Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

KANSAS IMPROPERLY RECEIVED MEDICAID REIMBURSEMENT FOR SCHOOL-BASED HEALTH SERVICES

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Office of Inspector General

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EXECUTIVE SUMMARY

Kansas received $10.7 million in Federal reimbursement for the Medicaid school-based health services program that was not reasonable, allowable, and adequately supported in accordance with Federal and State requirements.

WHY WE DID THIS REVIEW

The Social Security Act (the Act) permits Medicaid payment for medical services provided to children under the Individuals with Disabilities Education Act of 2004. States are permitted to use their Medicaid programs to help pay for certain services, such as physical and speech therapy services, that are delivered to children in schools. To ascertain (for purposes of claiming Federal reimbursement) the portion of time and activities of a school-based health program that is related to the provision of Medicaid services, States may develop an allocation methodology that is approved by the Centers for Medicare & Medicaid Services (CMS). Random moment sampling, which makes use of random moment timestudies (RMTS), is an approved allocation methodology and must reflect all of the time used and activities performed (whether allocable or allowable under Medicaid) by employees participating in a school-based health program.

State Medicaid agencies are increasingly using random moment sampling to allocate school-based health costs to Medicaid, eliminating the need for health care providers to submit claims for services provided in school-based settings. During previous Office of Inspector General reviews of school district administrative claiming and health services programs, we determined that the use of an RMTS allocation methodology may allow costs that are not reasonable, adequately supported, or otherwise allowable. We have therefore undertaken a series of reviews of the use of RMTS for the claiming of direct medical service costs related to Medicaid school-based health services (SBHS), including this review of the Kansas Department of Health and Environment, Division of Health Care Finance (State agency).

The objective of this review was to determine whether the direct medical service costs that the State agency claimed for SBHS were reasonable, adequately supported, and otherwise allowable in accordance with applicable Federal and State requirements.

BACKGROUND

Medicaid Program and Health-Related Services to Children

Congress amended section 1903(c) of the Act in 1988 to allow Medicaid coverage of health-related services provided to children. The school-based health program permits children to receive health-related services that are specified in each child's individualized education plan (IEP), generally without having to leave school.

SBHS included in a child's IEP may be covered under Medicaid as long as (1) the services are listed in section 1905(a) of the Act and are medically necessary; (2) all other relevant Federal and State regulations are followed; and (3) the services are included in the State Medicaid plan or

are available under the Early and Periodic Screening, Diagnosis, and Treatment Medicaid benefit. Covered direct medical services may include, but are not limited to, physical therapy, occupational therapy, speech pathology/therapy, psychological counseling, nursing, and specialized transportation services. Direct medical service costs are primarily composed of (1) salary and benefit costs for employees or contractors of the school districts who provide direct medical services to students and (2) approved direct medical service material and supply costs (e.g., gauze, stethoscope, latex gloves).

Kansas School-Based Health Services Program

The State agency administers the Medicaid program in Kansas, including the SBHS program, in accordance with a CMS-approved State plan. The Kansas Medicaid State Plan Amendment #09-07, effective July 1, 2009, defines SBHS as services to children listed in each child's IEP. These services include specialized transportation; nursing services; physical therapy; counseling services; social work services; psychological services; and speech, language, and hearing services.

In February 2006, the State agency contracted with Public Consulting Group, Inc. (the Contractor), to manage portions of the SBHS program.

The State agency's CMS-approved *Medicaid School District Administrative Claiming & Fee-For-Service Cost Settlement Implementation & Time Study Guide* (Implementation Guide) contains the policies and procedures that Kansas school districts follow to receive Medicaid reimbursement. The Implementation Guide also describes procedures for how the RMTS should be performed and applied.

On an ongoing basis, participating Kansas school districts submitted fee-based claims to the State agency for SBHS provided to students. The State agency paid the participating school districts interim payments for these services. The State agency claimed Federal reimbursement for these interim payments on a quarterly basis.

The purpose of the RMTS is to identify the portion of the direct service time allowable and reimbursable under Medicaid so that the State agency can thereby conduct a cost settlement on an annual basis. After each participating school district reported its annual costs associated with the provision of SBHS to the State agency, the Contractor (in coordination with the State agency) applied the results of the RMTS to determine the Medicaid-allowable direct medical service costs for each district. On an annual basis, the State agency then reconciled the total interim payments for the State fiscal year for the participating school district to the Medicaid direct medical service costs determined through the use of RMTS. The reconciliation process is referred to as cost settlement.

When the State agency performs an annual cost settlement, costs are limited to the Medicaid direct medical service costs determined through RMTS. If the interim payments were greater than the Medicaid direct medical service costs, the school district paid the State agency the difference. However, if the interim payments were less than the Medicaid direct medical service

costs, the State agency paid the school district the difference and received reimbursement for the Federal share of that difference.

The State agency received $24,792,498 ($17,270,734 Federal share) for interim payments and an additional $12,749,319 ($6,918,730 Federal share) as a result of cost settlements. Thus, the State agency received a total of $37,541,817 ($24,189,464 Federal share) for expenditures related to Medicaid direct medical service costs associated with SBHS provided by 288 participating school districts for the period July 1, 2009, through June 30, 2010. Because Federal regulations allow State agencies up to 2 years to claim Medicaid expenditures, and to ensure completeness of the interim payments for claims with dates of service in our audit period, we reconciled the State agency's claimed costs for the quarter ended September 2009 through the quarter ended September 2012 (13 quarters in all).

WHAT WE FOUND

Not all of the Medicaid direct medical service costs that the State agency claimed for SBHS were reasonable, adequately supported, or otherwise allowable in accordance with Federal and State requirements. As a result, the State agency received unallowable Federal reimbursement totaling $10,748,706 for services provided during the period July 1, 2009, through June 30, 2010. Specifically:

- The State agency accounted for only $17,067,870 ($11,891,835 Federal share) of the $24,792,498 ($17,270,734 Federal share) in interim payments during final cost settlement. Because the State agency excluded $7,724,627 ($5,378,899 Federal share) in interim payments at cost settlement, the Medicaid direct medical service costs were overstated and therefore not reasonable. As a result of this error, the State agency received $5,378,899 in unallowable Federal reimbursement.

- The State agency claimed unallowable costs based on RMTS errors. Specifically, the Contractor selected invalid participants, selected random moments on invalid dates, and coded some activities inaccurately. As a result of these errors, the State agency received $4,715,310 in unallowable Federal reimbursement.

