

**JUL 22 2003**

TO: Neil Donovan
Director, Audit Liaison Staff
Centers for Medicare and Medicaid Services

FROM: Dennis J. Duquette *D. Duquette*
Deputy Inspector General
for Audit Services

SUBJECT: Review of Washington State's Medical Assistance Costs Claimed for School-Based Health Services Provided in State Fiscal Year 2000 (A-10-02-00008)

As part of the Office of Inspector General's self-initiated audit work, we are alerting you to the issuance within 5 business days of our final report entitled, "Review of Washington State's Medical Assistance Costs Claimed for School-Based Health Services Provided in State Fiscal Year 2000." A copy of the report is attached. We suggest you share this report with the Centers for Medicare and Medicaid Services (CMS) components involved in program integrity, provider issues, and State Medicaid agency oversight, particularly the Center for Medicaid and State Operations. This report is one in a series of reports in our multi-state initiative focusing on direct costs claimed for Medicaid school-based health services.

The objective of our review was to determine whether the medical assistance costs claimed by Washington State (the State) for the school-based health services program (the program) were allowable and adequately supported.

We found the State did not adequately implement and monitor the program to ensure medical assistance expenditures were allowable and adequately supported. As a result, we determined the State submitted claims for unallowable costs as follows:

\$3,818,252 for services that were not covered under Medicaid or properly documented,

\$573,728 for billing fees that were not reimbursable, and

\$1 5,819 for services provided to children that were not Medicaid eligible.

Based on a projection of the statewide statistical sample, we estimated the errors to be at least \$4,407,799 (\$2,279,752 Federal share).

Our review also showed the State's service reimbursement rates for the program were not established in accordance with Federal Medicaid regulations. The rates included transportation costs for all special education individuals without regard to whether transportation was medically

necessary and prescribed in the beneficiary's Individualized Education Plan. Additionally, the reimbursement rates for group therapies were not based on valid statistical data. The overall effect of the incorrect rates on claims for Federal financial participation (FFP) could not be determined without the State first recalculating its reimbursement rates for State fiscal year (SFY) 2000.

We recommended the State:

1. refund \$2,279,752 to the Federal Government;
2. develop and implement a system to ensure costs claimed for FFP are allowable and adequately supported;
3. review paid claims in subsequent periods to determine whether the claims included unallowable billing fees and/or services provided to individuals in non-Medicaid programs, and refund the Federal share of inappropriately claimed amounts;
4. ensure service reimbursement rates for the program are developed in accordance with Federal regulations; and
5. recalculate the program's service reimbursement rates for SFY 2000 and subsequent periods, excluding transportation costs and using valid statistical data, and refund the Federal share for inappropriately claimed amounts.

In written comments to our draft report, State officials provided only a limited response to our finding and recommendations regarding services that were not covered under Medicaid or properly documented. They stated that they needed access to our working papers and additional time to complete their response. For the remaining findings, State officials agreed in part with some of our findings, but disagreed with our recommendations. Additionally, the State commented on items in the OTHER MATTERS section of the report.

We provided State officials information supporting our findings and recommendations. We will work with CMS and the State to provide the information necessary to resolve the findings and recommendations.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Audits, at (410) 786-7104 or Lori Ahlstrand, Regional Inspector General for Audit Services, Region IX, at (415) 437-8360.

Attachment



JUL 25 2003

Region IX
Office of Audit Services
50 United Nations Plaza, Rm.171
San Francisco, CA 94102
(415) 437-8360 FAX (415) 437-8372

Report Number: A-10-02-00008

Larry Laux, Deputy Assistant Secretary
Washington State Department of Social and Health Services
Medical Assistance Administration
805 Plum Street, Building 1
Post Office Box 45530
Olympia, Washington 98504-5530

Dear Mr. Laux:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Review of Washington State's Medical Assistance Costs Claimed for School-Based Health Services Provided in State Fiscal Year 2000." A copy of this report will be forwarded to the action official noted below for her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination. Should you have any questions, please direct them to the HHS action official.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the department chooses to exercise. (See 45 CFR part 5)

To facilitate identification, please refer to Report Number A-10-02-00008 in all correspondence relating to this report.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures – as stated

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Direct Reply To Action Official:

Linda Ruiz, Regional Administrator
Centers for Medicare and Medicaid Services, Region X
Department of Health and Human Services
2201 6th Avenue, M/S RX-40
Seattle, Washington 98121

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF WASHINGTON STATE'S
MEDICAL ASSISTANCE COSTS
CLAIMED FOR
SCHOOL-BASED HEALTH SERVICES
PROVIDED IN
STATE FISCAL YEAR 2000**



**JULY 2003
A-10-02-00008**

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.





JUL 25 2003

Region IX
Office of Audit Services
50 United Nations Plaza, Rm. 171
San Francisco, CA 94102
(415) 437-8360 FAX (415) 437-8372

Report Number: A-10-02-00008

Larry Laux, Deputy Assistant Secretary
Washington State Department of Social and Health Services
Medical Assistance Administration
805 Plum Street, Building 1
Post Office Box 45530
Olympia, Washington 98504-5530

Dear Mr. Laux:

This final report provides the results of our review of Washington State's (the State) medical assistance costs claimed under the school-based health services program (the program) provided in State fiscal year (SFY) 2000.

