Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

VULNERABILITIES EXIST IN STATE AGENCIES' USE OF RANDOM MOMENT SAMPLING TO ALLOCATE COSTS FOR MEDICAID SCHOOL-BASED ADMINISTRATIVE AND HEALTH SERVICES EXPENDITURES

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

Gloria L. Jarmon
Deputy Inspector General
for Audit Services

December 2018
A-07-18-04107

Office of Inspector General

https://oig.hhs.gov/

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

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.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at https://oig.hhs.gov

Section 8M 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.

Report in Brief
Date: December 2018
Report No. A-07-18-04107

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Vulnerabilities Exist in State Agencies' Use of Random Moment Sampling To Allocate Costs for Medicaid School-Based Administrative and Health Services Expenditures

Why OIG Did This Review

Previous OIG reviews of 10 State Medicaid agencies (State agencies) that used random moment timestudies (RMTS) to allocate costs for school district administrative claiming (SDAC) and school-based health services (SBHS) showed that RMTS was not an effective way of allocating costs to the Medicaid program. This report summarizes the findings of those reviews.

Our objective was to identify opportunities for the Centers for Medicare & Medicaid Services (CMS) to improve its oversight of costs associated with school-based administrative activities and health services by summarizing the results of our previous reviews of State agencies' use of RMTS as a basis to allocate and claim Federal Medicaid reimbursement for these costs.

How OIG Did This Review

We previously reviewed 10 State agencies (in Alabama, Arizona, Colorado, Kansas, Massachusetts, Mississippi, Missouri, New Jersey, North Carolina, and Texas) to determine whether the RMTS used in those States to allocate SDAC and SBHS costs complied with Federal requirements and was an effective way of allocating costs. Our previous reviews encompassed a total of more than $1.2 billion in SDAC and SBHS costs during timeframes that ranged from July 2003 through June 2015.

What OIG Found

Inadequate oversight at CMS and the State agency level created vulnerabilities in State agencies' use of RMTS as a basis to allocate and claim Federal Medicaid reimbursement for costs associated with SDAC and SBHS. Previous reviews determined that the 10 State agencies claimed a total of $435.4 million in SDAC and SBHS costs that were not in accordance with Federal requirements and guidance. We found that of the 10 State agencies, 5 claimed unallowable SDAC and SBHS costs, 3 claimed SDAC costs without having properly submitted cost allocation plans that described their RMTS methodologies, and all 10 did not correctly develop the RMTS methodologies used to allocate costs. We also found that some of the annual cost settlements performed by three State agencies did not take all interim payments into account. In addition, three State agencies could not provide medical record documentation to support the responses provided by RMTS participants; therefore, we could not determine whether services for which the State agencies had claimed SBHS costs had actually been performed. Finally, we could not determine which portions of an additional $325.1 million of SDAC and SBHS costs were allowable in two States whose RMTS methodologies used sample universes that were or may have been inaccurate.

What OIG Recommends and CMS Comments

We make procedural recommendations to CMS (detailed in the report) for instructions to all State agencies regarding their SDAC and SBHS programs and their RMTS methodologies. We also recommend that CMS distribute formal guidance for the use of RMTS to allocate SBHS costs or consider no longer permitting States to use RMTS methodologies to allocate and claim SBHS costs.

In written comments on our draft report, CMS concurred with both of our recommendations and described corrective actions that it said it would take, to include issuing updated guidance to State agencies regarding (1) policies and procedures to monitor SDAC and SBHS programs and (2) the requirement to maintain and retain adequate medical record documentation to validate RMTS responses and support SBHS costs claimed.

TABLE OF CONTENTS

INTRODUCTION 1

Why We Did This Review 1

Objective 1

Background 1

Medicaid Program 1

Medicaid Coverage of School-Based Administrative and Health Services Costs 1

CMS Guidance on Developing Payment Rates for School-Based Administrative and Health Services 2

Random Moment Timestudy Methodology 3

Cost Settlement 4

How We Conducted This Review 5

FINDINGS 5

State Agencies Claimed Unallowable Administrative and Health Services Costs 8

Cost Allocation Plans and Amendments Describing Random Moment Timestudy Methodologies Were Not Properly Submitted or Approved 9

State Agencies Used Random Moment Timestudy Methodologies That Did Not Comply With Federal Requirements 10

Federal Requirements and Guidance 10

Methods for Discarding Samples and Resolving Nonresponses Were Inappropriate 11

Random Moment Timestudy Activities Were Inaccurately Coded and Unsupported 11

Supporting Documentation Was Inadequate To Allow Reproduction and Verification of Random Moment Timestudy Sample Results 12

Incorrect Universes Were Used for Random Moment Timestudy Methodologies 12

State Agencies Did Not Take All Interim Payments Into Account and Did Not Always Report Correct Costs at Cost Settlement 13

Responses to Random Moment Timestudy Surveys for School-Based Health Services Could Not Be Verified 14

Potentially Unallowable Administrative and Health Services Costs as a Result of Sample Universes That Were or May Have Been Inaccurate 15

RECOMMENDATIONS 16

CMS COMMENTS 17

APPENDICES

A: Audit Scope and Methodology 18

B: Related Office of Inspector General Reports.....20

C: CMS Comments 21

INTRODUCTION

WHY WE DID THIS REVIEW

Previous Office of Inspector General (OIG) reviews of 10 State Medicaid agencies (State agencies) that used random moment timestudies (RMTS) to allocate costs for school district administrative claiming (SDAC) and school-based health services (SBHS) showed that RMTS was not an effective way of allocating costs to the Medicaid program.[1] This report summarizes the findings of those reviews to help the Centers for Medicare & Medicaid Services (CMS) and all State agencies improve oversight of school-based costs charged to the Medicaid program.

OBJECTIVE

Our objective was to identify opportunities for CMS to improve its oversight of costs associated with school-based administrative activities and health services by summarizing the results of our previous reviews of State agencies' use of RMTS as a basis to allocate and claim Federal Medicaid reimbursement for these costs.

BACKGROUND

Medicaid Program

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.

