPSDT program, Medicaid State plan amendment 04-19 authorizes rehabilitative services for at-risk children aged 20 or younger who are placed in residential group homes or Treatment Foster Care homes under the supervision of Maryland's Department of Human Resources or Department of Juvenile Services. The services must be provided in accordance with a plan of care and supported by documentation of the nature of the services provided.

The State agency claimed $108.5 million ($54.3 million Federal share) during our audit period, October 1, 2005, through September 30, 2007, for residential rehabilitative services to 5,269 Medicaid beneficiaries.

OBJECTIVE

Our objective was to determine whether the State agency's claims for residential rehabilitative services complied with Federal and State requirements.

SUMMARY OF FINDINGS

We could not determine whether residential rehabilitative services claimed by the State agency complied with Federal and State requirements. The State plan is unclear about the precise definition of a residential rehabilitative service and the requirements for documentation of claims for residential rehabilitative services. Therefore, we were unable to determine whether the

documentation submitted by the State agency as support for the 2,652 claims in our 100 sampled beneficiary-months was sufficient to demonstrate that a service had been provided.

RECOMMENDATIONS

We recommend that the State agency work with CMS to amend its State plan to:

- define residential rehabilitation services,
- define the necessary documentation requirements for each service, and
- adjust its reimbursement methodology if needed to reflect costs for services provided.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The State agency did not concur with our draft report findings and recommendations and said that the Office of Inspector General "misinterpreted the requirements of the State Plan" and that the State agency's methodology for "calculating residential rehabilitation costs for eligible children … negated any need to document the provision of reimbursable services on a daily basis." However, the State agency submitted additional documentation and said it was "willing to discuss changes to its claiming methodology on a prospective basis and to ensure its claims are properly documented in accordance with that methodology."

We considered the State agency's comments and revised the report and recommendations to reflect that the State plan is unclear about the precise definition of a residential rehabilitative service. The type of claimed service actually provided and the documentation necessary to demonstrate that a service was provided were also unclear.

The State agency's comments appear in the Appendix. We excluded the additional documentation because of its volume and because some individual documents contained personally identifiable information.

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 (the State agency) administers the Medicaid program.

Rehabilitative Services

Section 1905(a)(4)(B) of the Act authorizes early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals who are eligible under a Medicaid State plan and are under the age of 21. Section 1905(r)(5) of the Act allows States to include in their EPSDT programs any necessary services described in section 1905(a), including optional rehabilitative services specified in section 1905(a)(13).

Federal regulations (42 CFR § 440.130(d)) define rehabilitative services as "… any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level."

Maryland's Residential Rehabilitative Services Program

As part of Maryland's EPSDT program, Medicaid State plan amendment 04-19 (SPA 04-19) authorizes rehabilitative services for at-risk children aged 20 or younger who are placed in residential group homes or Treatment Foster Care[1] homes under the supervision of Maryland's Department of Human Resources (DHR) or Department of Juvenile Services (DJS).[2] Maryland provides residential rehabilitation services through its Residential Rehabilitation for Children in Certain Out-of-Home Placements Program.

The Code of Maryland Regulations, (COMAR) 10.09.28, implements SPA 04-19. COMAR 10.9.28.05 identifies covered residential rehabilitation services, which include symptom management, supportive counseling, behavioral modification, age-appropriate health information, medication management, and face-to-face interventions to modify inappropriate

[1] Treatment Foster Care is a 24-hour care program, operated by a licensed child placement agency for children with serious emotional, behavioral, medical, or psychological conditions.

[2] Attachment 3.1.A, section 12, pages 15D–15D6.

behaviors. Residential rehabilitation is limited to medically necessary services provided in accordance with a plan of care (COMAR 10.9.28.06).

Reimbursement Methodology

To develop a methodology for claiming residential rehabilitative services, the State agency contracted with a consultant, Maximus, Inc. (Maximus). Maximus calculated a per diem rate of $117.96 for rehabilitative services provided in residential group homes and a per diem rate of $55.27 for rehabilitative services provided in Treatment Foster Care homes.

Providers submit to the child's supervisory agency (DHR or DJS) invoices for days of services.[3] The supervisory agencies verify and pay the invoices and submit claims to the State agency. The State agency applies the per diem rate, consolidates the claims, and submits the expenditures on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64), for Federal reimbursement. SPA 04-19 states that "the providers will agree to allow the State agencies [DHR and DJS] to bill on their behalf for the portion of the service, which is the Medicaid covered rehabilitative service."[4]

In total, the State agency claimed $108,464,434 ($54,272,140 Federal share) for residential rehabilitative services during our audit period: $52,882,766 ($26,483,450 Federal share) for 448,311 claims using the $117.96 residential group home per diem rate and $55,581,668 ($27,788,690 Federal share) for 1,005,639 claims using the $55.27 Treatment Foster Care home per diem rate.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency's claims for residential rehabilitative services complied with Federal and State requirements.

Scope

We reviewed the State agency's claims for residential rehabilitative services from October 1, 2005, through September 30, 2007. We did not review the rates developed by Maximus or determine whether any of the services were eligible for other Federal programs because that was outside the scope of this audit. Our objective did not require a review of the overall internal control structure of the State agency. Therefore, we limited our review of internal controls to those controls related to State payments and claims for residential rehabilitative services.