EXECUTIVE SUMMARY

BACKGROUND

Under the Medicaid program, States were allowed to claim Federal financial participation (FFP) for medical assistance costs incurred for school-based health services. Costs were considered allowable if the services were (1) provided to Medicaid-eligible children, (2) medically necessary, (3) delivered and claimed in accordance with all other Federal and State regulations, and (4) included in the State plan. The State claimed approximately \$19.4 million as program costs for services provided in SFY 2000.

OBJECTIVE

The objective of our review was to determine whether the program's medical assistance costs claimed for FFP in SFY 2000 were allowable and adequately supported.

SUMMARY OF FINDINGS

Our review showed the State did not adequately implement and monitor the program to ensure its claims for medical assistance costs were allowable and properly supported. As a result, the State submitted claims for \$4,407,799 (\$2,279,752 FFP) of unallowable costs as follows:

- \$3,818,252¹ for services that were not covered under Medicaid or properly documented,
- \$573,728 for billing fees that were not reimbursable, and
- \$15,819 for services provided to children that were not Medicaid eligible.

Our review also showed the State's service reimbursement rates for the program were not established in accordance with Federal Medicaid regulations. The rates included transportation costs for all special education individuals without regard to whether transportation was medically necessary and prescribed in the beneficiary's Individualized Education Plan (IEP). Additionally, the reimbursement rates for group therapies were not based on valid statistical data. The overall effect of the incorrect rates on claims for FFP could not be determined without the State first recalculating its reimbursement rates for SFY 2000.

RECOMMENDATIONS

We recommended the State:

1. refund \$2,279,752 to the Federal Government;
2. develop and implement a system to ensure costs claimed for FFP are allowable and adequately supported;
3. review paid claims in subsequent periods to determine whether the claims included unallowable billing fees and/or services provided to individuals in non-Medicaid programs, and refund the Federal share of inappropriately claimed amounts;
4. ensure service reimbursement rates for the program are developed in accordance with Federal regulations; and
5. recalculate the program's service reimbursement rates for SFY 2000 and subsequent periods, excluding transportation costs and using valid statistical data, and refund the Federal share for inappropriately claimed amounts.

¹ Based on a statistical sample, we are 95 percent confident that the State claimed at least \$3,818,252 for services that were not reimbursable under the program.

STATE’S COMMENTS

In written comments to our draft report, State officials provided only a limited response to our finding and recommendations regarding services that were not covered under Medicaid or properly documented. They stated that they needed access to our working papers and additional time to complete their response. For the remaining findings, State officials agreed in part with some of our findings, but disagreed with our recommendations. Additionally, the State commented on items in the OTHER MATTERS section of the report.

OIG’S RESPONSE

We provided State officials information supporting our findings and recommendations. We will work with the Centers for Medicare and Medicaid Services (CMS) and the State to provide the additional information necessary to resolve the findings and recommendations. The OTHER MATTERS section of the report was provided for informational purposes only and, therefore, we did not respond to the State’s comments.

The State’s comments and the Office of Inspector General’s (OIG) responses are summarized at the conclusion of each individual finding in the FINDINGS AND RECOMMENDATIONS section. The complete text of the State’s response is included in Appendix D to this report.

OTHER MATTERS

During our review, we identified three additional areas for further consideration: (1) attendance records were not always available to document that students attended school on the day the service was provided, (2) the program did not have an approved indirect cost rate, and (3) the State’s program guidance did not appear to be followed by some local school districts.

INTRODUCTION

BACKGROUND

Medicaid Program

In 1965, Congress established the Medicaid program under title XIX of the Social Security Act (Act) to pay for medical assistance costs for persons with limited income and resources. Each State Medicaid program is administered in accordance with a State plan approved by CMS to ensure compliance with Federal requirements. The Federal Government and States share in the cost of the Medicaid program.

Medicaid Coverage of School-Based Health Services

Section 1903(c) of the Act was amended in 1988 to allow Medicaid coverage of health-related services provided to children under the Individuals with Disabilities Education Act (IDEA). Part B of IDEA allowed disabled children to receive special education and related services, such as physical therapy, occupational therapy, speech pathology, and psychological services, when they were in the child's IEP. CMS authorized Medicaid reimbursement for some or all of the costs of health-related services provided under IDEA when the services were (1) provided to Medicaid-eligible children, (2) medically necessary, (3) delivered and claimed in accordance with all other Federal and State regulations, and (4) included in the State plan.

Program Implementation

The State's Department of Social and Health Services (DSHS) and the Office of Superintendent of Public Instruction (OSPI) jointly administered the program. The primary responsibilities of DSHS were to verify beneficiary eligibility and submit claims for FFP, while OSPI was mandated by the State's legislature to coordinate and oversee all other aspects of the program.