Medicaid Coverage of School-Based Administrative and Health Services Costs

Section 1903(c) of the Social Security Act (the Act) permits Medicaid payment for health-related services that are specified in each child's individualized education plan (IEP), generally without the child having to leave school.[2] State agencies may be reimbursed for the administrative activities that support SBHS for children eligible for Medicaid; the administrative costs that

[1] In previous audits, we reviewed SDAC costs claimed by State agencies in Alabama, Arizona, Kansas, Mississippi, Missouri, and North Carolina. In other audits, we reviewed SBHS costs claimed by the State agencies in Colorado, Kansas, Massachusetts, New Jersey, and Texas. Because we audited 1 of the State agencies—in Kansas—for both its SDAC and SBHS costs, we performed a total of 11 previous reviews. See Appendix B.

[2] An IEP is a written plan that is designed to meet a disabled child's special education needs, health-related service needs, or both. The disabled child must meet the eligibility requirements as described in the Individuals with Disabilities Education Act.

State agencies claim for Federal reimbursement are called SDAC costs. In addition, SBHS costs are 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 Medicaid State plan or are available under the Early and Periodic Screening, Diagnosis, and Treatment Medicaid benefit (*Medicaid and School Health: A Technical Assistance Guide* (CMS Technical Guide) (Aug. 1997)).[3]

SBHS costs include direct medical services costs. Medicaid-covered direct medical services may include physical therapy, occupational therapy, speech pathology and speech therapy, psychological counseling, nursing, specialized transportation services, and personal care services (CMS Technical Guide). In addition, direct medical service costs include payroll costs (e.g., salaries, benefits, and contract compensation) and other direct costs (e.g., materials, supplies, and travel).

States are required to maintain "the records necessary for the proper and efficient operation of the [State] plan. The records must include—statistical, fiscal, and other records necessary for reporting and accountability as required by the Secretary [of Health and Human Services (HHS)]" (42 CFR § 431.17(b)(2)). Further, Federal regulations state that "[a] State plan must provide that the Medicaid agency and, where applicable, local agencies administering the plan will—Maintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements" (42 CFR § 433.32(a)).

CMS Guidance on Developing Payment Rates for School-Based Administrative and Health Services

CMS has issued two guides on reimbursement for Medicaid school-based activities: (1) the CMS Technical Guide and (2) the *Medicaid School-Based Administrative Claiming Guide* (CMS Claiming Guide) (May 2003). The CMS Technical Guide states that payment rates must be supported by information on how the rates were determined, such as historical data and timestudies.[4] Further, the States must maintain documentation of these payment rates that must be made available to CMS on request (CMS Technical Guide, pages 35-36).

The CMS Claiming Guide requires that documentation be retained to support timestudies used to allocate costs, including the sample universe determination, sample selections, and sample results (§ V.B.4.). The CMS Claiming Guide also clarifies the random moment sampling requirements in Office of Management and Budget (OMB) Circular A-87 by providing information on the sample universe, sampling plan methodology, treatment of the summer

[3] The Early and Periodic Screening, Diagnosis, and Treatment benefit is Medicaid's comprehensive and preventive children's health care program that conducts early assessment of children's health care needs through periodic examinations.

[4] A CMS-approved State plan describes, among other things, the scope of that State's Medicaid program, its eligibility groups and standards, the services provided, and the payment rates associated with those services.

period, and documentation (§ V.B.2.).[5] The CMS Claiming Guide applies only to SDAC. Requirements in the CMS Claiming Guide do not apply to SBHS.

Random Moment Timestudy Methodology

Use of Random Moment Sampling To Allocate Costs Between Reimbursable and Non-Reimbursable Medicaid Activities

To ascertain (for purposes of claiming Federal reimbursement) the portion of time and activities of SDAC and SBHS that is related to the provision of Medicaid services, States may develop an allocation methodology that is approved by CMS. For years, many State agencies have used random moment sampling—which makes use of RMTS and is a CMS-approved allocation methodology—to allocate SDAC costs. More recently, some State agencies have also used this methodology to allocate SBHS costs. There are limited Federal regulations and guidance that establish specific requirements for State agencies to develop and use RMTS to allocate SBHS costs.[6] Accordingly, State agencies develop their own guidance that establish RMTS methodologies for SBHS. These State-level guidance documents are reviewed and approved by CMS.

Random moment sampling must reflect all of the time used and activities performed (whether allocable to or allowable under Medicaid) by school district employees participating in an SDAC program, an SBHS program, or both (CMS Claiming Guide § IV.B.2.). Random moment sampling covers the entire sampled period, such as a quarter, but does not include periods when schools are not in session, such as holidays (CMS Claiming Guide § V.B.2.).

To claim Federal reimbursement, State agencies must allocate SDAC and SBHS costs for activities that are performed for a population of children that includes both those eligible and non-eligible for Medicaid (CMS Claiming Guide § IV.B.7.). The timestudy mechanism therefore requires careful documentation of all work performed by certain school staff over a set period of time and is used to identify, measure, and allocate the school staff time that is devoted to activities reimbursable by Medicaid (CMS Claiming Guide § IV.B.2.).

[5] OMB Circular No. A-87, *Cost Principles for State, Local, and Tribal Government,* was relocated to 2 CFR part 225 and made applicable by 45 CFR § 92.22(b). (HHS has promulgated new grant regulations and cost principles at 45 CFR part 75 that apply to awards made on or after Dec. 26, 2014.) OMB consolidated and streamlined its guidance, which is now located at 2 CFR part 200. Depending on their audit scopes, our 11 previously issued reports cited sometimes to the OMB Circulars and sometimes to Federal regulations at 2 CFR. In general, the relevant language in these criteria did not change as a result of the relocation of the cost principles to Federal regulations.

[6] CMS Central Office staff officials told us that they consider the guidance provided in the CMS Claiming Guide to apply to both SDAC and SBHS costs. Moreover, CMS officials told officials of two of the three State agencies—Massachusetts and Texas—that CMS considers the requirements in the Claiming Guide to apply as well to direct medical services. CMS has not, however, distributed this clarification nation-wide.

State agencies use contractors to manage portions of their SDAC and SBHS programs. The contractors work with the State agencies to develop and implement an RMTS methodology and to carry out the day-to-day administration of the timestudy and claim calculations.