- The State agency claimed Medicaid direct medical service costs that were not supported by its internal cost reporting system. As a result, the State agency received $643,094 in unallowable Federal reimbursement.

- The State agency claimed unallowable costs because the Kansas City, Kansas, public school district overstated employee benefit and supply costs by $94,835. As a result, the State agency received $11,403 in unallowable Federal reimbursement.

These errors occurred because the State agency did not have adequate policies and procedures to monitor the SBHS program and to ensure that it claimed all costs in accordance with applicable Federal and State requirements. Although the State agency performed either a desk review or an onsite visit of each school district at least once every 3 years, and although the State agency reviewed at least 5 percent of the RMTS response codes and communicated any necessary

changes with the Contractor, these procedures were not adequate to ensure that the State agency claimed costs correctly. As a result, the State agency received a total of $10,748,706 in unallowable Federal reimbursement.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $10,748,706 to the Federal Government for unallowable SBHS costs and

- strengthen policies and procedures to monitor the SBHS program and ensure that (1) SBHS costs are accurate and supported and (2) it claims all SBHS costs in accordance with applicable Federal and State requirements.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency did not directly address our recommendations. The State agency agreed with our first finding (regarding the interim payments not used at cost settlement). The State agency neither agreed nor disagreed with our third and fourth findings (regarding the unsupported expenditures claimed and the issues identified in the Kansas City, Kansas, public school district) but described corrective actions that it had implemented or planned to implement.

The State agency disagreed with our second finding, which involved $4,715,310 (Federal share) in costs that we questioned on the basis of RMTS errors. State agency officials said that our methodology for recoding the random moments in question and our methodology for calculating the unallowable Federal reimbursement were not statistically valid. The officials added that they had submitted an alternative methodology to CMS for approval that included individuals providing attendant care services (whom our finding describes as invalid participants) in the pool of direct medical service costs qualifying for Federal reimbursement. However, the officials did not implement the methodology because CMS never approved it. The State agency also provided information explaining the causes of RMTS errors involving invalid dates and inaccurate coding of some activities.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. Although State agency officials said that they requested CMS's approval of the alternative methodology, CMS did not respond to this request, and the State agency did not implement the methodology, as it acknowledged. The methodology through which we evaluated the coding of the RMTS survey responses and recalculated the claimed costs conforms to our policy and procedures and to methodologies that we have used in previous reviews. In executing that methodology, we based our findings on applicable Federal and State requirements, including the provisions of the State agency's CMS-approved State plan, which states that attendant care services are not allowable for Federal reimbursement.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Social Security Act (the Act) permits Medicaid payment for medical services provided to children under the Individuals with Disabilities Education Act of 2004. States are permitted to use their Medicaid programs to help pay for certain services, such as physical and speech therapy services, that are delivered to children in schools. To ascertain (for purposes of claiming Federal reimbursement) the portion of time and activities of a school-based health program that is related to the provision of Medicaid services, States may develop an allocation methodology that is approved by the Centers for Medicare & Medicaid Services (CMS). Random moment sampling, which makes use of random moment timestudies (RMTS), is an approved allocation methodology and must reflect all of the time used and activities performed (whether allocable or allowable under Medicaid) by employees participating in a school-based health program.

State Medicaid agencies are increasingly using random moment sampling to allocate school-based health costs to Medicaid, eliminating the need for health care providers to submit claims for services provided in school-based settings. During previous Office of Inspector General reviews of school district administrative claiming and health services programs (Appendix A), we determined that the use of an RMTS allocation methodology may allow costs that are not reasonable, adequately supported, or otherwise allowable. We have therefore undertaken a series of reviews of the use of RMTS for the claiming of direct medical service costs related to Medicaid school-based health services (SBHS), including this review of the Kansas Department of Health and Environment, Division of Health Care Finance (State agency).

OBJECTIVE

Our objective was to determine whether the direct medical service costs that the State agency claimed for SBHS were reasonable, adequately supported, and otherwise allowable in accordance with applicable Federal and State requirements.

BACKGROUND

Medicaid Program and Health-Related Services to Children

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, 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.

Congress amended section 1903(c) of the Act in 1988 to allow Medicaid coverage of health-related services provided to children. The school-based health program permits children to receive health-related services that are specified in each child's individualized education plan (IEP), generally without having to leave school.

SBHS included in a child's IEP may be covered under Medicaid as long as (1) the services are listed in section 1905(a) of the Act and are medically necessary; (2) all other relevant Federal and State regulations are followed; and (3) the services are included in the State Medicaid plan or are available under the Early and Periodic Screening, Diagnosis, and Treatment Medicaid benefit. Covered direct medical services may include, but are not limited to, physical therapy, occupational therapy, speech pathology/therapy, psychological counseling, nursing, and specialized transportation services.[1] Direct medical service costs are primarily composed of (1) salary and benefit costs for employees or contractors of the school districts who provide direct medical services to students and (2) approved direct medical service material and supply costs (e.g., gauze, stethoscope, latex gloves).

States use the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), to report actual Medicaid expenditures for each quarter. CMS uses the CMS-64 reports to reimburse States for the Federal share of Medicaid expenditures. The amounts that States report on the CMS-64 report and its attachments must be actual expenditures with supporting documentation.

Kansas School-Based Health Services Program

The State agency administers the Medicaid program in Kansas, including the SBHS program, in accordance with a CMS-approved State plan. The Kansas Medicaid State Plan Amendment #09-07, effective July 1, 2009, defines SBHS as services to children listed in each child's IEP. These services include specialized transportation; nursing services; physical therapy; counseling services; social work services; psychological services; and speech, language, and hearing services.

In February 2006, the State agency contracted with Public Consulting Group, Inc. (the Contractor), to manage portions of the SBHS program. The Contractor worked with the State agency on the design and implementation of a cost settlement process under which costs at both the school district and State levels could be reported and claimed for reimbursement. The current cost settlement process became effective in July 2009.

The State agency's CMS-approved *Medicaid School District Administrative Claiming & Fee-For-Service Cost Settlement Implementation & Time Study Guide* (Implementation Guide) contains the policies and procedures that Kansas school districts follow to receive Medicaid reimbursement. The Implementation Guide also describes procedures for how the RMTS should be performed and applied.

[1] The information on Medicaid coverage in this paragraph is drawn from CMS's *Medicaid and School Health: A Technical Assistance Guide*, issued in August 1997, which contains (on pages 15 and 19 through 23) specific technical information on the Medicaid requirements that govern State agencies seeking Federal reimbursement for coverable health services provided in a school-based setting.

