Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK IMPROPERLY CLAIMED $439 MILLION IN MEDICAID FUNDS FOR ITS SCHOOL-BASED HEALTH SERVICES BASED ON CERTIFIED PUBLIC EXPENDITURES

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Office of Inspector General

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Report in Brief
Date: July 2021
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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

New York Improperly Claimed $439 Million In Medicaid Funds for Its School-Based Health Services Based on Certified Public Expenditures

Why OIG Did This Audit

As part of its oversight activities, OIG is conducting a series of audits of States that claim Medicaid school-based costs with the assistance of contractors. Prior OIG audits found that States claimed unallowable Federal funds because contractors improperly conducted random moment time studies (RMTSs).

The objective of this audit was to determine whether New York properly claimed Federal funds based on time studies and costs used for its Medicaid school-based health services certified public expenditures claiming methodology.

How OIG Did This Audit

Our audit covered $439 million in Federal Medicaid payments for school-based health services provided from October 1, 2011, through June 30, 2016.

New York claims certified public expenditures through a complex process developed with the assistance of a contractor. As part of the process, the contractor conducts quarterly RMTSs and uses ratios to calculate cost settlements. We reviewed a statistical sample of 298 random moments and reviewed the methods that New York used to allocate costs to Medicaid.

What OIG Found

New York claimed unallowable Federal funds because it did not support that all random moments coded as health care were for Medicaid-eligible health services. New York also did not provide support that it did not double-claim for services when a student in one school district received services from another school district. In addition, New York improperly claimed excess costs for 1 year. Finally, New York did not follow Federal RMTS requirements and used an unsupported method to claim Medicaid costs.

New York and its contractor developed complex methods that were difficult or impossible to correctly implement and support with documentation. As a result, New York claimed estimated unallowable Federal funds totaling $98 million. In addition, New York claimed $32 million in Federal funds because it did not follow Federal RMTS requirements or document that CMS approved its allocation methodology, and $309 million in Federal funds using ratios that were not supported.

What OIG Recommends and New York State Department of Health Comments

We made several recommendations to New York, including that it refund $98 million in unallowable funds and support or refund the $32 million and the $309 million. We also made procedural recommendations to assist New York in preparing accurate, supportable claims.

In written comments on our draft report, New York generally disagreed with our findings and recommendations. Specifically, New York generally disagreed that sampled activity moments were unsupported. However, New York agreed to refund $1.2 million because it did not correctly offset certain costs and to include sufficient documentation to support these costs in future claims. New York also agreed that it claimed $19.6 million in error. New York did not agree that it claimed $32 million without CMS approval; however, it did not provide documentation of CMS's approval. Finally, New York did not agree to refund $309 million claimed using ratios that cannot be supported; however, it agreed that documentation to support the ratios is not available.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. New York improperly claimed Federal funds for school-based health services through its certified public expenditures claiming methodology.

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INTRODUCTION

WHY WE DID THIS AUDIT

As part of its oversight activities, the Office of Inspector General (OIG) is conducting a series of audits of States that claim Medicaid school-based costs with the assistance of contractors. Prior OIG audits found that States claimed unallowable Federal funds because contractors improperly conducted random moment time studies (RMTSs).[1]

OBJECTIVE

The objective of our audit was to determine whether the New York State Department of Health (State agency) properly claimed Federal funds through its Medicaid school-based health services certified public expenditures claiming methodology.

BACKGROUND

The 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, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In New York, the State agency administers the Medicaid program.

The Individuals with Disabilities Education Act

States may claim Federal Medicaid funds for health services provided by schools under the Individuals with Disabilities Education Act (IDEA), which requires schools to provide special education and related services[2] for children with disabilities.

Among other requirements for Medicaid payment, health services must be necessary, as determined by a child's individualized education plan (IEP). The IEP is a document describing a child's needs for special education and related services, and the educational and health services to be provided to the child. Health services must be provided by qualified practitioners that meet Federal and State license requirements.