[3] Reimbursement for residential rehabilitation services is in addition to foster care payments; however, foster care payments were outside the scope of this report.

[4] Attachment 4.19A & B, page 57B.

We performed our fieldwork at the State agency in Baltimore, Maryland, and at 46 residential group homes and Treatment Foster Care homes throughout the State.[5]

Methodology

To accomplish our objective, we:

- reviewed Federal laws, regulations, and other requirements, as well as the State plan and the COMAR;

- reviewed the State agency's residential rehabilitative service policies, procedures, and documentation requirements;

- reviewed contracts between DHR and providers to determine what record retention policies were required;

- interviewed State agency, DHR, and DJS officials to determine how residential rehabilitative services were provided and claimed;

- reconciled the residential rehabilitative services claimed for Federal reimbursement on Form CMS-64 to the accounting records of the State agency that supported the claims;

- selected, from a population of beneficiary-months of residential services for children (all residential rehabilitative services provided to a beneficiary for a month during our audit period), a random sample of 100 beneficiary-months for which the State agency reimbursed DHR or DJS for 2,652 days of residential rehabilitative services claimed by 48 providers; and

- reviewed beneficiary case records for our sample items to determine if the claimed residential rehabilitative services were supported by evaluations and assessments, plans of care, and therapy or progress notes.

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 finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

We could not determine whether residential rehabilitative services claimed by the State agency complied with Federal and State requirements. The State plan is unclear about the precise definition of a residential rehabilitative service and the requirements for documentation of claims for residential rehabilitative services. Therefore, we were unable to determine whether the

[5] Our sample included 48 providers; however, 2 providers were no longer in business at the time of our fieldwork.

documentation submitted by the Stage agency as support for the 2,652 claims in our 100 sampled beneficiary-months was sufficient to demonstrate that a service had been provided.

FEDERAL AND STATE REQUIREMENTS

Federal and State Documentation Requirements

Section 1902(a)(27) of the Act requires that providers enter into agreements with a State agency to provide services under a State plan. Providers must agree "(A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request …." Maryland's SPA 04-19 requires that "documentation of the days of rehabilitative services delivered will be retained in the client files as required by state and or federal law for a period of six years."

Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, Att. A § C.1 requires that, to be allowable, costs must be authorized or not prohibited under State or local laws or regulations and must be documented.

Section 2500.2(A) of *The State Medicaid Manual*, CMS Pub. No. 45 (the Manual), instructs States to "report only expenditures for which all supporting documentation, in readily reviewable form, has been compiled and which is immediately available when the claim is filed." The Manual states that supporting documentation must include, at a minimum: "date of service, name of recipient, Medicaid identification number, name of the provider agency, and person providing the service, nature, extent, or units of service, and the place of service."

State Requirements for Residential Rehabilitation

SPA 04-19 states that the "per diem cost will be billed for each day of rehabilitative services that each Medicaid recipient receives each month." Services must be based on a plan of care developed according to a clinically based evaluation and assessment of each child's needs.

Pursuant to COMAR 10.09.28.06, rehabilitative services will not be covered under the Medicaid program if the service is:

- not considered medically necessary,
- provided without an evaluation or assessment,
- provided without an appropriate plan of care,
- provided in an out-of-home setting,
- reimbursed as a separate therapeutic behavioral service administered by a therapeutic behavioral service provider,

- a vocational counseling or training service, or

- an academic or remedial educational service.

In addition, Medicaid payment may not be made for those days when the beneficiary is not a resident in foster care or a group home setting.

DOCUMENTATION FOR RESIDENTIAL REHABILITATIVE SERVICES INCONCLUSIVE

For the 2,652 total claims submitted for our sampled beneficiary-months, the type of service actually provided and the documentation necessary to demonstrate that a service had been provided were unclear. DHR and DJS claimed $117.96 for rehabilitative services for each day that a beneficiary was in a residential group home and $55.27 for each day a beneficiary was in a Treatment Foster Care home. The State plan allows this per diem for "each day of rehabilitative services that each Medicaid recipient receives each month." However, the State plan is not specific as to the services required to meet the definition of a day of rehabilitative service.

Each beneficiary record contained some or all of the following documents: court orders, intake forms, plans of care, progress notes, evaluation or assessment of needs, and discharge summaries. However, documentation did not always agree, was not always present, and generally did not specify the services performed. Therefore, we could not determine if the State agency complied with the requirements to adequately document each claim.

RECOMMENDATIONS

We recommend that the State agency work with CMS to amend its State plan to:

- define residential rehabilitation services,

- define the necessary documentation requirements for each service, and

- adjust its reimbursement methodology if needed to reflect costs for services provided.

STATE AGENCY COMMENTS

The State agency did not concur with our draft report findings and recommendations. It said that the Office of Inspector General "misinterpreted the requirements of the State Plan" and that the State agency's methodology for "calculating residential rehabilitation costs for eligible children … recognizes that, on any given day, a child may receive services valued significantly greater or less than the value of services represented in the global [per diem] rate, but the total value of the services is appropriately applied to the entire recipient pool, thus negating any need to document the provision of reimbursable service on a daily basis." The State agency submitted additional documentation and said it was "willing to discuss changes to its claiming methodology on a prospective basis and to ensure its claims are properly documented in accordance with that methodology."