Interim Payments

On an ongoing basis, participating school districts submitted fee-based claims to the State agency for SBHS provided to students. The State agency paid the participating school districts interim payments for these services. The State agency claimed Federal reimbursement for these interim payments on a quarterly basis.

Random Moment Timestudy Data Collection and Reporting

For each quarter during the school year, each school district gave the Contractor a list of all school district employees in the SBHS program (participants). The Contractor consolidated these personnel lists into a statewide pool and statistically selected participants from that pool. The Contractor then calculated the available moments per quarter using each school district's calendar of working days and statistically selected 3,000 specific dates and times (random moments) per quarter. Next, the Contractor matched a statistically selected random moment to a statistically selected participant. Finally, the Contractor emailed each selected participant 5 days before the selected random moment, notifying him or her of the requirement to participate in a survey and of the exact random moment. Each of the selected participants responded to the survey's questions about the activity he or she was performing at the random moment. The Contractor then coded the random moment based on the responses provided.

The Contractor analyzed the results of the RMTS responses for each school district to determine the direct medical service percentage—that is, the percentage of time that school districts' staffs spent on Medicaid-allowable SBHS activities—and then reported that information to the State agency. For each State fiscal year (SFY), the Contractor applied the direct medical service percentage to each school district's annual actual costs associated with the provision of SBHS to determine the Medicaid direct medical service costs. For SFY 2010, the Contractor calculated the direct medical service percentage to be 45.47 percent.

In addition to the direct medical service percentage, the calculation to determine the Medicaid direct medical service costs also applied each school district's:

- IEP Student Utilization Ratio[2] to the personnel costs and other direct medical service costs,

- Specialized Transportation Ratio[3] to transportation costs (if applicable), and

[2] This ratio compares the number of Medicaid-eligible students with IEPs to the total number of students with IEPs to estimate the percentage of services provided to Medicaid-eligible students.

[3] When a school district is not able to separate the specialized transportation costs from the general education transportation costs, the Specialized Transportation Ratio is applied to its transportation costs. The Specialized Transportation Ratio compares IEP students receiving specialized transportation to the school district's total student population receiving transportation. The resulting costs are further discounted to determine the portion of the specialized transportation costs related to Medicaid-eligible students.

- indirect cost rate to the personnel costs, other direct medical service costs, and transportation costs.

Cost Settlement[4]

The purpose of the RMTS is to identify the portion of the direct service time allowable and reimbursable under Medicaid so that the State agency can thereby conduct a cost settlement on an annual basis. After each participating school district reported its annual actual costs associated with the provision of SBHS to the State agency, the Contractor (in coordination with the State agency) applied the results of the RMTS to determine the Medicaid-allowable direct medical service costs for each district. On an annual basis, the State agency then reconciled the total interim payments for the SFY for the participating school district to the Medicaid direct medical service costs that had been determined through RMTS. The reconciliation process is referred to as cost settlement.

When the State agency performs an annual cost settlement, costs are limited to the Medicaid direct medical service costs determined through RMTS. If the interim payments were greater than the Medicaid direct medical service costs, the school district paid the State agency the difference. However, if the interim payments were less than the Medicaid direct medical service costs, the State agency paid the school district the difference and received reimbursement for the Federal share of that difference.

HOW WE CONDUCTED THIS REVIEW

We reviewed Medicaid direct medical service costs claimed for SBHS provided during the period July 1, 2009, through June 30, 2010. For this period, the State agency received $24,189,464 in Federal reimbursement for expenditures related to Medicaid direct medical service costs associated with 288 participating school districts.

The State agency received $24,792,498 ($17,270,734 Federal share) for interim payments and an additional $12,749,319 ($6,918,730 Federal share) as a result of cost settlements. Thus, the State agency claimed a total of $37,541,817 ($24,189,464 Federal share) for the period July 1, 2009, through June 30, 2010.

Federal regulations allow State agencies up to 2 years to claim Medicaid expenditures (45 CFR § 95.7). Therefore, to ensure completeness of the interim payments for claims with dates of service in our audit period, we reconciled the CMS-64 reports for the quarter ended September 2009 through the quarter ended September 2012 (13 quarters in all).[5]

[4] This section summarizing the cost settlement process is based on the Implementation Guide and interviews with State agency officials.

[5] Under the provisions of the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), as amended by P.L. No. 111-226, States' Federal medical assistance percentages (FMAPs) were temporarily increased for the period October 1, 2008, through June 30, 2011. All Federal share amounts given in this report include reimbursements for the Recovery Act's temporary increase in FMAP.

We reviewed all 2,894 survey responses that were (1) completed by employees of participating school districts in Kansas and (2) coded by the Contractor as IEP-covered direct medical services to determine whether the responses were coded appropriately. Because the Contractor statistically selected the random moments from the statewide pool of calculated moments and participants, our review of the RMTS affects all school districts.

Also, we selected a random sample of 337 random moments that the Contractor coded as allowable SBHS activities used in the RMTS; we did this to estimate the number of unsupported responses provided by participants completing the RMTS surveys. In addition, we reviewed the cost settlement process at the State agency, including a review of the interim payments to each school district.

We performed an indepth review of the SBHS expenditures filed on behalf of the Wichita public school district and the Kansas City, Kansas, public school district. We focused on these two school districts, with particular attention to that portion of SBHS that dealt with Medicaid direct medical service costs. We selected these districts on the basis of the amounts that the State agency claimed on their behalf for SBHS provided during the period July 1, 2009, through June 30, 2010. Of the $37,541,817 ($24,189,464 Federal share) mentioned above, $7,764,380 ($5,184,759 Federal share) was associated with the Wichita public school district, and $2,253,988 ($1,331,776 Federal share) was associated with the Kansas City, Kansas, public school district.

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

FINDINGS

Not all of the Medicaid direct medical service costs that the State agency claimed for SBHS were reasonable, adequately supported, or otherwise allowable in accordance with Federal and State requirements. As a result, the State agency received unallowable Federal reimbursement totaling $10,748,706 for services provided during the period July 1, 2009, through June 30, 2010. Specifically:

- The State agency accounted for only $17,067,870 ($11,891,835 Federal share) of the $24,792,498 ($17,270,734 Federal share) in interim payments during final cost settlement. Because the State agency excluded $7,724,627 ($5,378,899 Federal share) in interim payments at cost settlement, the Medicaid direct medical service costs were overstated and therefore not reasonable. As a result of this error, the State agency received $5,378,899 in unallowable Federal reimbursement.