School districts were required to bill DSHS for Medicaid-reimbursable services provided under the program. The services were billed using fee-for-service rates. DSHS, in turn, used these billings to claim FFP. Additionally, school districts were required to authorize OSPI to accept and disburse the Federal matching funds obtained under the program. Upon receipt of the Federal match, OSPI distributed a portion of it to school districts and deposited the remainder in the State's general fund. State legislation mandated that amounts deposited in the general fund be expended for future special education costs. In SFY 2000, school districts received less than \$10 for every \$100 in expenditures claimed under the program.

Program Guidance

CMS issued "Medicaid and School Health: A Technical Assistance Guide" (CMS Technical Guide), dated August 1997, to provide information and technical assistance regarding the specific requirements associated with the implementation of a school-based health services program and Medicaid reimbursement of program services. In addition, the State developed and issued two guides that detailed the responsibilities of each school district to be reimbursed for expenditures incurred under the program. The two guides were "School Medical Services For Special Education Students Billing Instructions," dated February 1997, and "Special Education Medicaid Reimbursement Program Procedures Manual For Washington," dated February 2000.

OBJECTIVE, SCOPE, AND METHODOLOGY

We conducted our review in accordance with generally accepted government auditing standards. The objective of our review was to determine whether the program's medical assistance costs claimed for FFP in SFY 2000 were allowable and adequately supported. Our review of internal

controls was limited to those considered necessary to achieve our objective, and included obtaining an understanding of the State's claims processing and payment systems for the Medicaid program.

For services provided by 271 local school districts in SFY 2000, the State claimed expenditures of approximately \$19.4 million. Through the use of computer applications, we identified \$573,728 for billing fees and \$15,819 for non-Medicaid program services. Because billing fees were not considered a medical service, and the children receiving services under other programs were not eligible for Medicaid, we reviewed these costs separately and in their entirety.

To review the remaining \$18.8 million in expenditures, we sorted the services claimed into beneficiary service months. A beneficiary service month contained all services that were provided to a beneficiary during a month. We randomly selected a sample of 100 months for review from the 98,333 total beneficiary service months. Services claimed within the 100 months totaled \$20,716. For each service claimed, we determined whether the services were properly authorized and documented. This included the determination of whether services were provided (1) by a qualified individual, (2) to a Medicaid-eligible beneficiary, and (3) on a day in which the student attended school.

The Office of Audit Services' Statistical Software Variable Appraisal program was used to project the amount of unallowable program expenditures found in our sample to the total population of 98,333 beneficiary service months. Appendix A presents additional details of our sampling methodology.

We conducted interviews with State officials to determine their roles in administering the program. We also reviewed the State's policies and procedures for monitoring the overall program, processing monthly claims from the school districts, and submitting claims for FFP. We met with school district officials to discuss their claims procedures and reviewed supporting documentation for claims of program expenditures.

Our fieldwork was completed in February 2003, and included site visits to the DSHS and OSPI administrative offices in Olympia, Washington, and to 58 school districts located throughout the State.

FINDINGS AND RECOMMENDATIONS

The State did not adequately implement and monitor the program to ensure its claims for FFP included only allowable expenditures and were adequately supported. As a result, the State claimed unallowable costs totaling \$4,407,799 (\$2,279,752 FFP) for (1) services that were not covered or properly documented, (2) billing fees that were unallowable under the program, and

(3) services provided to children that were not eligible for Medicaid. We also found that service reimbursement rates were developed using unallowable costs and group therapy rates were not based on accurate or valid data.

The State’s guidance and monitoring efforts were limited in ensuring compliance with Medicaid requirements. Additionally, during our review period, the State suspended its monitoring activities to revise its monitoring protocol. The State placed reliance upon its claims processing system edits and the school districts’ knowledge of program requirements to ensure claims were submitted in accordance with Federal Medicaid regulations. However, guidance provided by the State to the school districts did not properly address all Federal Medicaid requirements.

The State’s comments and the OIG’s responses are summarized at the conclusion of each individual finding in the FINDINGS AND RECOMMENDATIONS section. The complete text of the State’s response is included in Appendix D to this report.

COSTS CLAIMED

The State claimed \$19.4 million as program costs for services provided in SFY 2000. Our review showed that at least \$4,407,799 (\$2,279,752 FFP) was unallowable as follows:

Unallowable Cost	Total	FFP
Program Services	\$ 3,818,252	\$ 1,974,009
Billing Fees	573,728	297,152
Services to Ineligible Children	15,819	8,591
Totals	\$ 4,407,799	\$ 2,279,752

Program Services

Based on the results of our statistical sample review, we estimated the State claimed at least \$3,818,252 (\$1,974,009 FFP) of unallowable program service costs in SFY 2000. The unallowable costs included claims for services that were (1) either not covered by Medicaid or authorized for Medicaid reimbursement, (2) referred or provided by unqualified providers, and (3) not properly supported. Overall, 39² of the 100 sample items contained unallowable costs totaling \$6,672.