Random Moment Timestudy Data Collection and Reporting

Although specific procedures vary from State to State, the execution of an RMTS generally proceeds as follows. On a quarterly basis, participating school districts in a State submit to that State's contractor a list of all school district employees participating in the SDAC program, the SBHS program, or both (participants). The contractor consolidates these personnel lists into a state-wide pool and statistically selects participants from that pool to include in the RMTS. The contractor calculates the available moments per quarter using each school district's calendar of working days and statistically selects a designated number of specific dates and times (random moments) per quarter. The contractor then matches a statistically selected random moment to a statistically selected participant and contacts that participant to notify him or her of the requirement to participate in a survey and of the exact random moment. Each of the selected participants then respond to a series of questions identifying and explaining the activity he or she was performing at the selected random moment. After the selected participants have completed and submitted their responses, the contractor codes the random moments according to the responses provided.

Using the results of the RMTS, the contractor determines and reports to the State agency the state-wide percentages of time that school district employees spent on SDAC and SBHS activities reimbursable by Medicaid. The contractor also calculates personnel costs and indirect costs (for SDAC costs) and direct medical service percentages (for SBHS costs) and reports these to the State agency. In general, these calculations are made at the school district level and involve, among other factors, determinations of the ratio of students eligible for Medicaid to the total number of students in each school district. This ratio assists in the allocation of costs between reimbursable and non-reimbursable Medicaid activities.

Cost Settlement

On an ongoing basis, participating school districts submit claims to their State agency for SBHS provided to students. The State agency makes interim payments to the participating school districts for these services and, in turn, claims Federal reimbursement for these interim payments on a quarterly basis.

On an annual basis, to ensure that Federal reimbursement does not exceed the allowable direct medical service costs, the State agencies then reconcile interim payments to the direct medical service costs determined through RMTS. This reconciliation process is referred to as cost settlement.

Cost settlement takes into account all interim payments made during that year to determine the SBHS reimbursement. If the interim payments are found to be greater than the Medicaid

direct medical service costs, the school district pays the State agency the difference between the two. However, if the interim payments are found to be less than the Medicaid direct medical service costs, the State agency pays the school district the difference and claims reimbursement for the Federal share of that difference.

HOW WE CONDUCTED THIS REVIEW

We interviewed CMS staff and reviewed CMS's policies and procedures in relation to the administration of the SDAC and SBHS programs. In addition, we previously reviewed 10 State agencies (Appendix B) to determine whether the RMTS used in those States to allocate SDAC and SBHS costs complied with Federal requirements and were an effective way of allocating costs. We conducted these reviews at the State agencies in Alabama, Arizona, Colorado, Kansas, Massachusetts, Mississippi, Missouri, New Jersey, North Carolina, and Texas; the audit periods of these previous reviews ranged from July 2003 through June 2015.

Our previous reviews encompassed a total of $1,279,990,246 in SDAC and SBHS costs that these State agencies allocated to Medicaid. All 10 State agencies used RMTS to determine the portions of SDAC costs, SBHS costs, or both that they allocated to allowable Medicaid activities and for which they claimed Federal reimbursement.

In addition, for our reviews of the use of RMTS to claim SBHS in Kansas, Massachusetts, and Texas, we selected a statistical sample of random moments to estimate the number of unsupported responses provided by participants completing the RMTS surveys.

For this rollup report, we are summarizing the results of our 11 previous reviews (footnote 1) and making recommendations to CMS, the cognizant HHS operating division. To do so, we analyzed the findings and recommendations from those previous reviews, which evaluated the use of RMTS to allocate and claim SDAC and SBHS costs.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains details of our audit scope and methodology.

FINDINGS

Inadequate oversight at both CMS and the State agency level created vulnerabilities in State agencies' use of RMTS as a basis to allocate and claim Federal Medicaid reimbursement for costs associated with school-based administrative activities and health services. The State agencies claimed unallowable costs as a result of the incorrect allocation of costs, the use of inaccurate or incorrect RMTS methodologies, the incorrect exclusion of interim payments when

performing cost settlements, and the acceptance of unsupported responses provided by RMTS participants. Previous OIG reviews determined that the 10 State agencies claimed $435,448,603 in SDAC and SBHS costs that were not in accordance with Federal requirements and guidance. All 10 State agencies used RMTS to determine the portions of these costs that they allocated to allowable Medicaid activities and claimed for Federal reimbursement. Unallowable SDAC and SBHS costs included the following:

- Five of the 10 State agencies claimed unallowable SDAC and SBHS costs totaling $221,614,883 that were not reasonable, allowable, or adequately supported.

- Three of the 10 State agencies claimed SDAC costs without having properly submitted their cost allocation plans or amendments that described their RMTS methodologies. As a result, these State agencies received unallowable Federal reimbursements totaling $150,193,796.

- All 10 of the State agencies did not comply with Federal requirements and guidance in developing the RMTS methodologies that they used to allocate SDAC and SBHS costs. As a result, these State agencies claimed a total of $57,387,683 in unallowable Federal reimbursement.

- Some of the annual cost settlements performed by three State agencies did not take all interim payments into account, thus overstating the amounts claimed for Federal reimbursement, and some did not include correctly reported and adequately supported costs. As a result, these State agencies claimed unallowable SBHS costs totaling $6,252,241 in their annual cost settlements.

- The three State agencies whose random moments we evaluated using statistical sampling could not provide medical record documentation to support significant percentages of the responses provided by RMTS participants. As a result, neither these State agencies nor we could determine whether the direct medical service activities that were reimbursable by Medicaid and for which the State agencies claimed SBHS costs had actually been performed.

- We could not determine whether a combined total of $325,062,349 was allowable in two States whose RMTS methodologies used sample universes that were or may have been inaccurate. One of these State agencies also based its payment rates on unsupported RMTS. As a result, we set aside the combined total of $325,062,349 for the relevant State agencies to work with CMS to determine the allowable amounts.

The table on the following page summarizes, by State agency, the findings described in the first four bullets above, which were applicable to all 10 of the States covered by this audit.