The State agency's comments appear in the Appendix. We excluded the additional documentation because of its volume and because some individual documents contained personally identifiable information.

OFFICE OF INSPECTOR GENERAL RESPONSE

We considered the State agency's comments and revised the report and recommendations to reflect that the State plan is unclear about the precise definition of a residential rehabilitative service. The type of claimed service actually provided and the documentation necessary to demonstrate a service was provided were also often unclear.

APPENDIX

APPENDIX: 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 – John M. Colmers, Secretary

November 23, 2010

Mr. Stephen Virbitsky
Regional Inspector General for Audit Services
Office of Audit Services, Region III
Public Ledger Building,
Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106

Re: Report No. A-03-08-00209

Dear Mr. Virbitsky:

This correspondence is the State of Maryland's preliminary response to the United States Department of Health & Human Services, Office of Inspector General (OIG) draft audit report entitled *Review of Residential Rehabilitation Services for Children in Maryland.* In its letter dated September 10, 2010, the OIG invited the State to provide comments on each recommendation in the report. As set forth in detail below, the State both questions the validity of the facts upon which the OIG's findings are based and takes exception to the reasonableness of the draft report's three recommendations. Contrary to the contents of the report, during the audit period the State documented its provision of residential rehabilitative services to youth in a manner wholly consistent with a State Plan Amendment that had been approved by the Centers for Medicare and Medicaid Services. Inasmuch as the State adequately supported its claims for rehabilitative services during the audit period, it does not concur with the draft report's findings and consequent three recommendations.

INTRODUCTION

The report contains the following three recommendations for the audit period of October 1, 2005 through September 30, 2007:

- That the State refund $45,081,993 to the Federal government for allegedly unsupported residential rehabilitative services;

- That the State review residential rehabilitative service claims submitted after the audit period and report any necessary adjustments; and

- That the State ensures that future claims for residential rehabilitative services are properly documented in accordance with Federal and State requirements.

The State is willing to ensure, as it has in the past, that future claims are properly documented , but it takes exception to each of the OIG's recommendations, which are based on erroneous findings that the State has historically failed to document residential rehabilitative services.1 These recommendations are not based on valid findings but are based on a misinterpretation of the requirements of the State Plan, and they are not therefore reasonable, for the following reasons:

- In 2004 the Centers for Medicare & Medicaid Services (CMS) approved a State Plan Amendment (SPA 04-19), permitting the State to claim residential rehabilitation services for children in certain residential child care facilities and treatment foster care homes based on a daily or per diem rate using a global or capitated rate, which spreads the aggregated costs over an extended period of time;

- Contrary to the OIG's findings, SPA 04-19 contains, and CMS approved, a methodology for calculating residential rehabilitation costs for eligible children that recognizes that, on any given day, a child may receive services valued significantly greater or less than the value of services represented in the global rate, but the total value of the services is appropriately applied to the entire recipient pool, thus negating any need to document the provision of reimbursable services on a daily basis; and

- Even if the State were required to document reimbursable residential rehabilitation costs on a daily basis, the auditors failed to properly obtain, recognize, or review documents contained in provider records that clearly demonstrate the provision of reimbursable rehabilitation services provided to needy children throughout their stay in eligible facilities.

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[1] The State cannot fully respond to the draft report because the OIG did not provide, in either the draft itself or during the exit conference, any detail about the records it reviewed and the documentation standards it applied. The State, therefore, is unable to determine either the reason for the OIG's misconstruction of the SPA language or the basis for the discrepancy between the State's and the OIG's review. The State has filed two Freedom of Information (FOIA) requests in an effort to obtain this information, and the State expects to substantially supplement the instant response upon its receipt of the FOIA responses.

The OIG determined that the State claimed residential rehabilitative services that did not comply with the documentation requirements of SPA 04-19. Based on its review of 2,652 claims in 100 sampled beneficiary-months, the OIG concluded that 2,435 claims were unallowable because the State did not provide adequate documentation to support that the claimed rehabilitative services were provided.

The OIG auditors based their conclusion on a misinterpretation of the language of the SPA. As explained below, the auditors mistakenly interpreted SPA 04-19 as requiring the State to provide documentation of each incidence in which rehabilitative services were provided. This interpretation is contrary to the language of the SPA, which utilizes a per diem rate that allows each child, within a given class of provider, to receive the same daily reimbursement, regardless of the frequency, duration, or intensity of the services received by the child. In addition, at no time prior to receipt of the draft audit report was the State on notice of the interpretation of the SPA advanced by the OIG. Therefore, even if the OIG's interpretation of the SPA were a reasonable one, the State's lack of adequate and timely notice of that interpretation precludes its application during the audit period. However, if the OIG's interpretation reflects a change in policy by CMS, then the State is willing to discuss changes to its claiming methodology on a prospective basis.