- The State agency claimed unallowable costs based on RMTS errors. Specifically, the Contractor selected invalid participants, selected random moments on invalid dates, and coded some activities inaccurately. As a result of these errors, the State agency received $4,715,310 in unallowable Federal reimbursement.

- The State agency claimed Medicaid direct medical service costs that were not supported by its internal cost reporting system. As a result, the State agency received $643,094 in unallowable Federal reimbursement.[6]

- The State agency claimed unallowable costs because the Kansas City, Kansas, public school district overstated employee benefit and supply costs by $94,835. As a result, the State agency received $11,403 in unallowable Federal reimbursement.

These errors occurred because the State agency did not have adequate policies and procedures to monitor the SBHS program and to ensure that it claimed all costs in accordance with applicable Federal and State requirements. Although the State agency performed either a desk review or an onsite visit of each school district at least once every 3 years, and although the State agency reviewed at least 5 percent of the RMTS response codes and communicated any necessary changes with the Contractor, these procedures were not adequate to ensure that the State agency claimed costs correctly. As a result, the State agency received a total of $10,748,706 in unallowable Federal reimbursement. See Appendix E for a summary of our findings.

INTERIM PAYMENTS NOT USED AT COST SETTLEMENT

Kansas Medicaid State Plan Amendment #09-07 states that providers complete annual cost reports in order to reconcile interim payments to total CMS-approved Medicaid-allowable costs. (See Appendix F.) During the cost settlement process, the State agency did not include interim payments for some procedure codes. The State agency also paid some Medicaid claims after the cost settlement was completed. The State agency did not include all interim payments during cost settlement and paid some Medicaid claims after cost settlement. The State agency did not subsequently amend the cost settlement to include the payments made after cost settlement. As a result of these errors, the Medicaid direct medical service costs claimed were in excess of the Medicaid direct medical service costs determined through RMTS, and therefore not reasonable, when submitted for Federal reimbursement.

As a result of these errors, the State agency accounted for only $17,067,870 ($11,891,835 Federal share) of the $24,792,498 ($17,270,734 Federal share) in interim payments during final cost settlement. Because the State agency excluded $7,724,627 ($5,378,899 Federal share) in interim payments at cost settlement, the Medicaid direct medical service costs were overstated and therefore not reasonable. As a result of this error, the State agency received $5,378,899 in unallowable Federal reimbursement for services provided during the period July 1, 2009, through June 30, 2010.

[6] As explained above, we expanded our scope for this finding to ensure completeness of the interim payments, in recognition of the fact that State agencies have up to 2 years to claim Medicaid costs.

ERRORS IDENTIFIED WITH RANDOM MOMENT TIMESTUDIES

The State agency received some Federal reimbursement that was unallowable because of errors in the RMTS: namely, the use of invalid RMTS participants and dates and inaccurate RMTS activity codes. Specifically, the State agency used RMTS for which the Contractor selected invalid participants, selected random moments on invalid dates, and coded some activities inaccurately. As a result of these errors, the State agency received unallowable Federal reimbursement totaling $4,715,310.

Selection of Invalid Participants for Random Moment Timestudies

According to section 1903(a) of the Act, to be allowable for Federal reimbursement, services must be listed in the State plan. As of July 1, 2009 (the start of our audit period), attendant care services were no longer listed as allowable services under Kansas Medicaid State Plan Amendment #09-07.[7] Of the 9,000 moments randomly selected for the RMTS, the Contractor selected 2,441 moments associated with providers of attendant care services. As of November 22, 2010, the State agency was aware that these participants should not have been included in the RMTS. However, the State agency did not adjust the RMTS. Consequently, the results of these participants' 2,441 random moments were invalid.

Selection of Invalid Dates for Random Moment Timestudies

The Implementation Guide, page 24, states that (1) school district calendars will be reviewed each quarter to identify the dates that the school districts will be in session and for which their staff members are compensated and that (2) those dates will be included in the random moment sample. Of the 9,000 moments randomly selected for the RMTS, the Contractor selected 29 random moments for staff at the Wichita public school district on dates for which the schools were not in session and for which their staff members were not compensated. This error occurred because the State agency used an incorrect school district calendar as the basis for the RMTS sample, which allowed the erroneous selection. These random moments should not have been included in the RMTS; therefore, the results for the random moments were invalid.

Inaccurate Coding of Activities for Random Moment Timestudies

The Implementation Guide, pages 8 through 21, provides specific instructions on the coding of random moments based on participants' responses to the survey questions. According to this guideline, an RMTS code for an IEP-covered direct medical service is appropriately selected "… when school district staff (employees or contracted staff) provides direct client services as

[7] Before November 22, 2010, the State agency included attendant care services in the State plan and, accordingly, included the participants in the RMTS. CMS reviewed the State plan and sent a letter to the State agency on November 22, 2010, stating that attendant care services were only being provided in a school setting and added that the State agency could not restrict attendant care services to school settings. In response, the State agency decided not to provide attendant care services in the home or other location and deleted these services from its State plan. CMS approved the revised State plan on July 13, 2010, with a July 1, 2009, effective date.

covered services …" and "… also includes functions performed pre and post of the actual direct client services."

Of the 2,894 random moments coded as IEP-covered direct medical services, the Contractor coded 27 random moments incorrectly because it did not follow the coding guidelines specified in the Implementation Guide. The responses to these RMTS surveys did not indicate that the activities performed qualified as IEP-covered direct medical services; an alternative RMTS code should have been selected instead. (For example, a moment was coded as an IEP-covered direct medical service although the respondent stated that he or she was returning to the classroom following a tornado drill.) We recoded these 27 random moments appropriately.

Effect of Errors With Random Moment Timestudies

Because the State agency used invalid RMTS participants and dates and inaccurate RMTS activity codes, the direct medical service percentage was overstated. On the basis of our findings, we determined that the direct medical service percentage should have been 31.19 percent instead of 45.47 percent. As a result of these errors and the resulting decrease in the direct medical service percentage, the Federal share of Medicaid-allowable costs decreased from $18,810,565 to $14,095,255. Therefore, the State agency received unallowable Federal reimbursement totaling $4,715,310 that was associated with errors in the RMTS.