- **Non-covered/Unauthorized Services.** For 16 sample items, we found the State incorrectly claimed \$4,206 for services (1) not prescribed or documented in an

² One of the sample items contained errors in both the Unqualified Providers and Unsupported Services categories.

IEP, (2) expressly prohibited³ for Medicaid billing, (3) considered educational in nature, and (4) provided free to the community. Federal matching funds were only allowable for medically necessary services prescribed in an IEP.

- **Unqualified Providers.** For 14 sample items, we found the State incorrectly claimed \$1,623 for services that were either referred by or provided by unqualified Speech Language Pathologists, Physical Therapists, or Occupational Therapists. These providers did not meet the specific qualifications required by Federal regulations.
- **Unsupported Services.** For 10 sample items, we found the State incorrectly claimed \$843 for services that (1) occurred on dates when school was not in session or when the student was absent, (2) exceeded the number of services documented in service logs, and (3) were not supported by service logs or by medical evaluations. Federal regulations required that relevant documentation supporting the services claimed be retained.

The details of our sampling methodology and projection of unallowable costs are included in Appendices A and B of this report. The regulation containing provider qualifications is included in Appendix C.

State's Comments

State officials provided only a limited response to our finding and recommendations on program services that were not (1) covered or authorized or (2) properly supported. They stated that they needed access to our working papers and additional time to complete their response.

In addition, State officials did not concur with the finding on unqualified providers, citing insufficient guidance on specific qualification criteria. The State responded that it applied its own interpretation of “educational equivalency” for Speech Language Pathologists due to the lack of guidance. The State interpretation was that an individual with only the education portion of the qualification could perform covered services without a review and sign off from an individual with a Certification of Clinical Competence (CCC). The State did not comment on the unqualified physical or occupational therapists included in the finding.

OIG's Response

We provided State officials information supporting our findings and recommendations. We will provide additional information needed by CMS or the State to resolve the findings and recommendations on program services that were not (1) covered or authorized or (2) properly supported.

³ The parent explicitly rejected the billing to Medicaid.

OIG does not agree with the State’s interpretation of “educational equivalency.” The criteria stated that an individual’s education was to be combined with qualified work experience. In addition, the first year of work experience was to be supervised by an individual holding a valid CCC or equivalent. The State did not ensure the providers in question met these requirements.

Billing Fees

The State claimed \$573,728 (\$297,152 FFP) for unallowable billing fees. School districts or billing agent(s) were reimbursed for costs associated with billing for services under the program. The CMS Technical Guide specifically stated that billing fees were not reimbursable under the program as a direct service.

State’s Comments

The State did not concur, stating these costs were allowable administrative costs that could be claimed either by adding the costs into the individual service reimbursement rates or through the administrative match program. The State asserted the Federal matching funds claimed would be similar under the two methods. Additionally, the State responded that the proper remedy for the finding would be to reimburse the billing agent through a correct method in the future.

OIG’s Response

The CMS Technical Guide specifically stated that billing fees were not reimbursable as a direct service. Thus, these costs were not allowable as claimed. The scope of this review was limited to direct services billed under the program and, therefore, we cannot express an opinion as to (1) the allowability of these fees as an administrative cost, or (2) the differences in Federal matching funds using an alternative billing method.

Services Provided to Ineligible Children

The State claimed \$15,819 (\$8,591 FFP) for services provided to children that were not eligible. These individuals were enrolled in the (1) Children’s Health Insurance Plan and (2) Children’s Health program. The children were not eligible for Medicaid due to income thresholds or citizenship status. Medicaid eligibility was required for services to be claimed under the program.

During our review period, the State did not have procedures in place to ensure these costs were not claimed under the program. State officials told us an edit would be entered into the claims processing system to identify and reject Medicaid payment for these unallowable services. The edit was to become effective during August 2002. We did not test whether the edit was properly implemented.

State's Comments

The State concurred with this finding. However, the State commented there should be no fiscal finding since the claims processing system was modified during audit fieldwork to reject payments for such unallowable services.

OIG's Response

We acknowledge that the State modified the claims processing system to identify future unallowable services. We were provided with a record of the successful testing of a system edit that was put into place. The unallowable FFP claimed for ineligible children related to periods prior to implementation of the edit. Therefore, the unallowable FFP should be refunded.

SERVICE REIMBURSEMENT RATES

The State did not develop its service reimbursement rates in accordance with Federal regulations. As a result, the rates were overstated. The rates included costs for transportation that was not medically necessary. Additionally, group therapy rates were not based on valid statistical data.

- **Transportation Costs.** The State included transportation costs for all special education individuals in its service reimbursement rates. The inclusion of transportation costs in the rates provided no assurance that transportation was medically necessary for all special education individuals. Medicaid reimbursement was allowable for transportation only when the child received a Medicaid-covered service, and both the service and the transportation were identified in the beneficiary's IEP.

Transportation costs were included in the rates from SFY 1996 to SFY 2000. Officials from CMS also identified this issue during a December 1999 site visit, at which time it was required that the State no longer include these costs in the rates.