[1] See Appendix B for related OIG reports.

[2] Related services are services required to assist a child with a disability and may include health care services covered by Medicaid and non-health care services.

New York Medicaid School Supportive Health Services Program

The New York Medicaid School Supportive Health Services Program (SSHSP) is administered jointly by the State agency and the New York State Education Department. The SSHSP allows school districts and counties to submit claims for health services to the State agency that they identify as meeting all Medicaid requirements.[3] Before submitting claims, school districts and counties must obtain parental consent to release protected information, including the associated child's IEP.[4]

Certified Public Expenditures Claiming Methodology

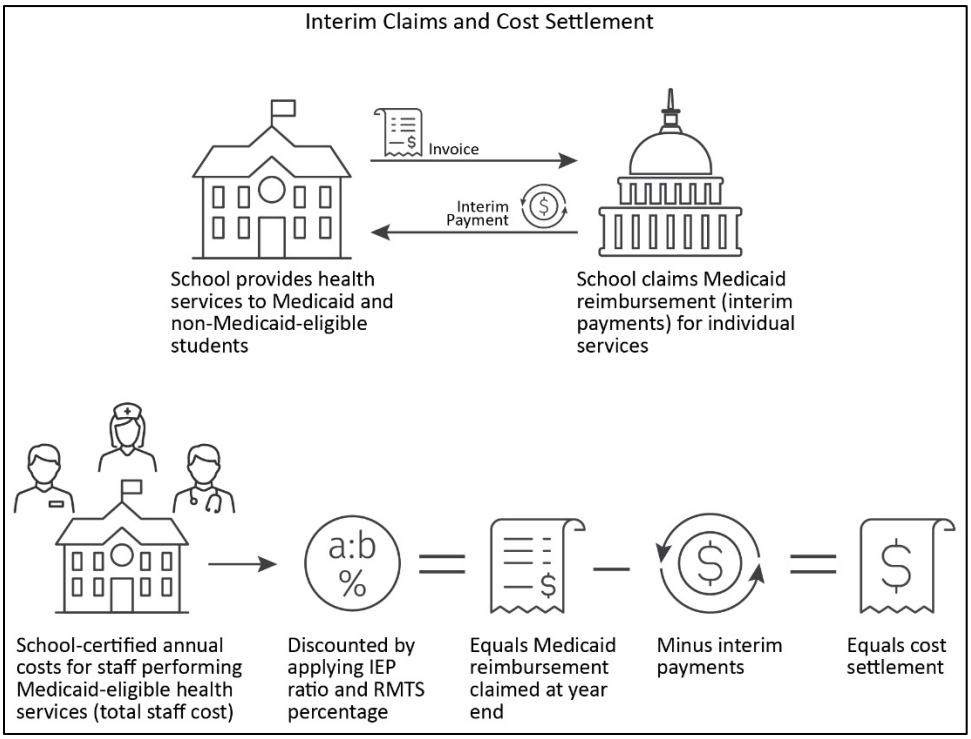
The State agency obtains Federal reimbursement for school districts' and counties' actual costs for SSHSP services through certified public expenditures.[5] The multistep process includes interim payments, end-of-year cost totals, and a cost settlement. Throughout each school year, the State agency makes interim payments to school districts for Medicaid-eligible health services, provided to Medicaid-eligible students, based on a fee schedule. End-of-year costs are calculated through a complex process discussed below. The process includes conducting quarterly statewide RMTSs and the application of a percentage known as the "IEP ratio." These final Medicaid-eligible costs are then compared to the interim payments to determine each school district's cost settlement. Figure 1 (next page) illustrates how the State agency determines each school district's cost settlement.

[3] Payments made to the school districts and counties are based on a fee schedule.

[4] See "Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records," issued by HHS and the U.S. Department of Education, and Federal regulations cited therein. Available online at https://www.hhs.gov/sites/default/files/2019-hipaa-ferpa-joint-guidance-508.pdf. Accessed on October 8, 2020.