UNSUPPORTED EXPENDITURES CLAIMED

Federal regulations (42 CFR § 433.32) require the State Medicaid agency to "… maintain an accounting system and supporting fiscal records to ensure that claims for Federal funds are in accordance with applicable Federal requirements." In addition, the CMS *State Medicaid Manual*, section 2500.2, provides instructions for the preparation of the CMS-64 report and states (§ 2500.2.A): "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 State agency claimed Medicaid direct medical service costs on the CMS-64 reports for the quarters ended September 30, 2009, through September 30, 2012, that were not adequately supported. The State agency was unable to provide support from its internal cost reporting system for the expenditures claimed. As a result of this error, the State agency received $643,094 in unallowable Federal reimbursement for claims paid during the period July 1, 2009, through September 30, 2012.

ISSUES IDENTIFIED AT KANSAS CITY, KANSAS, PUBLIC SCHOOL DISTRICT

The State plan specifies that allowable direct medical service costs include total compensation, such as salaries and benefits, and costs directly related to the delivery of medical services such as supplies and materials. These costs are included in the participating school districts' annual actual costs associated with SBHS that are reported to the State agency to be used in the cost settlements.

During our review of the costs claimed on the Kansas City, Kansas, public school district's annual cost report, we identified $89,841 in overstated employee benefit costs as well as $4,994 in overstated supply costs. Therefore, the total direct medical service costs for the Kansas City, Kansas, public school district during our audit period were overstated. After applying the revised direct medical service percentage of 31.19 percent to the corrected total Medicaid direct service costs, we determined that the State agency received additional unallowable Federal reimbursement totaling $11,403 for SBHS (employee benefit and supply costs) associated with this school district.

SCHOOL-BASED HEALTH SERVICES PROGRAM NOT ADEQUATELY MONITORED

These errors occurred because the State agency did not have adequate policies and procedures to monitor the SBHS program and to ensure that it claimed all costs in accordance with applicable Federal and State requirements. Although the State agency performed either a desk review or an onsite visit of each school district at least once every 3 years, and although the State agency reviewed at least 5 percent of the RMTS response codes and communicated any necessary changes with the Contractor, these procedures were not adequate to ensure that the State agency claimed costs correctly.

As a result, the State agency received a total of $10,748,706 in unallowable Federal reimbursement. See Appendix E for a summary of our findings.

RECOMMENDATIONS

We recommend that the State agency:

- refund $10,748,706 to the Federal Government for unallowable SBHS costs and

- strengthen policies and procedures to monitor the SBHS program and ensure that (1) SBHS costs are accurate and supported and (2) it claims all SBHS costs in accordance with applicable Federal and State requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not directly address our recommendations. The State agency agreed with our first finding (regarding the interim payments not used at cost settlement) and provided information as to the causes of these errors as well as corrective actions that it had implemented. The State agency neither agreed nor disagreed with our third and fourth findings (regarding the unsupported expenditures claimed and the issues identified in the Kansas City, Kansas, public school district) but described corrective actions that it had implemented or planned to implement.

The State agency disagreed with our second finding, which involved $4,715,310 (Federal share) in costs that we questioned on the basis of RMTS errors. State agency officials said that our methodology for recoding the random moments in question and our methodology for calculating

the unallowable Federal reimbursement were not statistically valid. The officials stated that individuals providing attendance care services were included in the direct medical service cost pool because the State agency had been in the process of requesting CMS approval to add attendant care services as a reimbursable service. Specifically, State agency officials said that they had requested CMS approval for an alternative methodology that included individuals providing attendant care services in the pool of direct medical service costs qualifying for Federal reimbursement. The State agency added that "[o]nce the determination was made to no longer seek reimbursement for attendant care services, the final time study sample for the April – June 2010 quarter had been selected and the quarterly process had begun." In addition, State agency officials said that they did not implement the alternative methodology because CMS never approved it. Although the State agency disagreed with our proposed recoupment related to this finding, officials said that they were willing to work with CMS to develop a method to recalculate the FY 2010 direct reimbursement percentage that would satisfy all parties.

The State agency attributed the selection of invalid dates for the RMTS to human error and attributed the inaccurate coding of the 27 random moments to insufficient information provided by the participants. For both of these elements of the RMTS finding, State agency officials described additional control measures that they had put into place.

The State agency's comments are included in their entirety as Appendix G.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid.

With respect to our first, third, and fourth findings, the State agency described corrective actions that, when fully implemented, should address the causes of these findings. In this sense, the State agency's comments suggested agreement with our second recommendation. The State agency did not directly address our recommendations. Even though the State agency agreed with our finding that it had received $5,378,899 in unallowable Federal reimbursement, it did not address our recommendation to refund this amount.

Although State agency officials said that they requested CMS's approval of the alternative methodology related to our second finding, they were unable to provide documentation that they had submitted this request to CMS. Furthermore, the officials acknowledged that they did not receive CMS approval and did not implement the methodology. Although the State agency decided not to claim reimbursement for costs associated with attendant care services, it did not take action to adjust its CMS-64 reports for previous quarters to account for those costs that it had claimed for services not approved for Federal reimbursement.

The methodology through which we evaluated the coding of the RMTS survey responses and recalculated the claimed costs conforms to our policies and procedures and to methodologies that we have used in previous reviews (Appendix A). In executing that methodology, we based our findings on applicable Federal and State requirements (Appendix F). These requirements include the provisions of the CMS-approved State plan, including Kansas Medicaid State Plan

Amendment #09-07. We maintain that the State agency received unallowable Federal reimbursement totaling $4,715,310 because of errors in the RMTS. Specifically, the State agency did not recalculate the direct medical service percentage to reflect that attendant care services were no longer allowable services under Kansas Medicaid State Plan Amendment #09-07.

OTHER MATTERS

STATISTICAL VALIDITY OF RANDOM MOMENT TIMESTUDIES

Acceptable statistical sampling methods involve using a random number generator to produce (1) a set of random numbers used to select the sample and (2) the "seed number" needed to recreate the random number selection so that the sample can be independently validated. The State agency was unable to provide documentation required to recreate the statistical methods used in selecting the random moments. Therefore, we were not able to verify the statistical validity of its sample as required by 2 CFR pt. 225, Appendix B, section 8.h.6.a(iii).