- **Group Therapy Rates.** The State calculated its group therapy reimbursement rates at one-third of the corresponding individual therapy rates. According to the CMS Technical Guide, reimbursement rates were to be (1) justified with statistically accurate and valid data and (2) limited to no more than the actual costs of providing the service. The CMS Technical Guide suggested the use of historical cost information (e.g., time studies, interviews, and cost reports) to support the establishment of new rates.

Because the State did not use historical cost information to establish the group rates and was unable to provide justification for the method used, we determined the group rates were not based on accurate or valid data. Further, the State's use

of a percentage of individual therapy rates as the basis for the group rate provided no assurance that rates were limited to no more than providers' actual costs.

The overall effect of the incorrect rates could not be determined without the State first recalculating its reimbursement rates for SFY 2000.

State's Comments

The State concurred that unallowable transportation costs were included in the rates, as the issue was identified by CMS in a 1999 site visit. However, the State responded that a refund of amounts claimed should not be required by OIG because CMS did not require it at the time of the site visit. The State also commented that the allowability of transportation costs was not clearly defined at the Federal level prior to the CMS site visit. When the error was identified by CMS, the State took corrective action as soon as possible, which was prior to the OIG review.

The State did not concur with the finding on group therapy rates, stating it did not use historical cost information because it was not available. The State also commented that data would be collected to validate the current methodology.

OIG's Response

We acknowledge that CMS did not request a refund of amounts claimed for unallowable transportation costs in 1999. However, the inclusion of transportation costs for all special education students without consideration of medical necessity or allowability was not in accordance with Federal regulations. The CMS Technical Guide, available prior to the CMS site visit, clearly stated the criteria for transportation costs to be reimbursable under the program. Further, although the transportation component may have been taken out of the reimbursement rates subsequent to CMS's review, it was included in the rates used to claim FFP during our review period. Therefore, we believe it is appropriate to question FFP amounts associated with any unallowable costs included in the reimbursement rates.

Although the State did not have historical data to establish group therapy rates, the CMS Technical Guide provided specific guidance on the establishment of new rates, including the use of estimates or interim rates. Further, even though the State did not concur with the finding, it recognized the need to determine whether the current methodology was valid and properly supported.

RECOMMENDATIONS

We recommended the State:

1. refund \$2,279,752 to the Federal Government;
2. develop and implement a system to ensure costs claimed for FFP are allowable and adequately supported;
3. review paid claims in subsequent periods to determine whether claims included unallowable billing fees and/or services provided to individuals in non-Medicaid programs, and refund the Federal share of inappropriately claimed amounts;
4. ensure service reimbursement rates for the program are developed in accordance with Federal regulations; and
5. recalculate the program's service reimbursement rates for SFY 2000 and subsequent periods, excluding transportation costs and using valid statistical data, and refund the Federal share for inappropriately claimed amounts.

OTHER MATTERS

ATTENDANCE RECORDS

The school districts were unable to provide attendance records for 11 of the 100 sample items. Attendance records for our review period were either purged, not located, or not obtained from preschool or Head Start programs. Since these records were unavailable, student attendance on the day of service could not be verified.

Currently, there are no requirements that school districts retain attendance records of all students for whom they bill Medicaid services. However, it would be helpful if attendance records were required as relevant supporting documentation to verify whether students were in attendance on the dates services were documented as having been provided.

INDIRECT COST RATES

In contrast to the State's other programs for disabled children, the program did not have an indirect cost rate approved by the cognizant agency. To provide assurance that indirect costs are reasonable and properly allocated, the State should consider obtaining and using an approved indirect cost rate for the program.

LOCAL GUIDANCE

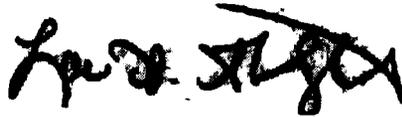
The State established procedures for school districts to obtain parental consent to (1) verify an individual's Medicaid eligibility and (2) submit program expenditures for Medicaid reimbursement. Several school districts in our review could not document parental consent for these approvals. In addition, school districts were to submit the names and qualifications of their service providers to the State before reimbursement would be made for the services provided. During our review, we found that school districts submitted service provider information. However, it appeared that the State did not properly verify or validate the information as we found it to be incomplete, inaccurate, and/or outdated.

* * * * *

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR, part 5.)

To facilitate identification, please refer to Report Number A-10-02-00008 in all correspondence relating to this report.

Sincerely,



Lori A. Ahlstrand
Regional Inspector General
for Audit Services

APPENDICES

Sampling Methodology

Review Objective

Our objective was to determine whether the program costs claimed by the State were allowable and adequately supported.

Population

The sampling population was comprised of beneficiary service months for Medicaid beneficiaries who received program services at 271 local school district service providers. The population consisted of 98,333 beneficiary service months within SFY 2000 (July 1, 1999 – June 30, 2000) for which payments for medical services to Medicaid eligible children, totaling \$18.8 million, were recorded in the Medicaid Management Information System as of May 10, 2002. A beneficiary service month is defined as a month in which a service was provided to a Medicaid beneficiary, regardless of the number of services actually provided in that month.