[5] New York uses funds certified as actual expenditures by the school districts and counties as the State share in order to receive matching Federal Medicaid funds.

Figure 1: How the State Agency Calculates Cost Settlement



The State agency contracts with Public Consulting Group (PCG) to assist with determining school districts' cost settlements. To calculate end-of-year costs, PCG conducts quarterly statewide RMTSs to estimate time spent on Medicaid-eligible health services. The resulting "RMTS percentage" is applied to total staff costs (i.e., Medicaid- and non-Medicaid-eligible costs) for school employees[6] providing health services to determine the estimated total health services costs. To identify Medicaid-eligible costs, PCG applies a percentage known as the "IEP ratio" to the estimated total health services costs. This percentage is calculated by dividing the number of students enrolled in Medicaid that have IEPs containing health services by the total number of students (Medicaid- and non-Medicaid-eligible) that have IEPs containing health services. PCG then calculates the cost settlement as the difference between Medicaid-eligible costs and interim payments for each school district for each school year (SY) 2 years after the end of each SY.[7]

Exhibit: Random Moment Time Study

An RMTS is a statistical method used to identify the percentage of time personnel spent on a particular activity. It generally must reflect all of the time used and all activities performed (whether or not allowable under Medicaid) by school district staff participating in the Medicaid program.

[6] Health services costs for non-school employees (e.g., contractors) are identified by the school districts.

[7] In New York, the SY runs from July 1 through June 30.

Every year since the State agency began using this methodology in October 2011, total school districts' Medicaid-eligible costs have exceeded their total interim payments, resulting in the State agency claiming additional Federal Medicaid funds. The State agency keeps 86.95 percent of these additional funds and pays school districts the remaining 13.05 percent.[8] As noted earlier, the State agency only uses this methodology for providers located outside of New York City.[9]

School districts may purchase services *from* or provide services *to* other school districts. The SSHSP accounts for the resulting financial transactions as "intergovernmental agreement costs." School districts that purchase services record the payments as intergovernmental agreement costs in PCG's data system. School districts that receive payment for providing services to other districts record the receipt of these payments in PCG's system. Accordingly, the State plan requires the State agency to offset the payment received by a school district that provided a service to another school district by an amount equal to the expense incurred by the school district that purchased the service. Therefore, such payments and receipts are expected to net to zero. Without this adjustment, the State agency would double-claim for intergovernmental agreement costs.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $439,238,640 in Federal Medicaid payments for school-based health services provided from October 1, 2011, through June 30, 2016.[10] Of this amount, $154,606,543 was paid based on RMTSs used to statistically estimate the portion of school costs for providing health care. We reviewed a stratified random sample of RMTS moments coded as "health care." The stratified random sample was comprised of 298 unique random moments.[11] The remaining $284,632,097 was paid based on specific health care costs identified by school districts. For all amounts, we reviewed the methods used to allocate costs to Medicaid.

We did not review the overall internal control structure of the State agency or PCG. Rather, we limited our review to those controls related to the State agency's certified public expenditures methodology.

[8] These percentages are set by New York statute.

[9] For the purposes of this report, "state-wide" and "New York State" include every school district and county that participates in the SSHSP located outside of New York City. For the remainder of this report, we refer to school districts and counties collectively as school districts. Our scope did not include New York City school district services.

[10] The State agency takes 2 years to prepare its claims for reimbursement. This was the most current data available at the time we initiated the audit.

[11] Our sample was composed of combinations of activity moments and school districts. Because the sample unit was a combination of an activity moment and a school district, it was possible for the same activity moment to appear more than once within the sample. Within our sample, 2 activity moments were selected more than once. As a result, the 300 items in our sample corresponded to 298 unique activity moments.