Second, it appears that the OIG failed to obtain, or in some cases to recognize, compliant assessments, evaluations, and treatment plans and documentation of children's length of stay in the therapeutic environment of treatment foster or group care. The Maryland Department of Human Resources (DHR) and the Maryland Department of Juvenile Services (DJS) have reviewed the provider records for the sampled children and beneficiary-months and have found documentation of assessments, evaluations, treatment plans, and service provision sufficient to meet the requirements of the SPA and federal law.

ANALYSIS OF THE RECOMMENDATION THAT THE STATE REFUND $45,081,993 TO CMS

Background

The Medicaid program, established under Title XIX of the Social Security Act (the Act), provides medical care to the country's most financially needy and disabled children. The federal government and the states share the program's costs. 42 U.S.C. §§ 1396-1, 1396b; 42 C.F.R. § 430.0. Each state establishes and administers its own Medicaid program in accordance with various federal requirements and the terms of its Medicaid state plan, which must be approved by the Secretary of the Department of Health & Human Services (DHHS). 42 U.S.C. § 1396a; 42 C.F.R. §§ 430.10-430.16. The intent of the federal regulations is to provide the states with a great degree of flexibility in developing methods of provider reimbursement, and thus, "requirements on states [are kept] to the minimum level necessary to assure accountability, and not to burden states with unnecessary paperwork requirements." *South Dakota Dep't of Soc. Servs*, DAB No. 934 at 2 (1988). Once a state plan is approved, the state becomes

entitled to receive federal financial participation (FFP) for a percentage of its program-related expenditures.

Maryland's Medicaid Residential Rehabilitative Option Program (the Rehab Program) provides 24-hour care to children who have behavioral or emotional disorders and who have been determined to need placement in structured therapeutic environments that can provide for safety, guidance, behavior modification, counseling, and other appropriate interventions. COMAR 10.09.28. Placement types include group homes that provide a structured set of services and treatment foster homes operated by treatment foster care agencies. Providers and treatment foster care parents, who are specially trained, have the skills necessary to address the behaviors of children in their care. The rehabilitative services offered to an individual child depend on the needs of that child and can include the following:

- Behavior management training and intervention;
- Supportive counseling to promote interpersonal skill building, conflict resolution, and self-reinforcement;
- Age appropriate health and sex information;
- Medication management;
- Individual, group, or family therapy sessions;
- Teaching, coaching and assisting with daily living and self-care skills such as the use of transportation, meal planning, and preparation, personal grooming, management of financial resources, shopping, use of leisure time, and interpersonal problem-solving;
- Assistance in developing skills necessary to support a full and independent life in the community.

These treatment foster care programs in their totality create an appropriate therapeutic environment for children, many of whom have suffered abuse and neglect and therefore require daily care by skilled treatment providers in a structured setting with access to therapeutic services and interventions. Although not every child requires access to each of these individual services on a daily basis, every child enrolled in the program relies on the structures, interventions, and treatment services that are embodied in the residential rehabilitation program. Every child in therapeutic care benefits from the collective impact of these services on a daily basis.

The State's Interpretation of its State Plan Overrides the OIG's Interpretation, Which Incorrectly Interpreted the SPA.

At the October 19, 2010 exit conference, OIG representatives revealed that OIG interpreted SPA 04-19 as permitting reimbursement only for days where the State had documentation that detailed specific rehabilitative services provided to a particular child on that day. The auditors based this interpretation on a single sentence on the last page of the SPA (captioned "Unit Rate Establishment"), which states as follows: "Documentation of the days of rehabilitative services delivered will be retained in the

client files as required by state and/or federal law for a period of six years." The OIG's interpretation of the SPA is incorrect and, in any event, the State's different interpretation is entitled to deference.

Under State law, there is no requirement that every clinical intervention and supportive therapeutic service be documented on a daily basis for each child in a therapeutic residential placement. Such a standard would prove unworkable on both a clinical and fiscal basis. The residential rehabilitation model of care is different from a medical model that properly requires definitive progress notes at frequent intervals. With treatment foster care, the emphasis is on the creation and maintenance of a home-like therapeutic setting that incorporates a capacity to maximize adaptive behavior skills. Treatment foster care is designed to function as the least restrictive appropriate setting for monitoring maladaptive behavior and encouraging the development of socially appropriate skills. Because therapeutic services are provided in a home- like residential setting, and the value of the services is dependent on the overall capabilities and resources of the treatment foster care providers, all that is required is that the State document an individual child's placement in the treatment foster care setting on the days for which the State claims reimbursement. Accordingly, the auditors should not have focused upon the presence or absence of daily contact or progress notes by treatment foster parents or residential staff but only on whether there was documentation that the child was placed in the residential therapeutic setting on the days for which the State claimed reimbursement.