Table: Unallowable SDAC and SBHS Costs Resulting From Errors With Random Moment Time Studies

State	Contractor	Unallowable SDAC and SBHS Costs	Cost Allocation Plans and Amendments Not Properly Submitted	Errors Identified With RMTS That Did Not Comply With Federal Requirements[7]	Incorrect Costs Used at Cost Settlement	Total
AL	Fairbanks, LLC	$0	$75,274,946	$0	$0	$75,274,946
AZ	Maximus, Inc.	0	0	11,716,850	0	11,716,850
CO	Public Consulting Group, Inc.	191,625	0	484,719	194,902	871,246
KS	Maximus, Inc. 2000-2005 Public Consulting Group, Inc. Feb. 2006	100,565	0	6,422,070	6,033,396	12,556,031
MA	University of Massachusetts Medical School	377,095	0	0	23,943	401,038
MS	Business Computers - Memphis	0	21,199,651	0	0	21,199,651
MO	Maximus	631,479	0	19,838,191	0	20,469,670
NJ	Public Consulting Group, Inc.	220,314,119	0	0	0	220,314,119
NC	Public Consulting Group, Inc., and Fairbanks, LLC	0	53,719,199	0	0	53,719,199
TX	Fairbanks, LLC	0	0	18,925,853	0	18,925,853
Total		**$221,614,883**	**$150,193,796**	**$57,387,683**	**$6,252,241**	**$435,448,603**

These errors occurred because CMS had not developed or distributed formal guidance directing State agencies to maintain and retain adequate medical record documentation to support SBHS costs claimed. In addition, the State agencies in question did not have adequate policies and procedures to monitor the SDAC and SBHS programs in their States; to ensure that their RMTS

[7] Previous reviews were able to quantify the unallowable Federal reimbursement for only 5 of the 10 State agencies that did not comply with Federal requirements and guidance in developing the RMTS methodologies that they used to allocate SDAC and SBHS costs.

methodologies were valid, reliable, and adequately supported by documentation; to ensure that claimed SBHS costs were reasonable and accurate for all calculations used in their annual cost settlements with school districts; and to ensure that their RMTS methodologies for allocating SDAC and SBHS costs conformed to Federal requirements and guidance.

STATE AGENCIES CLAIMED UNALLOWABLE ADMINISTRATIVE AND HEALTH SERVICES COSTS

Federal regulations state that "[t]o be allowable under Federal awards, costs must meet the following general criteria: . . . (j) Be adequately documented" (2 CFR part 225, App. A, § (C)(1)). In addition, "[a]ny cost allocable to a particular Federal award or cost objective under the principles provided for in 2 CFR part 225 may not be charged to other Federal awards to overcome fund deficiencies, to avoid restrictions imposed by law or terms of the Federal awards, or for other reasons" (2 CFR part 225, App. A, § (C)(3)(c)).[8]

CMS guidance states that "[c]ertain revenues must offset allocation costs in order to reduce the total amount of costs in which the federal government will participate. . . . The following include some of the revenue offset categories which must be applied in developing the net costs: All federal funds. . . . All state expenditures which have been previously matched by the federal government" (CMS Claiming Guide § V.C.).

The CMS Claiming Guide also states that "[w]here indirect costs are allowed, the school district must certify that costs claimed as direct costs do not duplicate those costs reimbursed through the application of the indirect cost rate" (CMS Claiming Guide § V.E.). Accordingly, States may not claim the same costs once as direct costs and again as indirect costs.

Contrary to these Federal regulations and guidance, five State agencies claimed SDAC and SBHS costs that were not reasonable, allowable, or adequately supported in accordance with Federal regulations.[9] Portions of these costs were allocated to Medicaid, and on that basis, were then claimed for Federal reimbursement using the State agencies' RMTS methodologies.

Specifically, SDAC and SBHS costs were allocated inappropriately, were duplicated, and included unallowable costs. In addition, two of these five State agencies did not correctly calculate costs and three State agencies claimed costs that were unsupported.[10]

For example, in New Jersey, we found that the State agency's contractor included unallowable special education costs of $22,730,807 that inflated the payment rates used to claim Federal Medicaid reimbursement. The salaries of the special education teachers were unallowable because the teachers did not provide any health services.

[8] For an explanation of the earlier formulation of these regulations (as OMB Circular A-87) and their subsequent relocation to 2 CFR part 200, see footnote 2.

[9] These five State agencies were in Colorado, Kansas, Massachusetts, Missouri, and New Jersey.

[10] Two of the three agencies with unsupported costs were the two that also had incorrectly calculated costs.

These errors occurred because the State agencies did not have adequate policies and procedures to monitor the SDAC and SBHS programs in their States and thereby ensure that costs claimed under these programs were reasonable and accurately calculated. As a result, these State agencies received unallowable Federal reimbursements totaling $221,614,883 for SDAC and SBHS costs.

COST ALLOCATION PLANS AND AMENDMENTS DESCRIBING RANDOM MOMENT TIMESTUDY METHODOLOGIES WERE NOT PROPERLY SUBMITTED OR APPROVED

States must submit for review by the HHS, Division of Cost Allocation (DCA), a cost allocation plan that follows Federal requirements (45 CFR § 95.507(a)). States must also promptly amend the cost allocation plan and submit the amended plan when certain conditions are met (45 CFR § 95.509(a)).

Three of the 10 State agencies (in Alabama, Mississippi, and North Carolina) claimed SDAC costs without having properly submitted their cost allocation plans or amendments that described their RMTS methodologies. Specifically, these State agencies did not promptly submit their cost allocation plans or their amendments to DCA for review and approval. Instead, each of these three State agencies claimed costs based on one or more implementation plans or guides that it had submitted to CMS for consideration and negotiation. In each case, CMS approved the State agency's RMTS methodology on the condition that the State agency submit its cost allocation plan to DCA for approval.

The Mississippi State agency did not take that step until nearly 3 years after receiving CMS's conditional approval (which was after our audit period). The North Carolina State agency received CMS's conditional approval in July 2008 but had not submitted to DCA its cost allocation plan amendment, which described its RMTS methodology, as of the conclusion of our fieldwork in October 2015. The Alabama State agency worked with CMS on implementing its program for over 10 years beginning in calendar year 2002 but did not receive CMS's conditional approval of that program until May 2013 (which was after our audit period).

These errors involving the submission of their cost allocation plans occurred because the State agencies' policies and procedures did not take applicable Federal regulations into account. For example, the Alabama State agency attributed its lack of compliance regarding submission of its cost allocation plan to staff turnover and a lack of knowledge of Federal requirements. As a result, these State agencies received unallowable Federal reimbursements totaling $150,193,796 for SDAC costs.[11]

[11] The State agencies that did not properly submit their cost allocation plans or amendments also had other findings (described just below) regarding their RMTS methodologies. For the sake of clarity, our reports on these three State agencies assigned these questioned costs entirely to this finding.