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

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

FINDINGS

The State agency improperly claimed Federal funds for SSHSP services through its certified public expenditures claiming methodology. Specifically, the State agency claimed estimated unallowable Federal funds totaling $98 million[12] because it did not support that all random moments coded as health care were for Medicaid-eligible health services or that it did not double-claim when a student in one school district received services from another school district, and it claimed excess costs for 1 year on its Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). In addition, the State agency improperly claimed an additional $32 million when it did not follow Federal RMTS requirements and $309 million when it used an unsupported cost allocation method to claim Medicaid costs.

THE STATE AGENCY CLAIMED UNALLOWABLE FEDERAL FUNDS

The State Agency Did Not Support That All Random Moments Coded as Health Care Were for Medicaid-Eligible Health Services

Federal regulations require documentation to be maintained to assure that claims for Federal funds are in accord with applicable Federal requirements and that documentation be made available for audits and examinations (42 CFR § 433.32, 45 CFR § 75.364). Federal regulations also require that certain service providers be appropriately supervised and licensed (42 CFR part 440) and the State Medicaid plan[13] requires that providers be licensed and practice in accordance with State law, which requires that service providers with a "limited license" provide services under a licensed professional in the same field.[14]

Of the 298 unique moments in our sample, 129 moments were supported but 169 were not. For 135 moments, based on the State agency's documentation, we could not determine whether the moment covered Medicaid-eligible health services listed in the associated

[12] $77.2 million in estimated unsupported RMTS coding; $1.2 million for possible duplicate claiming; $19.6 million for excess claimed in error.

[13] Attachment 3.1-A, Supplement, page 2(xii) 4b (effective Sep. 1, 2009).

[14] New York Education Law, Articles 136, 154, 156, and 159.

student's IEP because PCG did not adequately question the school employee. For 57 moments, the State agency did not provide adequate documentation indicating that services provided by persons with a limited license were appropriately supervised. Finally, for six moments, we were unable to verify that the service provider was licensed.[15] On the basis of our sample results, we estimated that the State agency claimed at least $77,152,491 in unallowable Federal Medicaid funds.[16]

For the 135 moments, PCG did not ask enough questions to ascertain whether an employee performed a Medicaid-eligible health care service. For example, a licensed speech language therapist stated that she was "identifying similes and metaphors" with four special education students because these goals were "related to the English Language Arts Curriculum." However, PCG did not ask whether this was a Medicaid-eligible health service or an educational service. Nevertheless, PCG made this determination. Further, as with all 135 moments, PCG did not collect students' names or other identifying information; therefore, neither it nor the State agency could identify students to obtain student health records or IEPs to determine whether the services included in students' IEPs were Medicaid-eligible health care services or educational services.

The State Agency Did Not Support That It Did Not Double-Claim for Services When a Student in One School District Received Services From Another School District

The State plan requires the State agency to offset intergovernmental agreement costs so that it does not double-claim for the associated services.[17] The State plan states that these costs are expected to net to zero.

The State agency did not support that it did not double-claim reimbursement for services when a student in one school district received services from another school district. Specifically, the State agency claimed $1,238,102 in intergovernmental agreement costs that it did not support. The State agency claimed a total of $1,525,055 in intergovernmental agreement costs that it said related to transactions involving school districts that do not participate in the SSHSP and provided documentation to support that $286,953 of the costs were allowable. However, for the remaining $1,238,102, the documentation provided by the State agency did not support that these costs related to transactions involving school districts that did not participate in the SSHSP.

We determined that PCG did not successfully offset payments and receipts because of the complexity of the process for netting intergovernmental agreement costs to zero. The process

[15] The number of errors exceeds 169 because 29 moments contained more than 1 error.

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

[17] Attachment 4.19-B, pages 17(l)(i)-(ii), 17(r)(i)-(ii) (effective Oct. 1, 2011).

is complicated because of the large number of school districts, many of which reported transactions with three to five other school districts. As a result, the State agency claimed $1,238,102 in unallowable Federal Medicaid funds.

The State Agency Mistakenly Claimed Excess Costs for 1 Year

Federal Medicaid payments are only available for actual expenditures supported by adequate documentation (42 CFR § 433.32, State Medicaid Manual § 2497).