The OIG and the State differ in their interpretation of SPA 04-19 and, according to the Departmental Appeals Board (the Board), a state's interpretation of its own state plan is entitled to deference if the interpretation (1) gives reasonable effect to the language of the plan as a whole and (2) is reasonable in light of the purpose of the provision and program requirements, including applicable federal law and regulations. *South Dakota Dep't of Soc. Servs.*, DAB No. 934 (1988); *see also Kansas Health Policy Authority*, DAB No. 2255 at 18 (2009). Regarding the second criterion, the State must show that its interpretation is consistent with the intent of the provision, as demonstrated by contemporaneous documentary evidence or consistent administrative practice. DAB No. 934. The existence of consistent administrative practice demonstrates that the state was applying an official interpretation of the provision, rather than merely advancing an interpretation "as an after-the-fact attempt to justify acting inconsistently with or simply ignoring its plan." DAB No. 934; *see also Texas Health & Human Servs. Comm'n*, DAB No. 2176 at 3 (2008) (stating that "a state's interpretation is entitled to more weight when it has been officially adopted, reflects consistent practice, and/or was applied contemporaneously rather than articulated for the first time in litigation").

The State and the OIG differ in their interpretation of the following language, located on page 57B of SPA 04-19: "This per diem cost will be billed for each day of rehabilitative services that each Medicaid recipient receives each month. Documentation of the days of rehabilitative services delivered will be retained in the client files as required by state and/or federal law for a period of six years." The OIG auditors interpret this language to mean that the State should be reimbursed only for days where documentation shows that specific rehabilitative services were provided to a particular

child. This interpretation is flawed because the auditors failed to understand that, according to the per diem rate in SPA 04-19, a child is receiving rehabilitative services every day that he or she is housed in a treatment foster care or residential group home. Unlike the auditor interpretation, the State's interpretation of this provision reflects this understanding.

As explained in SPA 04-19, the per diem rate was calculated using a capitated rate, which means that the aggregated costs of the the Rehab Program were spread out over an extended period of time. In developing the per diem rate, the State employed a rate-setting methodology that separated allowable Medicaid covered services from non-allowable budget items. The State used a capitated method because the frequency, duration, and intensity of rehabilitative services that a particular child receives while in a treatment foster care or residential group home varies each day. The per diem rate in SPA 04-19 recognizes that, on any given day, a child may receive rehabilitative services valued greater or less than the capitated rate. Thus, the per diem rate recognizes that a child is receiving rehabilitative services each day that the child is in a treatment foster care or residential group home by virtue of the child's presence in the home.

On September 30, 2003, DHMH submitted a SPA to CMS for residential rehabilitation services. Affidavit of Susan Tucker ¶ 4, Attachment 1. Developers of the SPA from the State included representatives of the Department of Human Resources, the Department of Juvenile Services, the Governor's Office for Children, Youth and Families, the Maryland State Department of Education, the Department of Budget and Management, and experts from Maximus. As part of the development of the SPA, a telephone conference call was held on December 19, 2003 with DHMH and CMS. Affidavit of S. Tucker, ¶ 6. At that time, CMS informed the State of the need to publish a public notice before submitting a SPA on this service. Consequently, DHMH was asked to withdraw the SPA and resubmit after the notice was published in the Maryland Register. CMS representatives also gave guidance on changes they would like to see in the SPA. *Id.*, Attachment 2. The agreement to exclude leave days is consistent with the State's interpretation that the SPA was understood to cover the balance of the days that each eligible child receives the therapeutic benefits of the greater structure, support, and rehabilitative services found in the treatment foster care and group home settings.

Following the withdrawal of the SPA, a new SPA was submitted to CMS on December 31, 2003 Affidavit of S. Tucker ¶ 7, Attachment 3. For the months that followed, CMS requested the State to answer a series of both formal and informal questions regarding the newly proposed SPA. The State complied with these requests. Affidavit of S. Tucker ¶¶ 8, 9, 10, 12. Two telephone conference calls were also conducted with both State and CMS representatives. Affidavit of S. Tucker, ¶¶ 8, 11. During this process, the State submitted information concerning the rate setting methodology to CMS including a rate study that included a description of the methodology. This document described the staff that would be included as individuals providing the therapeutic services to children. Affidavit of S. Tucker, ¶ 15, Attachment 5. The staff included the child care workers who would be managing the day to day implementation of services within the group home setting thereby indicating that the rate was meant to include the costs of providing these services to the children. Therefore,

because CMS received the rate study and ultimately approved the SPA, the State assumed that CMS knew it would be submitting claims on a daily basis. Per Susan Tucker: "Since CM approval of the SPA-04-19, the Department has understood it to be proper to bill for each day the child is in attendance in the residential treatment program. Until this audit, the Department has received no communications from CMS to indicate that daily billing of the per diem rate requires daily documentation by direct child care staff." Affidavit of S. Tucker ¶ 16.

Because of the methodology used to calculate the per diem rate, the State intended the language on page 57B of SPA 04-19 to mean that it would be reimbursed at the per diem rate for every day a child is housed in a treatment foster care or residential group home. In other words, because the per diem rate recognizes that a child receives rehabilitative services every day that he or she is housed in a therapeutic environment, the State should be reimbursed for every day a child is so housed. The OIG finding, by contrast, is based on sampling principles that do not apply in the particular circumstances here. *See* DAB No. 934 (explaining that auditors erred when they used a general accounting principle to define an ambiguous term in the state plan instead of using what the state plan required).