STATE AGENCIES USED RANDOM MOMENT TIMESTUDY METHODOLOGIES THAT DID NOT COMPLY WITH FEDERAL REQUIREMENTS

All 10 State agencies used RMTS methodologies that did not comply with Federal requirements and, as a result, claimed a total of $57,387,683 in unallowable Federal reimbursement.

Federal Requirements and Guidance

Federal regulations state that costs must "[b]e adequately documented" (2 CFR part 225, App. A, § (C)(1)(j)). In addition, "[a] cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received" (§ (C)(3)(a)). (See footnote 5.)

Furthermore, Federal regulations state that random moment sampling must meet acceptable statistical standards, which require that the results be statistically valid (2 CFR part 225, App. B, § 8.h.6.a(iii)). The CMS Claiming Guide states that the validity and reliability of the sampling methodology must be acceptable to CMS and adds that all nonresponses should be coded as non-Medicaid activities: "Many schools oversample and/or factor in a non-response rate in their time study methodology" (CMS Claiming Guide § V.B.2.).

According to CMS officials, the meaning of this language in the CMS Claiming Guide is that State Medicaid agencies may use oversampling to factor nonresponses into their methodology but only with prior approval from CMS. That is, any methodology that a State agency wants to use to compensate for nonresponses must be submitted to CMS for review and approval before implementation and must also be statistically valid and reliable. Furthermore, the random moment sample "must reflect all of the time and activities (whether allowable or unallowable under Medicaid) performed by employees participating in the Medicaid administrative claiming program" (CMS Claiming Guide § IV.B.2.).[12]

The CMS Claiming Guide also states: "Documentation to be retained must support and include the following: the sample universe determination, sample selection, sample results, sampling forms, costs data for each school district, and summary sheets showing how each school district's claim was compiled" (§ V.B. 4.). Additionally, "documentation for administrative activities must clearly demonstrate that the activities/services directly support the administration of the Medicaid program. . . . The burden of proof and validation of time study sample results remains the responsibility of the states. To meet this requirement, some states currently include space on time study forms for a brief narrative description of the Medicaid activity, function, or task being performed" (CMS Claiming Guide § V.A.).

[12] In addition, "[t]he sampling universe must include all of the employees whose salaries and wages are to be allocated based on sample results" (2 CFR part 225, App. B, § 8.h.6.a(i)).

Methods for Discarding Samples and Resolving Nonresponses Were Inappropriate

Contrary to these Federal regulations and guidance, two State agencies used invalid RMTS methodologies to allocate SDAC costs. Specifically, we found that the Arizona State agency inappropriately discarded RMTS responses in its state-wide RMTS calculations. In addition, the Missouri State agency applied an alternate methodology, which CMS had not approved, in which it opted to oversample to ensure a minimum number of responses but did not consider the nonresponses in the results.

The errors in these two States occurred because the State agencies did not have adequate policies and procedures to ensure that their RMTS methodologies for allocating SDAC costs were valid and reliable. As a result, these two State agencies received a combined total of $24,465,106 in unallowable Federal reimbursement.

Random Moment Timestudy Activities Were Inaccurately Coded and Unsupported

Five State agencies inaccurately coded RMTS responses and subsequently used them in their state-wide RMTS calculations, which in turn affected the amounts claimed for Federal reimbursement.[13] Specifically, the RMTS responses were not properly coded and some responses were not adequately documented so as to support activities performed.

For example, in Missouri the RMTS responses (1) were not properly completed and (2) were not supported by documentation of the activities performed. Specifically, some RMTS responses had activity codes and written descriptions that did not match the activities performed, while the written descriptions in some other responses vaguely described occupational duties rather than the specific activities being performed during the selected random moments.

The errors identified in these five States occurred because the State agencies did not have adequate policies and procedures to ensure that their RMTS were properly completed and supported by documentation of activities performed that were reimbursable by Medicaid. As a result, these State agencies received a total of $22,785,556 in unallowable Federal reimbursement.[14]

[13] The State agencies were in Colorado, Kansas, Missouri, New Jersey, and Texas.

[14] We were unable to quantify the financial impact of the unsupported SBHS costs claimed by New Jersey. We therefore set aside these amounts for New Jersey to work with CMS to determine the allowable amounts.

Supporting Documentation Was Inadequate To Allow Reproduction and Verification of Random Moment Timestudy Sample Results

Seven State agencies did not maintain adequate documentation to support their RMTS sample selections, and for that reason, we could neither reproduce nor verify their sample results.[15] Specifically, six State agencies either did not store the seed numbers used in their RMTS or employed software that did not use seed numbers.[16] One State agency (Arizona) was unable to provide documentation to support the selection of random moments for selected participants.

The errors in these seven States occurred because the State agencies did not have adequate policies and procedures to ensure that they maintained adequate documentation to permit their RMTS sample results to be reproduced after the fact for purposes of verification. As a result, these State agencies received a total of $5,421,711 in unallowable Federal reimbursement.

Incorrect Universes Were Used for Random Moment Timestudy Methodologies

Six State agencies did not comply with Federal requirements regarding statistical sampling because the sample universes from which the State agencies selected the sample random moments were incorrect.[17] Six State agencies selected random moments that did not align with the correct time period involved because some sample moments specified dates when schools were not in session and other sample moments specified times that were outside employee work hours. For example, Mississippi school district employees had completed and submitted responses for designated random moments that fell on Thanksgiving, Christmas, and other holidays. In addition, the contractor-prepared participant lists used by the State agencies in Alabama, Arizona, Mississippi, and North Carolina contained duplicate employees in every quarter of the audit periods. And in Kansas, we found that of the 9,000 moments randomly selected for the RMTS used to develop SBHS costs, the State agency's contractor selected 2,441 moments associated with providers of attendant care services. As of the start of our audit period in that State, these services were no longer listed as allowable services under the Kansas Medicaid State plan.

In Alabama, Arizona, Massachusetts, and North Carolina, the State agencies constructed sample universes that did not cover the entire time periods, (i.e., all employee work hours); and in the Wichita, Kansas, public school district (in the State's largest city), the contractor selected random moments on dates for which the schools were not in session and for which school district employees were not compensated.