For SY 2013, the State agency claimed $19,607,699 in excess of school districts' final cost settlement amounts on the Form CMS-64. The State agency mistakenly claimed this amount because of miscommunication between State agency officials related to a change in the cost allocation methodology. After we informed the State agency of the overpayment during our fieldwork, the State agency informed us that it refunded the overpayment.

THE STATE AGENCY DID NOT FOLLOW FEDERAL REQUIREMENTS

The State Agency Applied School Year 2013 Random Moment Time Study Results to School Year 2012 Without Adequate Justification

Federal regulations state that RMTS results must be applied to the sample period (45 CFR § 75.430(i)(5)(i)(C)). Exceptions are allowed if it is determined that the amount is minimal or would result in lower costs to the Federal Government (45 CFR § 75.430(i)(5)(iii)). Also, CMS may approve using one period's RMTS to allocate costs for another period when no better documentation is available, and the State can establish that no substantial change occurred between the sampled and unsampled periods.[18]

The State agency applied RMTS results from one SY to allocate costs for another SY without adequate justification. Specifically, the State agency used RMTS results from SY 2013 to allocate costs for SY 2012. The State agency did not provide documentation to support that no substantial change occurred between SYs 2012 and 2013 and that CMS approved the allocation. According to State agency officials, the State agency believed that the stability of RMTS percentages during sampled periods justified applying one of these percentages to an unsampled period. As a result, the State agency claimed $32,267,478 in Medicaid school-based services for SY 2012.

The State Agency Did Not Sample Moments During September

Federal regulations state that RMTS results must be applied to the sample period and the entire time period involved must be covered by the sample (45 CFR § 75.430(i)(5)(i)).

[18] Ohio Dep't of Human Servs., DAB No. 900 (1987); Massachusetts Dep't of Social Servs., DAB No. 1308 (1992)). The State has the burden of showing the circumstances to support this exception. Massachusetts, DAB No. 1308.

RMTSs performed by PCG did not include the month of September even though school was in session during that month. The State agency incorrectly claimed that information in a CMS Guide[19] indicated that it is not required to sample during the July through September quarter,[20] and used RMTSs conducted in the other three quarters to allocate costs for the July through September quarter. As a result, the State agency may have claimed excess Medicaid school-based costs.[21]

THE STATE AGENCY USED AN UNSUPPORTED COST ALLOCATION METHOD

States must provide adequate support to show that their Medicaid funds have been used according to Federal requirements and maintain adequate source documentation to support their expenditures (45 CFR § 75.302). In order to be allowable, costs must be allocable to Medicaid (i.e., chargeable or assignable to Medicaid in accordance with relative benefits received) (45 CFR §§ 75.403(a), 75.405). Also, State Medicaid agencies must assure appropriate audit of records if payment is based on costs of services (42 CFR § 447.202).

The State agency could not validate or provide support that school districts' IEP ratios[22] used to allocate health services costs to Medicaid were correctly calculated. Federal privacy requirements[23] do not allow the State agency to review IEPs of students not enrolled in Medicaid,[24] which would be required to audit the school districts' IEP ratios. Therefore, the State agency could not verify the *total* number of students (including those *not* enrolled in Medicaid) that had IEPs recommending health services (i.e., the denominator used in each school district's IEP ratio).

The State agency's cost allocation method applied the IEP ratio to all costs claimed, therefore;

[19] CMS, *Medicaid School-Based Administrative Claiming Guide* (issued May 2003). Available online at https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/medicaidbudgetexpendsystem/downloads/schoolhealthsvcs.pdf. Accessed on October 8, 2020.

[20] CMS officials confirmed to us that it would expect an RMTS to include days worked in September.

[21] We are unable to quantify the effect of not including September days worked in the RMTS.

[22] The number of students enrolled in Medicaid that have IEPs containing health services divided by the total number of students (including those *not* enrolled in Medicaid) that have IEPs containing health services.