The State's interpretation of the provision in question is entitled to deference because its interpretation meets all of the criteria for deference. First, the State's interpretation gives reasonable effect to the language of the plan as a whole. The provision is located in the section of the SPA entitled "Unit Rate Establishment," which merely explains how the per diem rate was calculated. Contrary to the auditor belief, the provision does not impose any independent documentation requirement. It merely states for how long the State must retain any documentation that is created.

Second, the State's interpretation is reasonable in light of the purpose of the provision and program requirements, including applicable federal law and regulations. The State does not interpret the provision in question as requiring providers to maintain daily documentation of therapeutic or rehabilitative services beyond that necessary to show that the child was housed in the treatment setting. This interpretation is consistent with both federal guidance and State regulations, which do not require daily documentation. *See e.g.,* State Medicaid Manual, CMS Pub. No. 45 § 2500.2A; COMAR 10.09.28.03.

Additionally, the State's interpretation is consistent with the intent of the provision. As explained by Interim Secretary Brian Wilbon, who directed the early development of the SPA, the quoted language is simply "part of the explanation for computing the unit rate on a per diem basis reflecting the total number of days in a reimbursable care setting." Affidavit of Interim Secretary Brian Wilbon at ¶ 11. The language "was not included in the SPA to impose any additional documentation requirement on the State." *Id.* Rather, "the basis for the capitated rate in the approved SPA is the child's presence in the treatment foster care home or in the residential group home, as supported by the monthly attendance record, where the child receives the bundle of services comprising the 'treatment milieu' over the course of the child's stay."

Id. The OIG's interpretation fails to give reasonable effect to the language of the plan as a whole and is unreasonable in light of the purpose of the program requirements. *Id.*

Finally, there is no dispute that the State's administrative practices have been consistent with its interpretation of the intent and purpose of the provision. In this regard, the OIG audit shows itself that the State's consistent administration of the Rehab Program is in conformity with the State's interpretation: During the exit interview, the auditors acknowledged that the State informed them at the beginning of the audit that the Rehab Program was always intended to employ a bundled rate and that CMS had approved the plan with that understanding. Thus, there can be no question that the State has consistently administered the Rehab Program in precisely the manner described by Interim Secretary Wilbon.

The OIG Did Not Obtain, Recognize, or Review Documents Contained in Provider Records.

The OIG auditors reviewed recipient files and found errors if the files lacked a "current evaluation or assessment," a "current plan of care," or both. By "current evaluation or assessment," the auditors apparently meant a "determination of need." *See Review of Residential Rehabilitation Services for Children in Maryland*, draft audit report A-03-08-00209 at 5 (finding that "[t]he files for 83 of the sampled beneficiary-months also lacked the required assessment to determine medical necessity"). The Code of Maryland Regulations (COMAR) defines a "determination of need" as "a documented assessment of a recipient's functioning by a licensed human services professional which indicates the presence of certain behavioral or emotional disorders which prevent the recipient from functioning normally in homes, schools, or other community settings and necessitates placement in a more structured environment . . . ." COMAR 10.09.28.01(B)(2). Although the auditors were looking for a "current" Determination of Need, neither COMAR 10.09.28.01(B)(2) and .04 nor the SPA use the word "current" in describing the requirements for the determination of need. The auditors neither addressed why they imposed this additional requirement nor explained what they meant by "current."

COMAR defines "plan of care" as a written individual service plan developed by a licensed human services professional2 that: uses information derived from an evaluation and assessment; states the recipient's level of functioning; states the services necessary to meet the recipient's needs; provides information on the amount, duration, and scope of services; describes the setting(s) in which the services will be provided; describes the individuals responsible for implementing the plan of care; and states the expected functional outcomes. COMAR 10.09.28.01(B)(6).

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[2] "Licensed human services professional" is defined as a DHR or DJS employee who is licensed as a social worker, psychologist, nurse, or psychiatrist. COMAR 10.09.28.01(B)(4).

The State's review of selected case records indicates that the OIG failed to obtain, recognize or review various records that represent determinations of need, plans of care, or which evidence the services received by the child during his or her stay in care.3

Review of PATIENT A Case Record

The OIG found that the case record of PATIENT A maintained by Cedar Ridge Children's Home & School, Inc., lacked assessments, evaluations and treatment plans for the beneficiary month of May 2005. Attached to the State's response is an evaluation and treatment plan, conducted in February and March 2005, which describes PATIENT A's suicidal ideations, self-mutilation, depression, dysphoria, paranoia, history of violence, destruction of property, and fire setting activity. The evaluation, conducted by Dr. C.K., M.D., Board Certified Child & Adolescent Psychiatrist, recommended placement at Cedar Ridge, intense therapy, administration of antipsychotic medication and medication management. A Behavior Intervention Plan conducted by the school system to address PATIENT A's behavior issues and recommend appropriate long term behavior goals and strategies is also contained in the Cedar Ridge case record. Cedar Ridge's February 2005 twelve page Assessment and Treatment Plan are contained in the record and approved by Dr. C.K. and P.A., MSW, LCSW. Detailed short and long-term objectives are contained on pages five through twelve of the Treatment Plan and include significant behavioral interventions to deal with PATIENT A's anger, suicidal ideations and suicide attempts, conduct disorder, ADHD, anxiety, depression and phobias. The record also contains a psychological evaluation conducted during the beneficiary month on May 2 and 5, 2005 documenting a variety of social, emotional and behavioral issues. Psychiatric progress notes for the beneficiary month, dated May 6, 2005 are contained in the record. The case file contains P.A., MSW, LCSW's treatment notes dated May 2, 6, 12, 13, 16, 24 and 26.. Also included in the record are nursing notes for May 6, 9, 16 and 19. Medication management records for May 6, 7, 13, 14, 15, 20, 21, 22, 27, 28 and 29 are in the case file. Finally, the record contains a blood pressure and pulse record for the beneficiary month reflecting daily monitoring of PATIENT A's vital signs as part of his medication monitoring.