Sample Unit

The sample unit was a beneficiary service month for which program services were provided during our review period.

Sample Design

A simple random sample design was used. We randomly selected 100 beneficiary service months with services provided to Medicaid beneficiaries in SFY 2000.

Sample Size

We selected 100 sample units (beneficiary service month).

Estimation Methodology

We used the Office of Audit Services' Statistical Software Variable Appraisal program for simple random sampling to project the amount of unallowable service costs to the total population of 98,333 beneficiary service months in our sample.

Projection of Unallowable Costs

We reviewed 100 randomly selected beneficiary service months with expenditures totaling \$20,716. We found that 39 of the 100 sample items contained unallowable costs totaling \$6,672. The unallowable costs included claims for services that were (1) either not covered by Medicaid or authorized for Medicaid reimbursement, (2) referred or provided by unqualified providers, and (3) not properly supported. The FFP amount of the unallowable costs for projection was \$3,450.

We used the results of the 100 sample items to project the value of the overpayments for the population of 98,333 beneficiary service months. The results of the projection are:

Point Estimate of Differences:	\$6,560,306
Upper Limit:	\$9,302,359
Precision Amount:	\$2,742,054
Lower Limit at the 90 percent Confidence Level:	\$3,818,252

During our audit period, two different FFP rates applied. Therefore, we applied the applicable matching rate to each sample error to project the federal portion of the unallowable costs. The results of the projection are:

Point Estimate of Differences:	\$3,392,814
Upper Limit:	\$4,811,620
Precision Amount:	\$1,418,806
Lower Limit at the 90 percent Confidence Level:	\$1,974,009

Schedule of Unallowable Costs				
Sample Item	Total Unallowable Amount	Non-Covered/ Unauthorized Services	Unqualified Providers	Unsupported Services
1	\$ 164.34	\$ 0.00	\$ 164.34	\$ 0.00
4	486.20	486.20	0.00	0.00
5	230.56	230.56	0.00	0.00
9	137.22	137.22	0.00	0.00
11	51.12	0.00	51.12	0.00
12	29.82	0.00	0.00	29.82
16	28.98	28.98	0.00	0.00
18	11.30	0.00	0.00	11.30
23	100.14	100.14	0.00	0.00
25	14.98	14.98	0.00	0.00
27	173.70	0.00	0.00	173.70
28	11.56	0.00	11.56	0.00
30	358.80	358.80	0.00	0.00
32	1,045.78	1,045.78	0.00	0.00
34	54.98	0.00	0.00	54.98
35	99.68	99.68	0.00	0.00
41	174.88	174.88	0.00	0.00
43	100.85	100.85	0.00	0.00
44	34.08	34.08	0.00	0.00
45	204.48	0.00	204.48	0.00
54	68.98	0.00	68.98	0.00
66	21.25	0.00	21.25	0.00
70	246.68	246.68	0.00	0.00
71	98.40	0.00	0.00	98.40
72	17.70	0.00	0.00	17.70
73	56.80	0.00	56.80	0.00
75	151.52	0.00	151.52	0.00
76	25.62	0.00	25.62	0.00
77	488.65	0.00	488.65	0.00
79	89.46	0.00	0.00	89.46
80	191.36	0.00	0.00	191.36
83	33.02	0.00	33.02	0.00
85	97.37	97.37	0.00	0.00
86	142.96	0.00	142.96	0.00
88	170.46	0.00	0.00	170.46
93	14.72	14.72	0.00	0.00
94	1,034.62	1,034.62	0.00	0.00
98	72.32	0.00	72.32	0.00
99	136.18	0.00	129.99	6.19
Totals	\$ 6,671.52	\$ 4,205.54	\$ 1,622.61	\$ 843.37

TITLE 42--PUBLIC HEALTH
CHAPTER IV--HEALTH CARE FINANCING ADMINISTRATION,
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PART 440--SERVICES: GENERAL PROVISIONS

Sec. 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(a) Physical therapy.

- (1) Physical therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment.
- (2) A “qualified physical therapist” is an individual who is--
 - (i) A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and
 - (ii) Where applicable, licensed by the State.

(b) Occupational therapy.

- (1) Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.
- (2) A “qualified occupation therapist” is an individual who is--
 - (i) Registered by the American Occupational Therapy Association; or
 - (ii) A graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

TITLE 42--PUBLIC HEALTH
CHAPTER IV--HEALTH CARE FINANCING ADMINISTRATION,
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PART 440--SERVICES: GENERAL PROVISIONS (CONT.)