[23] See "Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records," issued by HHS and the U.S. Department of Education, and the regulations cited therein. Available online at https://www.hhs.gov/sites/default/files/2019-hipaa-ferpa-joint-guidance-508.pdf. Accessed on October 8, 2020.

[24] School districts obtain consent to disclose information to the State agency from a Medicaid-enrolled student's parent before they submit associated interim claims for Medicaid payment. However, some parents of Medicaid-enrolled students do not consent to disclose information to the State agency. Additionally, school districts do not request consent from parents of students not enrolled in Medicaid.

the entire amount claimed ($439,238,640) is unsupported. Because we believe that the State agency proposed the IEP ratio method to CMS in good faith, the State agency should work with CMS in continuing good faith to develop an alternative method to support its past allocation of costs to Medicaid. We recognize that any method developed to support the past allocations will not be perfect but should be reasonable under the circumstances. For future years, the State agency should develop an accurate, supportable method in accordance with Federal requirements, such as the specific identification method school districts currently use for contractor and tuition health care costs.[25]

CONCLUSION

The State agency and its contractor developed complex methods that were difficult or impossible to correctly implement and support with documentation. As a result, the State agency claimed estimated unallowable Federal funds totaling $97,998,292,[26] another $32,267,478 in Federal funds because it did not follow Federal RMTS requirements, and $308,972,870 in Federal funds using ratios that were not supported.

RECOMMENDATIONS

We recommend that the New York State Department of Health:

- Refund to the Federal Government or provide documentation of such refund, totaling $97,998,292. Specifically:
    - Refund to the Federal Government $77,152,491 related to random moments that could not be supported as Medicaid-eligible health services.
    - Refund to the Federal Government $1,238,102 for intergovernmental agreement payments that the State agency did not support that it did not double-claim.
    - Refund to the Federal Government or provide documentation of the refund to CMS of $19,607,699 for excess costs claimed on the Form CMS-64 for 1 year.
- Refund $32,267,478 to the Federal Government or provide documentation to CMS to establish that it met an exception to use SY 2013 RMTSs to allocate costs for SY 2012.

[25] School districts claim Medicaid-eligible health services directly from the State for Medicaid-eligible students.

[26] $77.2 million in estimated unsupported RMTS coding; $1.2 million for possible duplicate claiming; $19.6 million for excess claimed in error.

- Refund $308,972,870[27] to the Federal Government or provide documentation that it can reasonably support, under the circumstances, its allocation of health services costs to Medicaid without using unverifiable IEP ratios.

- Ensure that its contractor (1) collects sufficient information so the State agency can validate the contractor's coding of sampled moments and (2) correctly offsets and supports intergovernmental agreement transactions.

- Revise its certified public expenditures SSHSP to (1) include September days worked in its RMTS and (2) develop an accurate, supportable method to identify Medicaid costs instead of unverifiable IEP ratios.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency generally disagreed with our findings and recommendations.[28] Specifically, the State agency disagreed with our finding that sampled activity moments were unsupported. However, it agreed that it did not correctly offset intergovernmental agreement costs and claimed excess costs on the Form CMS-64 for 1 year. The State agency did not concur with our finding that it did not follow Federal requirements when it applied SY 2013 RMTS results to SY 2012 without adequate justification. It also disagreed with our recommendation that it revise its certified public expenditures SSHSP to include September days worked in its RMTS. Finally, although it agreed that documentation used to calculate IEP ratios is not available, the State agency disagreed with our recommendation to develop an accurate, supportable method to identify Medicaid costs instead of unverifiable IEP ratios.

The State agency's comments are further summarized below and are included in their entirety as Appendix E. After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. Our responses to the State agency's comments are detailed below.

[27] This recommendation applies to the entire amount claimed of $439,238,640 less the amounts above, for a remainder of $308,972,870 if all other financial recommendations are implemented.