Review of PATIENT B Case Record

The OIG concluded that the file of PATIENT B, whose sampled beneficiary-month was January 2006, did not include a "current evaluation or assessment" or a "current plan of care," and disallowed 26 out of 31 claims for that month. PATIENT B was placed at Pressley Ridge, a treatment foster care provider.

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[3] At the Exit Conference conducted on October 19, 2010, in response to the State's suggestion that the auditors had not obtained all available records evidencing the provision of services received by the children, the OIG auditors agreed that the State's submission of five files containing the allegedly missing documentation would assist OIG in determining whether it had, in fact, missed relevant material in record reviews. The State is prepared to provide additional records upon request.

Upon its review of PATIENT B, the State located documents that represent a determination of need and a plan of care per COMAR requirements. The document entitled "Psychosocial Assessment," prepared in March 2005, is a determination of need because it states that PATIENT B has Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder, which prevent her from functioning normally and necessitate placement in a more structured environment. The assessment report also explains that at times, PATIENT B's "behaviors were unmanageable in her mother's home," but indicates that she "will benefit from family therapy . . . [and] individual therapy."

Additionally, the document entitled "Authorization Request Form," dated January 13, 2006, contains an authorization for medication management, family therapy, and individual therapy. It includes a Treatment Plan and Treatment Plan Service Goals that together represent a plan of care. First, the document addresses those issues that were identified in PATIENT B's determination of need, such as anger, hostility, and defiance. Second, the document gives details about PATIENT B's level of functioning by rating the following as "mild," "moderate," or "severe": activities of daily living; anger/temper; assertiveness; exacerbation of existing disorder; family/marriage; coping skills; safety to self/others; school performance; sexual issues; social relationships; and trauma. It also notes that PATIENT B has ongoing aggression, shows disrespect towards her foster parents, and exhibits negative behavior during home visits with her mother. Third, the document refers to the services that are necessary to meet PATIENT B's needs , and provides information on the amount, duration, and scope of services, as well as details about the goals of her treatment.4

Four pages of detailed "Session Notes" for the month in question, signed by a licensed human services professional, demonstrate that PATIENT B resided in a therapeutic and rehabilitative environment and evidence that PATIENT B received the authorized therapeutic and rehabilitative services. The "Home Visit Notes/Progress Report Prep" furnishes additional documentation of the provision of these services, addressing education issues, family interaction, cultural, recreational, and social issues, as well as TS' mental and medical health. Additionally, for each day in the month of January 2006, PATIENT B'S file contains a "Log of Daily Event" (LODE) that describes her behavioral issues and any corrective actions taken. These LODES also indicate whether PATIENT B is making progress toward her treatment goals and whether the treatment plan needs to be modified. Further, these LODES indicate the date and time that PATIENT B received therapy or other medical treatment.

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[4] By way of example, it includes the following recommendations and goals: "Help TS to verbalize the sources of negative hostile feelings in an open accepting and understanding manner; . . . learn to recognize and verbalize hurt or angry feelings in constructive ways;" and "develop the ability to identify and verbalize what she needs from her mom and foster parents").

Review of PATIENT C Case Records

OIG review for December 2004 found that the case records for PATIENT C lacked an evaluation or assessment, and OIG accordingly did not allow any claims for that month. This was an error because PATIENT C's record contains documents that assess and describe PATIENT C's need for placement in a rehabilitative environment, and there are monthly case contact notes signed by social workers demonstrating rehabilitative services throughout the month.

PATIENT C, along with her sisters were placed in foster care after their mother abandoned them in June 2003 when she moved out of state, leaving the girls in the care of the mother's former boyfriend. PATIENT C was previously in foster care due to her mother's substance abuse. Several documents contained in PATIENT C's record and applicable to the sample period detail PATIENT C's treatment needs and the course of treatment she received. In addition to the Referral of Child for Purchase of Care dated March 9, 2004, that describes PATIENT C's need for treatment foster care, the record contains a Psychiatric Evaluation signed by S.L., M.D.- Board of Child Care, that although dated 8/24/05 states that PATIENT C was originally assessed on 6/2/03 and then again on 5/27/04. It describes in detail PATIENT C's illness (a diagnosis of Adjustment disorder NOS, R/O Cyclothymic Mood Disorder, and Anxiety Disorder NOS), and her need for treatment, including behavioral management. There are also recommendations for therapy, including family therapy, and for PATIENT C to continue her psychotropic medications, Depakote and Seroquel.