[15] The State agencies were in Alabama, Arizona, Kansas, Massachusetts, Mississippi, North Carolina, and Texas.

[16] 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.

[17] The State agencies were in Alabama, Arizona, Kansas, Massachusetts, Mississippi, and North Carolina.

These errors occurred because these six State agencies did not have adequate policies and procedures to ensure that their methods for selecting sampled items conformed to Federal requirements. As a result, these State agencies received a total of $4,715,310 in unallowable Federal reimbursement.

STATE AGENCIES DID NOT TAKE ALL INTERIM PAYMENTS INTO ACCOUNT AND DID NOT ALWAYS REPORT CORRECT COSTS AT COST SETTLEMENT

Federal regulations require that State Medicaid agencies "maintain an accounting system and supporting fiscal records to ensure that claims for Federal funds are in accordance with applicable Federal requirements" (42 CFR § 433.32). In addition, the CMS *State Medicaid Manual*, section 2500.2, provides instructions for the preparation of the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report) and states: "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" (§ 2500.2.A).[18]

When a State agency performs an annual cost settlement with a school district, the calculation of allowable Medicaid SBHS costs is limited to the Medicaid direct medical service costs determined through RMTS. The reimbursement resulting from cost settlement is the final reimbursement for the fiscal year. If the interim payments are found to be greater than the Medicaid direct medical service costs, the school district pays the State agency the difference between the two. However, if the interim payments are found to be less than the Medicaid direct medical service costs, the State agency pays the school district the difference and claims reimbursement for the Federal share of that difference.

Three State agencies (those of Colorado, Kansas, and Massachusetts) claimed unallowable Federal reimbursement totaling $6,252,241 for SBHS costs after performing their cost settlements with school districts. These three State agencies also reported incorrect costs (i.e., overstated employee benefits and supply costs) when performing their cost settlements. For example, Kansas incorrectly excluded some interim payments to school districts when it was performing its annual cost settlements, and consequently it overstated the SBHS costs that it claimed for Federal reimbursement. In addition, Kansas was unable to provide support from its internal cost reporting system for the Medicaid direct medical service costs that it claimed.

The Colorado, Kansas, and Massachusetts State agencies lacked policies and procedures to ensure that claimed SBHS costs were reasonable and accurate for all calculations used in their annual cost settlements with school districts. As a result, these State agencies received unallowable Federal reimbursements totaling $6,252,241 for claimed SBHS costs.

[18] States use the 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.

RESPONSES TO RANDOM MOMENT TIMESTUDY SURVEYS FOR SCHOOL-BASED HEALTH SERVICES COULD NOT BE VERIFIED

Federal regulations state that costs must "[b]e adequately documented" (2 CFR part 225, App. A, § (C)(1)(j)). In addition, "[a] cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received" (§ (C)(3)(a)). (See footnote 5.)

The CMS Claiming Guide establishes documentation requirements for SDAC costs allocated based on RMTS: "documentation for administrative activities must clearly demonstrate that the activities/services directly support the administration of the Medicaid program. . . . The burden of proof and validation of time study sample results remains the responsibility of the states. To meet this requirement, some states currently include space on time study forms for a brief narrative description of the Medicaid activity, function, or task being performed" (CMS Claiming Guide § V.A.).

In our previous reviews of the use of RMTS to claim SBHS costs in three State agencies, we selected a statistical sample of random moments to estimate the number of unsupported responses provided by participants completing the RMTS surveys. Specifically, the Kansas, Massachusetts, and Texas State agencies could not provide medical record documentation (such as nurse logs or Medicaid service logs) to support approximately 23 percent, 61 percent, and 94 percent of participants' responses, respectively, for the random moments we evaluated.

The selected participants' completed timestudy forms, with which the participants attested to the activities that they were performing during the selected random moment, met the CMS requirements for Medicaid reimbursement. Therefore, we did not question SBHS costs associated with the random moments that were not supported by medical record documentation. Those reviews noted, though, that in significant percentages of the sampled random moments, the three State agencies could not provide sufficiently detailed documentation to support and permit verification that direct medical services (that were reimbursable by Medicaid and for which the State agencies had claimed SBHS costs) had actually been performed. For example, one of the sampled timestudy forms that was completed by a registered nurse included "delivering medication" as the narrative description. The relevant school district did not have documentation in the associated Medicaid service log or the nurse's log to support this direct medical service activity.

Verifying the performance of direct medical services necessitates creating and retaining medical record documentation. CMS has distributed documentation requirements in the CMS Claiming Guide that support SDAC costs claimed, but CMS has not distributed any corresponding guidance about documentation requirements related to retaining medical records that support SBHS costs claimed. Consequently, the three State agencies did not retain some medical record documentation to support the SBHS costs that they claimed because nothing in the CMS Technical Guide required them to do so.

CMS Central Office officials informed us during the current audit that they believed that participating school districts would file interim fee-for-service-based claims.[19] The Technical Guide requires that fee-for-service claims be supported by medical record documentation. However, these officials added that many contractors are informing school districts that interim claims are not necessary because the final reimbursement derives from total costs allocated based on RMTS.

POTENTIALLY UNALLOWABLE ADMINISTRATIVE AND HEALTH SERVICES COSTS AS A RESULT OF SAMPLE UNIVERSES THAT WERE OR MAY HAVE BEEN INACCURATE

Federal regulations state that sampling methods used to allocate salaries to Federal awards must meet acceptable statistical sampling standards, including (1) the sampling universe must include all of the employees whose salaries and wages are to be allocated on the basis of the sample results, (2) the entire time period involved must be covered by the sample, and (3) the results must be statistically valid and be applied to the period being sampled (2 CFR part 225, App. B, §§ 8.h.6.a(i), (ii), and (iii)).

Federal regulations also state that costs must "[b]e adequately documented" (2 CFR part 225, App. A, § (C)(1)(j)).

Regarding statistical validity, the CMS Claiming Guide states that the random moment sample "must reflect all of the time and activities (whether allowable or unallowable under Medicaid) performed by employees participating in the Medicaid administrative claiming program" (CMS Claiming Guide § IV.B.2.). Furthermore, the validity and reliability of the sampling methodology must be acceptable to CMS, and all nonresponses should be coded as non-Medicaid activities: "Many schools oversample and/or factor in a non-response rate in their time study methodology" (CMS Claiming Guide § V.B.2.).