- (c) Services for individuals with speech, hearing, and language disorders.
- (1) Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment.
 - (2) A “speech pathologist or audiologist” is an individual who--
 - (i) Has a certificate of clinical competence from the American Speech and Hearing Association;
 - (ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or
 - (iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

State Response



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
P.O. Box 45500, Olympia, Washington 98504-5500

May 9, 2003

Lori A. Ahlstrand, Regional Inspector General
for Audit Services
Department of Health & Human Services
Office of the Inspector General
Region IX Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, California 94102

SUBJECT: DRAFT AUDIT REPORT WITH COMMON IDENTIFICATION
NUMBER A-10-02-00008

Dear Ms. Ahlstrand:

Enclosed is Washington State's Department of Social and Health Services, Medical Assistance Administration's (MAA) response to your office's draft audit report titled "Review of Washington State's Medical Assistance Costs Claimed for School-Based Health Services Provided in State Fiscal Year 2000.

MAA strongly disagrees with most of the findings and expressed our views in the enclosed response.

MAA appreciates the opportunity to comment on the draft audit report.

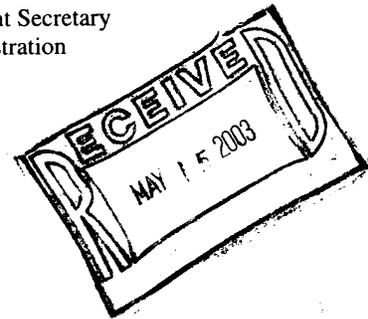
Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "Larry Lank".

Larry Lank, Deputy Assistant Secretary
Medical Assistance Administration

Enclosure



DRAFT RESPONSE

Common Identification Number A-10-02-00008

The following is the response from the Department of Social and Health Services, Medical Assistance Administration (MAA) to the Department of Health and Human Services, Office of Inspector General's draft audit report. The response is to the March 2003 report titled, "Review of Washington State's Medical Assistance Costs Claimed For School-Based Health Services Provided In State Fiscal Year 2000" with the Common Identification Number A-10-02-00008. The response was developed with input from both the Department of Social and Health Services, Medical Assistance Administration, and the Office of Superintendent of Public Instruction (OSPI).

FINDINGS AND RESPONSES

GENERAL STATEMENT

MAA cannot determine concurrence/nonconcurrence with some of the findings as written. We have not been given access to the working papers that would provide the level of detailed information necessary to appropriately respond to the audit findings. In addition, the timelines for response create a problem for a complete review of the findings. We will, however, provide as much response as possible, with the limited information we have available. Also, because many of the issues presented in the report relate directly to controls at the individual school district level, we cannot accurately respond without additional input from that level. In order to obtain that level of input, MAA again needs the working papers in order to follow up on the specific findings.

FINDING: COSTS CLAIMED

PROGRAM SERVICES

A. Non-Covered/Unauthorized Services. For 16 sample items, we found that the state incorrectly claimed \$4,206 for services (1) not prescribed or documented in an IEP, (2) expressly prohibited for Medicaid billing, (3) considered educational in nature, and (4) provided free to the community. Federal matching funds were only allowable for medically necessary services prescribed in an Individualized Education Plan.

Response: MAA does not concur with this condition of the audit finding. Without specific School District identification, Special Education student information or the ability to review the transaction being questioned, we cannot respond to this condition.

B. Unqualified Providers. For 14 sample items, we found that the state incorrectly claimed \$1,623 for services that were either referred by or provided by unqualified Speech Language Pathologists, Physical Therapists, or Occupational Therapists. These providers did not meet the specific qualifications required by federal regulations.

Response: MAA does not concur with this condition of the finding. The question regarding Speech Language Pathologist qualifications is based on the State's interpretation of "educational equivalency". Due to lack of detailed guidance, equivalency was interpreted to mean the practitioner must have obtained a Masters in Speech, plus have completed one year of speech language service in schools to be eligible to bill without signoff by someone with a Certificate of Clinical Competence.

C. Unsupported Services. For ten sample items, we found the state incorrectly claimed \$843 for services that (1) occurred on dates when school was not in session or when the student was absent, (2) exceeded the number of services documented in service logs, and (3) were not supported by service logs or by medical evaluations. Federal regulations required that relevant documentation supporting the services claimed be retained.

Response: MAA does not concur with this condition of the finding. Without specific School District identification, Special Education student information or the ability to review the transaction being questioned, we cannot respond to this condition of the finding. Exceptions related to item 1 were based on Negotiated School Calendars published prior to the start of the audited school year, which would not take into account any employee strikes, snow days or other items that would cause school to be rescheduled into consideration. Exceptions noted with regard to item 2 may be a result the auditor reviewing only the selected items for the audit. We believe that a review of all documents available (service logs, HCFA 1500 and DSHS/MAA Remittance Status Reports) would clarify these noted exceptions. It is not clear if the findings in Item 3 are due to the appropriate logs and evaluations not being available at the time of audit or due to non-existent documentation.

BILLING FEES

The state claimed \$573,728 (\$297,152 FFP) for unallowable billing fees. School districts or billing agent(s) were reimbursed for costs associated with billing for services under the program. The CMS Technical Guide specifically stated that billing fees were not reimbursable under the program as a direct service.