In addition, PATIENT C's case record contains an Individual Service Treatment Plan October 11, 2004-Board of Child Care, signed by a case manager, LCSW-C supervisor and psychiatrist. That treatment plan identifies PATIENT C's various treatment recommendations, strengths, and goals.

Finally the Monthly Case Contacts – December 2004, signed by V.E., LCSW-C, Supervisor, documents individual sessions with PATIENT C by A.W., MSW, (PATIENT C's case manager), on 12/1/04, 12/6/04, 12/7/04, and 12/15/04. The case notes also document family sessions with PATIENT C and her siblings by A.W. on 12/15/04 and 12/22/04. Additionally, the contact notes reference PATIENT C's attendance and positive participation in the Treatment Foster Care Christmas Party on 12/11/04.

Review of PATIENT D Case Record

OIG review for February 2005 found that the case record for PATIENT D lacked a current plan of care and accordingly disallowed claims 26 of the 28 days in the month. This is an error because the care record documents both PATIENT D needs and the treatment provided in accordance with his treatment plan.

During the month under review, February 2005, PATIENT D was placed with The Children's Choice of Maryland, a Treatment Foster Care Placement provider. The record contains an extensive ten page Individual Service Plan dated 11/17/04 describing PATIENT D history, reasons for placement, and medications. The plan covers the services to be provided by the treatment foster parent in the following areas:

- Permanency Planning;
- Safety;
- Justification of Service level;
- Medical/Dental (Medication Management);
- Academic Progress;
- Extra-Curricular/Recreational Social Activities (Behavior Modification);
- Interactive Behavior (Behavior Modification);
- Life Skills (Behavior Modification).

The record contains a Quarterly Report covering the period from 2/5/05 through 5/5/05. The Quarterly Report provides a description and status of the services the child received to implement the Individual Service Plan referred to above. Among other things, the report notes that "[t]reatment foster care continues to be necessary to assist PATIENT D with the given Impulse Control Disorder, Attention Deficit Hyperactivity Disorder, and Anxiety Order, NOS. PATIENT D has benefited from the nurturing, structure, and support that he received in the . . . home." Report at p. 2. The report also describes the involvement of the treatment foster parents in behavior management efforts designed to provide PATIENT D with the tools he needs to thwart his impulsivity. Report at p. 3. It also details the life skills training provided by the treatment foster care parents with regard to, among other things, hygiene, behavior toward peers, and sexuality. In addition, the Report addresses PATIENT D's involvement in counseling through the provider on a weekly basis and his twice-monthly visits with the provider's social worker.

Finally, the case record contains a letter dated May 25, 2005, signed by T.M., LCSW-C, that states that she has been treating PATIENT D for the past year (May 2004 –May 2005) for a diagnosis of Attention –Deficit –Disorder –Hyperactive, Oppositional Defiant Disorder, Depressive Disorder NOS and Neglect of a Child. The letter states that the child received treatment every other week for the year he was in treatment, including the month under review.

Review of PATIENT E Case Record

The OIG concluded that the file of PATIENT E, whose sampled beneficiary-month was August 2005, did not include a "current evaluation or assessment", and disallowed all 31 claims for that month. JG was placed at Associated Catholic Charities, a treatment foster care provider.

The State's review of the record, however, revealed that it contains a document entitled "Individual Treatment Plan / Quarterly Assessment," which covers July 13, 2005 through October 13, 2005. This document states that PATIENT E has ADHD, mood disorder, enuresis, and a history of neglect and that he is taking Adderall and Risperdal. Specifically, it states, PATIENT E "continues to have behavioral problems which require the structure of a corrective and therapeutic foster home." His therapist is identified as P.S., LCSW-C, and his psychiatrist as Dr. M. H. This treatment plan lists nine treatment

goals and for each goal, it describes measurable objectives, a target date, the frequency of service or intervention, the list of responsible team members for achieving the goal including his foster parents, and an assessment of the progress toward the goal. PATIENT E's treatment plan was reviewed and signed by a physician.

In addition, the record contains a document entitled "Transfer Summary," prepared on July 28, 2005, which represents an additional determination of need and assessment because it states that PATIENT E has ADHD and a mood disorder, which prevent him from functioning normally and necessitate placement in a more structured environment. This document also explains that PATIENT E's birth and extended family have been unable to care for him because of his behavioral problems. Lastly, the document was signed by a licensed social worker.

PATIENT E's file also contains a medication management log for the beneficiary-month in question.

CONCLUSION

For all of the foregoing reasons, the State requests that OIG reconsider the findings in its draft report, and that it defer issuing a final report until the State has had the opportunity to review and supplement this response based on the federal government's response to the State's FOIA requests. Finally, as stated above, if the OIG's interpretation of the State's SPA is indicative of a change in policy by CMS, the State is willing to discuss changes to its claiming methodology on a prospective basis and to ensure that claims are properly documented in accordance with that methodology.

Sincerely,

John M. Colmers
Secretary

Attachments

Cc: Brian Wilbon,
DHR Secretary

Thomas Russell,
DHMH Inspector General