In two State agencies (in Arizona and New Jersey), we could not determine whether a combined total of $325,062,349 was allowable. Both of the State agencies' RMTS methodologies used sample universes that were or may have been inaccurate to the point that we could not determine which portions of the claimed costs were allowable. In addition, the New Jersey State agency based its payment rates for SBHS on unsupported RMTS. We therefore set aside the combined total of $325,062,349 and recommended that the State agencies work with CMS to determine the allowable amounts.

In Arizona, we found that the State agency's RMTS methodology did not meet acceptable statistical sampling standards. Specifically, the sample universes from which the State agency selected the sample moments were incomplete or incorrect. For example, when selecting random moments for the sample, the Arizona State agency's contractor used a standardized work schedule that did not account for employees who had different work schedules. We were unable to determine which portion of the Arizona State agency's claim for Federal

[19] See also the discussion in "Cost Settlement" earlier in this report.

reimbursement would have been allowable if complete or correct universes had been used to calculate the state-wide Medicaid percentages. We therefore set aside costs totaling $18,828,972 for the Arizona State agency to work with CMS to determine the allowable amount.

In New Jersey, the State agency's contractor discarded most of the sample moments in the RMTS it used to develop the payment rates for SBHS. When the contractor removed sample moments, it could have created a biased sample that produced inaccurate results. Changes to the number of sample moments greatly changed the results of the RMTS. Because of this error, New Jersey claimed $306,233,377 in Federal reimbursement calculated using unallowable costs that we could not quantify because the State agency based its rates on unsupported RMTS. We therefore set aside that amount for the State agency to work with CMS to determine the allowable amount.

The Arizona and New Jersey State agencies did not have adequate controls to ensure that they maintained all required documentation to support their RMTS methodologies and to ensure that those methodologies complied with Federal requirements and guidance. For example, the Arizona State agency's contractor was required to maintain all required documentation, but the State agency did not exercise adequate oversight to ensure that the contractor did so.

RECOMMENDATIONS

We recommend that CMS:

- instruct all State agencies to review, revise, develop, and implement policies and procedures to monitor the SDAC and SBHS programs in their States and thereby ensure that:

    - claimed SDAC and SBHS costs comply with Federal requirements with respect to reasonableness, allowability, and supportability;

    - State agencies obtain DCA approval for their cost allocation plans before submitting their RMTS methodologies to CMS for approval;

    - RMTS methodologies comply with Federal requirements for statistical validity, reliability, and allowability and are always submitted to CMS for approval before being implemented;

    - RMTS responses are properly coded and include documentation adequate to support activities performed that were reimbursable by Medicaid and to permit reproduction and verification of sample results;

    - random moment samples generated through RMTS reflect all of the time and activities performed by employees participating in SDAC and SBHS and do not

reflect times when schools are not in session or times that are outside employee work hours;

- annual cost settlements of school districts limit the districts' calculations of allowable Medicaid costs to Medicaid direct medical service costs and take interim payments to the school districts into account, in accordance with Federal requirements; and

- either develop and distribute formal guidance for the use of RMTS to allocate SBHS costs, which includes guidance directing State agencies to maintain and retain adequate medical record documentation to validate the RMTS responses and support the SBHS costs claimed, or consider no longer permitting States to use RMTS methodologies to allocate and claim SBHS costs.

CMS COMMENTS

In written comments on our draft report, CMS concurred with both of our recommendations and described corrective actions that it said it would take, to include issuing updated guidance to State agencies regarding (1) policies and procedures to monitor SDAC and SBHS programs and (2) the requirement to maintain and retain adequate medical record documentation to validate RMTS responses and support SBHS costs claimed. CMS's comments appear in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We previously reviewed selected State agencies to determine whether the RMTS used in those States to allocate SDAC and SBHS costs complied with Federal requirements and were an effective way of allocating costs; we are summarizing the results of those reviews for this report. We conducted these reviews at 10 State agencies. The audit periods of these previous reviews ranged from July 2003 through June 2015.

Our previous reviews encompassed a total of $1,279,990,246 in SDAC and SBHS costs that these State agencies allocated to Medicaid. All 10 State agencies used RMTS to determine the portions of SDAC costs, SBHS costs, or both that they allocated to allowable Medicaid activities and for which they claimed Federal reimbursement.

In our previous reviews of the use of RMTS to claim SBHS in Kansas, Massachusetts, and Texas, we selected a statistical sample of random moments to estimate the number of unsupported responses provided by participants completing the RMTS surveys.

In this report, we summarize the results of our 11 previous reviews (footnote 1) and make recommendations to CMS, the cognizant HHS operating division. To do so, we analyzed the findings and recommendations from those previous reviews, which evaluated the use of RMTS to allocate and claim SDAC and SBHS costs.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements and CMS guidance;
- analyzed the findings and recommendations from 11 previous reviews of the use of RMTS to allocate and claim SDAC and SBHS costs (Appendix B);
- reviewed the methodologies and audit steps conveyed in our previous audit reports, which included:
    - reviewing State agencies' policies and procedures for using RMTS to allocate and claim SDAC and SBHS costs,
    - interviewing CMS officials to obtain an understanding of CMS guidance regarding the RMTS methodology,
    - reconciling State agencies' CMS-64 reports to their accounting records,

- interviewing State agency and contractor officials to obtain an understanding of their policies and procedures for the use of RMTS in identifying Medicaid and non-Medicaid activities,

- analyzing sample results listing RMTS responses to verify that all RMTS responses were completed and returned,

- reviewing completed RMTS responses to determine whether the Medicaid activities performed were SDAC or SBHS activities,

- determining whether the State agencies' sampling methodology complied with Federal laws and regulations,

- evaluating available documentation to determine whether it was adequate to support costs claimed and to permit the reproduction and verification of RMTS sample results,

- used statistical sampling to estimate the numbers of unsupported responses provided by participants completing RMTS surveys in Kansas, Massachusetts, and Texas that the State agencies then used to claim SBHS costs,

- recalculating SDAC and SBHS costs in cases in which we identified errors in calculations,

- determining the financial effects of the errors identified in the reviews, and

- reviewing the cost settlement processes at State agencies, to include policies and procedures governing the review of interim payments made to school districts;

- summarized the results of our analysis, including totaling the costs that our previous reviews both questioned and set aside for resolution by the appropriate State agencies and CMS; and

- provided the results of this review to CMS officials on April 11, 2018.