Response: MAA does not concur with this finding. In reviewing this topic during the audit, it was noted that MAA erred in categorizing the payments to Leader Services using Code 0170S as direct service costs. These costs are allowable administrative costs, which MAA could claim by either building the administrative costs into the rates (per page 41 of the CMS Technical Guide) or through administrative match. Administrative match may be applied since Leader Services contracts with a state agency (the Office of the Superintendent of Public Instruction) rather than individual school districts. Thus, the billing costs paid to Leader Services are an administrative expense under the state agency's contract with Leader Service to administer the Medicaid program. Because billing costs were not factored into the cost-based rates paid to school districts they should be allowable as an administrative expense to the state under its contract with Leader Services.

During conversations about potential findings, the federal auditor agreed with the interpretation. The dollar amount for the federal match using the alternative billing method remains about the same. MAA believes that reimbursing the billing agent through a correct method in the future is the proper remedy for this finding of error.

SERVICES PROVIDED TO INELIGIBLE CHILDREN

The state claimed \$15,819 (\$8,591 FFP) for services provided to children that were not eligible. These individuals were enrolled in the (1) Children's Health Insurance Plan and (2) Children's Health Program. The children were not eligible for Medicaid due to income thresholds or citizenship status. Medicaid eligibility was required for services to be claimed under the program.

Response: MAA concurs with this finding. It appears that edits in the system had not been entered correctly. When this condition was noted during the testing phase, edits were entered into the claims processing system to reject payments for the unallowable services. This was a systemic oversight that MAA moved to correct immediately upon discovery. Since it has been corrected, MAA feels there should be no fiscal finding.

SERVICE REIMBURSEMENT RATES

A. Transportation Costs. The state included transportation costs for all special education individuals in its service reimbursement rates. The inclusion of transportation costs in the rates provided no assurance that transportation was medically necessary for all special education individuals. Medicaid reimbursement was allowable for transportation only when the child received a Medicaid-covered service and both the service and the transportation were identified in the beneficiary's IEP.

Response: MAA concurs with this condition. Officials from CMS identified this problem during a December 1999 site visit at which time MAA immediately started the process of correcting the error. The problem was fixed and the solution was in place prior to the start of this audit. At no time during the December 1999 site visit was there mention of refunding past dollars. MAA acted in good faith and made the correction as quickly as possible. Prior to the December 1999 site visit, the issue of allowable transportation costs had been under discussion nationally and was not clearly defined at the federal level.

B. Group Therapy Rates. The state calculated its group therapy reimbursement rates at one-third of the corresponding individual therapy rates. According to the CMS Technical Guide, reimbursement rates were to be (1) justified with statistically accurate and valid data and (2) limited to no more than the actual costs of providing the service. The CMS Technical Guide suggested the use of extensive historical cost information (e.g., time studies, interviews, and cost reports) to support the establishment of new rates. Because the state did not use historical cost information to establish the group rates and was unable to provide justification for the method used, we determined the group rates were not based on accurate or valid data. Further, the state's

use of a percentage of individual therapy rates as the basis for the group rate provided no assurance that the rates were limited to no more than providers' actual costs.

Response: MAA does not concur with the finding. The state did not use historical cost information to establish the group rates because initially there was no historical data available for use. Thus the state used a common sense method to establish the group therapy rate. The minimum number of people required for a group session is two. In larger school districts the typical group session may consist of three to five people, but in smaller school districts two to three is more likely. Three is a reasonable average number of people per group therapy session. On that basis, MAA set the group therapy rate at one-third the rate for the individual session.

The December 1999 site visit did not raise any issue with the method used to set group therapy rates. However, MAA will begin collecting data, by asking the school districts to track group therapy attendance and expenditures starting next school year, to validate current methodology.

OTHER MATTERS

A. Attendance Records. The school districts were unable to provide attendance records for 11 of the 100 sample items. Since these records were unavailable, student attendance on the day of service could not be verified.

Response: MAA does not concur with the finding. A standard has been established by the Secretary of State, which requires school districts to maintain student attendance records for a period of three years. As to why the records were not available at the time of the audit, it can only be resumed that the location of required records might not have been available during the summer break, when the majority of site visits were made.

B. Indirect Cost Rates. The program did not have an indirect cost rate approved by the cognizant agency.

Response: MAA does not concur with the finding. The indirect cost rate identified by the cognizant agency is based on costs for the school. OSPI is the cognizant agency for calculating indirect rates for all school district administered federal programs. Indirects are not calculated/approved for individual programs but are calculated at the school district level.

C. Local Guidance. The state had established procedures for school districts to obtain parental consent to (1) verify an individual's Medicaid eligibility and (2) submit program expenditures for Medicaid reimbursement. Several school districts in our review could not document parental consent for these approvals. In addition, school districts were to submit the names and qualifications of their service providers to the state before reimbursement would be made for the services provided. During our review, we found that school districts submitted service provider information. However, it appeared that the state did not properly verify or validate the information as we found it to be incomplete, inaccurate, and/or outdated.

Response: MAA does not concur with the finding in that we cannot accurately respond to these exceptions without specific information regarding the districts not having parental consent available for audit.