TIMELY SUBMISSION OF RESPONSES TO RANDOM MOMENT TIMESTUDY SURVEYS

The Implementation Guide, page 27, states that participants will submit RMTS survey responses no more than 5 days after the end of the quarter in which the random moment took place. Although no participant submitted survey responses more than 5 days after the end of the quarter, we identified 694 survey responses that had not been submitted within 7 days from the time of the random moment itself. For example, one participant completed the RMTS survey on the fifth day after the end of the quarter, which was 74 days after the selected random moment. A timelag of this nature could result in inaccurate responses. It is unlikely that a participant could remember what task he or she had performed during a specific moment 74 days after the fact. A CMS official stated that responses should be completed and returned within 5 to 7 calendar days of the moment, at most, to ensure that no potential bias is introduced, because the staff person's memory of the assigned random moment will inevitably fade over time.

UNSUPPORTED RESPONSES TO RANDOM MOMENT TIMESTUDY SURVEYS

We selected a statistical sample of 337 random moments coded as IEP-covered direct medical services and requested documentation from the school districts to support the activities performed. (See Appendix C.) Of the 337 random moments selected, school districts could not provide support for the responses for 143 moments. On the basis of the documentation received, the participants' responses could not be supported 22.61 percent of the time. (See Appendix D.)

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Review of Missouri Medicaid Payments for the School District Administrative Claiming Program for Federal Fiscal Years 2004 Through 2006	A-07-08-03107	3/10/10
Review of Kansas Medicaid Payments for the School District Administrative Claiming Program During the Period April 1, 2006, Through March 31, 2009	A-07-10-04168	10/06/11
Review of Colorado Direct Medical Service and Specialized Transportation Costs for the Medicaid School Health Services Program for State Fiscal Year 2008	A-07-11-04185	4/3/12
Arizona Improperly Claimed Federal Reimbursement for Medicaid School-Based Administrative Costs	A-09-11-02020	1/22/13

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed Medicaid direct medical service costs claimed for SBHS provided during the period July 1, 2009, through June 30, 2010. For this period, the State agency received $24,189,464 in Federal reimbursement for Medicaid direct medical service costs associated with 288 participating school districts in Kansas.

We performed an indepth review of the SBHS expenditures filed on behalf of the Wichita public school district and the Kansas City, Kansas, public school district. We focused on these two school districts in this review, with particular attention to that portion of SBHS that dealt with Medicaid direct medical service costs. We selected these districts on the basis of the amounts that the State agency claimed on their behalf for SBHS provided during the period July 1, 2009, through June 30, 2010. Of the $24,189,464 in Federal reimbursement mentioned above, $5,184,759 was associated with the Wichita public school district and $1,331,776 was associated with the Kansas City, Kansas, public school district.

We did not perform a review of Medicaid direct medical service costs at the remaining 286 participating school districts in Kansas. However, because the State agency used statewide RMTS percentages to calculate SBHS costs for all Kansas school districts, any errors in the statewide RMTS percentages affected the SBHS costs for every participating school district. Therefore, we applied the revised statewide RMTS percentages to the costs for all 288 participating school districts.

We did not perform a detailed review of the State agency's internal controls because our objective did not require us to do so. We limited our internal control review to obtaining an understanding of the State agency's policies and procedures to claim SBHS expenditures.

We conducted fieldwork from June 2012 to August 2013 at the State agency in Topeka, Kansas, and at the Wichita and Kansas City, Kansas, public school districts.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- reviewed the State agency's policies and procedures concerning SBHS, which included the State agency's monitoring and oversight procedures;
- interviewed State agency employees to understand how they administered the SBHS program statewide;
- interviewed Contractor employees to understand how they administered the SBHS program and how the statewide RMTS percentages were calculated;

- reconciled the State agency's CMS-64 reports to supporting documentation to determine whether interim costs claimed were adequately supported;[8]

- reconciled the actual costs reported on the annual cost reports for the Wichita and Kansas City, Kansas, public school districts to accounting records;

- interviewed Wichita and Kansas City, Kansas, public school district employees to understand how they administered the SBHS program;

- judgmentally selected 30 healthcare providers each, that were performing direct medical services for the Wichita and Kansas City, Kansas, public school districts, and ensured that the providers were qualified to provide these services as defined by the State plan;

- judgmentally selected 30 direct medical service claims each for the Wichita and Kansas City, Kansas, public school districts to determine whether they were properly billed;

- reviewed all 2,894 survey responses that were (1) completed by employees of participating school districts in Kansas and (2) coded by the Contractor as IEP-covered direct medical services, to determine whether the responses were coded appropriately;

- reviewed a sample of 337 random moments that the Contractor coded as allowable SBHS activities used in the RMTS (we did this to estimate the number of unsupported responses provided by participants completing the RMTS surveys);

- recalculated the Wichita and Kansas City, Kansas, public school districts' annual costs, using the corrected expenditures and the corrected statewide RMTS percentages, to determine the amounts that should have been claimed;

- recalculated the other participating Kansas school districts' annual costs, using the audited statewide RMTS percentages, to determine the amounts that should have been claimed;

- used the State agency's formulas for calculating actual annual costs and determined the financial effect of all errors identified by comparing the original annual costs to the recalculated annual costs using audited costs and RMTS responses;

- shared the results of this review, including the details of our recommended adjustments, with Wichita public school district officials on July 31, 2013, and with Kansas City, Kansas, public school district officials on August 6, 2013; and

[8] Federal regulations (45 CFR § 95.7) allow State agencies up to 2 years to claim Medicaid costs. Therefore, to ensure completeness of the interim payments for claims with dates of service in our audit period, we reconciled the CMS-64 reports for the quarter ended September 2009 through the quarter ended September 2012 (13 quarters in all).

- shared the results of this review, including the details of our recommended adjustments, with State agency officials on August 6, 2013.

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 C: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of all random moments selected in the RMTS and the participant responses that the State agency used to determine allowable costs for claiming Federal reimbursement for SBHS provided during the period July 1, 2009, through June 30, 2010.

SAMPLING FRAME

We obtained spreadsheets for the random moments selected in the State's RMTS performed for the quarters ended December 31, 2009, March 31, 2010, and June 30, 2010, and the related responses. We combined these three spreadsheets to create one list including 9,000 random moments. We removed all random moments not coded as "4B-IEP-DMS," leaving 2,894 random moments.[9]

SAMPLE UNIT

A sample unit was a selected random moment and the related participant responses to the RMTS survey.

SAMPLE DESIGN

We used a stratified random sample:

Stratum 1 – Wichita and Kansas City, Kansas, public school districts – 307 random moments
Stratum 2 – All other school districts – 2,587 random moments

SAMPLE SIZE

We selected a sample of 337 random moments:

Stratum 1 – 307 random moments
Stratum 2 – 30 random moments

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

[9] The "4B-IEP-DMS" code denotes direct medical services.