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: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
New Jersey Claimed Hundreds of Millions in Unallowable or Unsupported Medicaid School-Based Reimbursement	A-02-15-01010	11/27/17
Texas Improperly Received Medicaid Reimbursement for School-Based Health Services	A-06-14-00002	8/14/17
Mississippi Claimed Millions in Unallowable School-Based Medicaid Administrative Costs	A-04-15-00103	3/15/17
North Carolina Claimed Millions in Unallowable School-Based Medicaid Administrative Costs	A-04-15-00101	10/6/16
Alabama Claimed Millions in Unallowable School-Based Medicaid Administrative Costs	A-04-13-00094	7/13/16
Massachusetts Generally Complied with Medicaid Requirements When Claiming Reimbursement for School-Based Health Services	A-01-14-00003	9/30/15
Kansas Improperly Received Medicaid Reimbursement for School-Based Health Services	A-07-13-04207	8/6/14
Arizona Improperly Claimed Federal Reimbursement for Medicaid School-Based Administrative Costs	A-09-11-02020	1/22/13
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
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 Missouri Medicaid Payments for the School District Administrative Claiming Program for Federal Fiscal Years 2004 Through 2006	A-07-08-03107	3/18/10

APPENDIX C: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: NOV 16 2018

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Vulnerabilities Exist in State Agencies' Use of Random Moment Sampling To Allocate Costs for Medicaid School-Based Administrative and Health Services Expenditures (A-07-18-04107)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS takes seriously its responsibilities to protect taxpayer funds by conducting thorough oversight of Medicaid expenditures claimed by states.

Because Medicaid is jointly funded by states and the Federal Government, and is administered by states within Federal guidelines, both CMS and states have key roles as stewards of the program, and work together closely to carry out these responsibilities. As such, CMS conducts multiple activities to oversee Medicaid expenditures and verify that Federal financial participation matches states' actual expenditures. For example, on a quarterly basis, states must submit to CMS their Medicaid expenditures and include supporting documentation such as invoices, cost reports, and eligibility records. CMS then reviews these expenditures and works with states to resolve any questionable expenditures to ensure that the appropriate amounts are spent and that higher matching rates are reported correctly.

As OIG notes, current statute allows Medicaid payment for health-related services that are specified in each child's individualized education plan, generally without the child having to leave school. State Medicaid agencies may be reimbursed for the administrative activities that support school-based health services for children eligible for Medicaid. In addition, school-based health services costs are covered under Medicaid as long as the services are listed in section 1905(a) of the Act and are medically necessary, all other Federal and state regulations are followed, and the services are included in the Medicaid state plan or available under the Early and Periodic Screening, Diagnosis and Treatment benefit. States may develop a random moment sampling allocation methodology to determine and allocate school-based administrative and health costs, however, the methodology must be approved by CMS and be adequately supported by the necessary documentation as outlined in statute[1].

CMS has issued guidance to states on how to properly claim reimbursement for school-based activities. For example, in the Medicaid School-Based Administrative Claiming Guide issued in 2003, CMS requires that documentation be retained to support time studies used to allocate costs,

[1] 42 CFR 433.32(a)

and also clarifies the random moment sampling requirements as outlined at 2 Code of Federal Regulations (CFR) Part 200.
In addition, CMS reviews and approves time studies used to allocate administrative costs and direct service cost to Medicaid to assure that they only allocate allowed cost; comport with the state's approved public assistance cost allocation plans for administrative costs and the Medicaid state plan for direct service costs; are statistically valid; appropriately capture all time allocated to billable and non-billable activities; and account for no more than 100 percent of staff time. Through the state plan amendment review process and the public assistance cost allocation plan review process, CMS provides extensive technical assistance to help assure states adopt a method of cost allocation consistent with statute. CMS also routinely shares an approved cost reporting template and provides model state plan language and time study examples that comprehensively describes the school-based services methodology.

CMS provides oversight by performing financial management review and taking action through the disallowance process where costs are not claimed correctly. The process of determining whether to issue a deferral or disallowance consists of significant legal, financial, and policy analyses to ensure that CMS' final determination is consistent with Medicaid statute and regulations.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that CMS instruct all State agencies to review, revise, develop, and implement policies and procedures to monitor the school district administrative claiming and school-based health services programs in their States and thereby ensure that:

- Claimed school district administrative claiming and school-based health services costs comply with Federal requirements with respect to reasonableness, allowability, and supportability;
- State agencies obtain division of cost allocation approval for their cost allocation plans before submitting their random moment time studies methodologies to CMS for approval;
- Random moment time studies' methodologies comply with Federal requirements for statistical validity, reliability, and allowability and are always submitted to CMS for approval before being implemented;
- Random moment time studies responses are properly coded and include documentation adequate to support activities performed that were reimbursable by Medicaid and to permit reproduction and verification of sample results;
- Random moment samples generated through random moment time studies reflect all of the time and activities performed by employees participating in school district administrative claiming and school-based health services and do not reflect times when schools are not in session or times that are outside employee work hours;
- Annual cost settlements of school districts limit the districts' calculations of allowable Medicaid costs to Medicaid direct medical service costs and take interim payments to the school districts into account, in accordance with Federal requirements.

CMS Response

CMS concurs with OIG's recommendation. CMS will update the 2003 guidance to instruct states to review, revise, develop, and implement policies and procedures to monitor school district administrative claiming and school-based health services programs in their States.

OIG Recommendation

The OIG recommends that CMS either develop and distribute formal guidance for the use of random moment time studies to allocate school-based health services costs, which includes guidance directing State agencies to maintain and retain adequate medical record documentation to validate the random moment time studies responses and support the school-based health services costs claimed, or consider no longer permitting States to use random moment time studies' methodologies to allocate and claim school-based health services costs.

CMS Response

CMS concurs with OIG's recommendation. CMS will update the 2003 guidance to remind states of their obligations regarding maintaining and retaining adequate medical record documentation to validate the random moment time studies responses and support the school-based health services costs claimed.