METHOD OF SELECTING SAMPLE ITEMS

We reviewed all random moments in stratum 1. We sequentially numbered the random moments in stratum 2. We generated 30 random numbers and selected the corresponding random moments in stratum 2.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total number of unsupported RMTS responses.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Sample Results

Stratum	Frame Size	Sample Size	Number of Responses Not Supported
1	307	307	137
2	2,587	30	6
Total	**2,894**	**337**	**143**

Estimates of Percent and Total Number of Responses That Were Not Supported
(Limits Calculated for a 90-Percent Confidence Interval)

Stratum	Percent of Responses Not Supported	Number of Responses Not Supported
1	44.625	137
2	20.000	517
Total	**22.612**	**654**

	Percent of Responses Not Supported	Number of Responses Not Supported
Point estimate	22.612	654
Lower limit	11.754	340
Upper limit	33.470	969

APPENDIX E: SUMMARY OF FINDINGS

	State-Determined Costs Using 45.47% (A)	OIG-Determined Costs Using 31.19% (B)	Difference (A–B)
Medicaid-allowable costs at direct medical service percentage	$18,810,565	$14,095,255	$4,715,310
Less: interim costs used at cost settlement	11,891,835	17,270,734	(5,378,899)[10]
Additional costs paid at cost settlement	6,918,730	(3,175,479)	10,094,209
		Unsupported costs claimed	643,094
		Unallowable reimbursement related to Kansas City school district	11,403
		Total unallowable reimbursement	10,748,706

[10] The State agency used $17,067,870 (Total Computable) interim costs at cost settlement. We determined that the interim costs should have been $24,792,498 (Total Computable) at cost settlement. The difference between the State agency's Total Computable interim costs used at cost settlement and our calculations of those costs was $7,724,627.

APPENDIX F: FEDERAL AND STATE REQUIREMENTS AND GUIDANCE RELATED TO SCHOOL-BASED HEALTH SERVICES

FEDERAL REQUIREMENTS

Section 1903(a) of the Act states that Federal reimbursement is available only for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the State plan.

Federal regulations (2 CFR § 225, Appendix B, section 8.h.6.a(iii)) state that to meet acceptable statistical sampling standards the results of the sample must be statistically valid and applied to the period being sampled.

Federal regulations (42 CFR § 433.32(a)) require the Medicaid State agency to "… maintain an accounting system and supporting fiscal records to ensure that claims for Federal funds are in accordance with applicable Federal requirements."

The CMS *State Medicaid Manual*, section 2500.2, provides instructions for the preparation of the CMS-64 report and states (§ 2500.2.A): "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."

CMS's *Medicaid and School Health: A Technical Assistance Guide*, issued in August 1997, contains specific technical information on the Medicaid requirements that govern State agencies seeking Federal reimbursement for coverable health services provided in a school-based setting.

STATE REQUIREMENTS

The Kansas Medicaid State Plan Amendment #09-07, effective July 1, 2009, defines SBHS as services to children listed in each child's IEP. These services include specialized transportation; nursing services; physical therapy; counseling services; social work services; psychological services; and speech, language, and hearing services. As of July 1, 2009 (the start of our audit period), attendant care services were no longer allowable for reimbursement under the State plan. This State Plan Amendment also states that providers complete annual cost reports in order to reconcile interim payments to total CMS-approved Medicaid-allowable costs.

STATE GUIDANCE

The State agency's Implementation Guide contains the policies and procedures that Kansas school districts follow to receive Medicaid reimbursement. The Implementation Guide, page 24, states that school district calendars will be reviewed each quarter to identify the dates that the school districts will be in session and for which their staff members are compensated and that those dates will be included in the random moment sample. The Implementation Guide, pages 8 through 21, provides specific instructions on the coding of random moments based on participants' responses to the survey questions. According to this guideline, an RMTS code for an IEP-covered direct medical service is appropriately selected "… when school district staff (employees or contracted staff) provides direct client services as covered services …" and "… also includes functions performed pre and post of the actual direct client services." The

Implementation Guide, page 27, states that participants will submit RMTS survey responses no more than 5 days after the end of the quarter in which the random moment took place.

APPENDIX G: STATE AGENCY COMMENTS

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Division of Health Care Finance

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Robert Moser, MD, Secretary

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May 30, 2014

Patrick J. Cogley
Regional Inspector General for Audit Services
US Department of Health and Human Services
Office of Audit Services
Region VII
601 East 12th Street
Room 0429
Kansas City, MO 64106

Report Number: A-07-13-04207

Dear Mr. Cogley:

The Kansas Department of Health and Environment, Division of Health Care Finance (KHDE/DHCF) appreciates the opportunity to provide this response to the April 2014 draft audit report by the U.S. Department of Health and Human Services, Office of the Inspector General (OIG). KDHE would like to thank the OIG audit team for its professionalism throughout our review of its initial findings and recommendations.

Based on its findings, the OIG recommended that: "The State agency accounted for only $17,067,870 ($11,891,835 Federal share) of the $24,792,498 ($17,270,734 Federal share) in interim payments during final cost settlement. Because the State agency excluded $7,724,627 ($5,378,899 Federal share) in interim payments at cost settlement, the Medicaid direct medical service costs were overstated and therefore not reasonable. As a result of this error, the State agency received $5,378,899 in unallowable Federal reimbursement."

KDHE agrees with the above findings. KHDE has since put measures in place to ensure that these inaccuracies do not occur in the future. Interim payments were made for attendant care services because KHDE was in the process of adding these services for reimbursement under the State Plan Amendment that was submitted to the Center for Medicare and Medicaid Services (CMS). These interim payments for attendant care were not included in cost settlement. Once the decision was made to remove these services for reimbursement, system changes needed to be made to remove these services from payment. KDHE stopped accepting and paying Medicaid interim claims for attendant care services by school based service providers effective 7/1/2010. This ensures that the interim payments used during cost settlement are not inflated with unallowable costs and adheres only to allowable cost categories.

In addition, the cost settlement payments now occur 24 months after the cost reporting period. Per state policy, LEAs have one year to bill Medicaid services based on the date of service. This intentional delay ensures that all interim payments are received, processed, and paid before the FY interim payment total is calculated and compared to the cost settlement amount for each district. This action plan ensures that no interim payments will be received after the cost settlement occurs.

Based on its findings, the OIG recommended that: "The State agency claimed unallowable costs based on RMTS errors. Specifically, the Contractor selected invalid participants, selected random moments on invalid dates, and coded some activities inaccurately. As a result of these errors, the State agency received $4,715,310 in unallowable Federal reimbursement."

KDHE disagrees with the above findings. The report suggests that invalid participant random moment responses, specifically the attendant care providers, were included in the quarterly time studies from October 1, 2009 through June 30, 2010. During that time, attendant care providers were included in the direct service cost pool. Attendant care staff were included in the direct service cost pool because, during this time period, KHDE was in the process of seeking approval to add attendant care services as a reimbursable service. Once the determination was made to no longer seek reimbursement for attendant care services, the final time study sample for the April – June 2010 quarter had been selected and the quarterly process had begun. KHDE removed these staff from the staff pool list prior to the start of the October – December 2010 quarter as outlined in the report. The October – December 2010 quarter was the next time study quarter in which updates to the staff pool list were made and a time study was conducted.

It is important to note that while attendant care services were no longer included as direct service providers, the direct service percentage for the 2011 Fiscal Year, the first full year after the removal of the attendant care personal, remained virtually identical to the 2010 Fiscal Year direct service percentage. The manner in which the OIG recoded and reclassified the moments was improper and not statistically valid. As a requirement for approval of the time study methodology, KHDE submitted a backcasting methodology to CMS for approval. The backcasting methodology was developed to outline how to account for the changes in the methodology from original submission to prior approval, particularly around the inclusion of attendant care staff in the direct service cost pool. The submitted backcasting methodology outlined a specific methodology that accounts for the changes in the time study cost pools that is consistent with methodologies approved in other states. The backcasting methodology proposes to utilize the FY 2011 time study results, which did not include attendant care services, to recalculate the FY 2010 direct service percentage and state cost settlement. KHDE did not implement this methodology since it had not obtained any feedback from CMS on this proposal. KHDE believes the submitted backcasting methodology is a more accurate and statistically valid process to calculate Federal reimbursement than the method utilized / recommended in this audit, which is automatically coding the time of sampled attendant care staff as non-reimbursable.

KHDE also believes the methodology utilized by the OIG to obtain the recommended unallowable Federal reimbursement is incorrect. First, the OIG assumes that all of these moments are non-reimbursable. While attendant care services were not added to the final approved State Plan Amendment, these staff did deliver IEP direct services at the same rate as the other direct service providers. This is evident through a comparison of direct service percentages across years. In other words, if attendant care staff had not been in the sample pool, others would have been selected for those moments and would have delivered IEP direct medical services at the same frequency as those attendant care staff, thus resulting in no change in the allowable Federal reimbursement. Second, simply recoding those moments violates the validity of the sample. If the OIG would have removed all attendant care staff moments from the sample and recalculated the direct service percentage without those moments, the overall direct service reimbursement percentage would have remained virtually the same. While those moments would have

been removed from the overall responses, the results of the annual time study results would have still met the requirement of a 95% confidence level with an error rate of +/- 2% since more than 2,401 annual moments would have still been utilized to calculate the annual direct service percentage.

KHDE disagrees with the findings, but realizes that the change to the reimbursement status of attendant care services was done after the time study samples had been generated for FY 2010. KHDE believes the proposed recoupment is inaccurate but is willing to work with CMS to develop a method to recalculate the FY 2010 direct service reimbursement percentage that will satisfy all parties.

Regarding the selected random moments on invalid dates, this was a data entry mistake caused by human error. While this was an error, the error did not have a material impact on the claim and this error cannot be tied to a specific unallowable Federal reimbursement. Certain dates for Wichita public schools were selected for random moments even though they were not in session on that date. These moments, since school was not in session, would be coded as code 11 which is not a reimbursable code. To ensure that this calendar error does not occur again, additional quality control measures have been put into place.

The report also identified 27 random moments that were coded inaccurately. Additional follow-up measures have now been put in place to ensure that enough detailed information is provided by the random moment participant prior to coding the random moment. These moments would account for a drop in the direct service reimbursement percentage of about 0.03%. This issue would be accounted for in the proposed backcasting methodology as well.

Based on its findings, the OIG recommended that: "The State agency claimed Medicaid direct medical service costs that were not supported by its internal cost reporting system. As a result, the State agency received $643,094 in unallowable Federal reimbursement."

KDHE's fiscal agent's financial sub-system contained decreasing Cost Settlement data that did not make its way into their MAR expenditure reports located in Content Manager - used to complete the CMS 64. Therefore, by not including all negative adjustments, [current] expenditures were over-stated on the CMS 64. There was no systematic/code correction needed to be made to the reports as the April 2012 report creation had an error due to an incorrect version of a file that got promoted. A pivot chart will be used to validate the MARS Quarterly reports which feed into the CMS64. KDHE will work with OIG to report this amount correctly on the CMS 64.

Based on its findings, the OIG recommended that: "The State agency claimed unallowable costs because the Kansas City, Kansas, public school district overstated employee benefit and supply costs by $94,835. As a result, the State agency received $11,403 in unallowable Federal reimbursement."

While each district is responsible for their own reported costs, KDHE has implemented various quality assurance checks to safeguard against potential errors. The corrective action plan for this finding includes enhanced trainings, additional support, and enhanced oversight activity. The enhanced training includes in-person trainings at the start of every school year to ensure that new business staff has the proper knowledge and information to report financials accurately. In addition to the in-person trainings, WebEx trainings are provided along with user guides, manuals, and access to the PowerPoint presentation. Each WebEx is also recorded and posted to the dashboard of the financial website for future reference. These trainings address what are the allowable costs/unallowable costs, how to report them, and reminders about maintaining documentation of reported costs.

Additionally, the State vendor conducts more in depth reviews of service utilization.. The school districts are now required to include additional support documentation and submit corrective action plans for

systemic findings. In addition, if it has been determined that a finding may have also impacted the staff who were not included in the sample, the school district is required to make the necessary changes and the remaining staff costs is reviewed.

The enhanced trainings and detailed monitoring reviews described above are part of the corrective action plan to decrease the probability that similar errors will occur in the future.

If you have any questions or comments regarding KDHE's response, please call Jason Osterhaus at (785) 296-2319 or email at josterhaus@kdheks.gov.

Sincerely,

Christiane Swartz
Deputy Medicaid Director
KDHE/DHCF

cc: Kari Bruffett, Director DHCF
Dr. Susan Mosier, Medicaid Director, DHCF
Mike Randol, Director of Finance and Informatics, DHCF
Rowena Regier, Institutional Reimbursement Manager, DHCF