[28] We note that the State agency did not respond to our finding that, for 57 moments, it did not provide adequate documentation indicating that services provided by persons with a limited license were appropriately supervised, or that, for 6 moments, we were unable to verify that the service provider was licensed.

THE STATE AGENCY CLAIMED UNALLOWABLE FEDERAL FUNDS

The State Agency Did Not Support That All Random Moments Coded as Health Care Were for Medicaid-Eligible Health Services

State Agency Comments

The State agency disagreed with our recommendation to refund $77,152,491 and, except for three sampled activity moments that the State agency contended were potentially *correctly* coded, it disagreed with our finding that the sampled activity moments were unsupported. The State agency engaged PCG as a coding expert to review the sample moments we identified as potentially miscoded or unsupported.[29] According to the State agency, PCG concluded that three moments may potentially be correctly coded but unsupported based on a lack of available documentation. The State agency also stated that, had OIG considered the context in which the remaining sample moments were delivered, OIG would likely not have considered these moments to be unsupported. To illustrate its point, the State agency provided examples of what it considered to be faulty conclusions by OIG. The examples included participants associated with sample moments who indicated that they were working on aspects of language such as vocabulary, irregular nouns, adjectives, and verbs as part of the students' IEPs. According to the State agency, OIG also identified moments as incorrectly coded as direct services when respondents noted that they were completing session notes, which CMS guidance states may be considered direct services.

The State agency also stated that duplicate sample moments reflect possible problems with OIG's sample design and selection methodology. Finally, the State agency agreed to follow up with time study participants to collect additional information when their initial responses do not allow for the appropriate coding of moments.

Office of Inspector General Response

PCG's opinion on our findings did not include any supporting documentation; therefore, we did not change our conclusions. In addition, PCG originally coded the moments and was therefore reviewing its own work. Regarding the State agency's examples of what it considered to be faulty conclusions by OIG, we maintain that the services provided during the sampled moments we identified as unsupported could have been for health or *educational* purposes. The State agency did not support that these moments were health-related because it did not provide service documentation and IEPs to indicate which type of service was provided—either during our fieldwork or in response to our draft report. For two examples, the State agency asserted that the moments were correctly coded based on what the IEPs *might* state; however, it did not provide the actual IEPs. Regarding the example indicating that that an occupational therapist

[29] The State agency erroneously indicated that, in the draft report, OIG identified 166 of 300 sample moments as potentially miscoded or unsupported.

was completing session notes, we note that the practitioner indicated that they were completing session notes for students seen throughout 1 day—not a particular student.

Regarding the State agency's comments about duplicate moments and our sampling methodology, we note that our sample frame, which we detail in Appendix C, was composed of unique combinations of activity moments and school districts.[30] Because the sample unit was a combination of an activity moment and each school district the moment impacted, it was possible for the same activity moment to appear more than once within the sample. Consequently, within our sample, 2 activity moments were selected more than once.[31] However, the combinations from which we sampled are unique and not duplicative. We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation.

Finally, while we commend the State agency for agreeing to collect sufficient information from respondents so that PCG can properly code moments, we continue to believe that the State agency should require students' identifying information to be included in time study responses so it can review service documentation and IEPs to validate its contractor's coding against source documentation.

The State Agency Did Not Support That It Did Not Double-Claim for Services When a Student in One School District Received Services From Another School District

State Agency Comments

The State agency agreed that it did not correctly offset intergovernmental agreement tuition costs totaling $1,078,759 for SYs 2014 and 2015, and an additional $151,830 for the remaining periods covered by our audit. The State agency agreed to refund $1,230,589 to the Federal Government. The State agency also agreed to include, when calculating future claims, sufficient documentation to clearly display offsets and support intergovernmental agreement transactions.

Office of Inspector General Response

While we commend the State agency for reviewing its unsupported intergovernmental agreement costs and concluding that it should refund $1,230,589, we note that our calculation

[30] These combinations were created because the coding of a moment from one school district could impact reimbursements associated with other school districts in the same cost pool.

[31] As a result, we note, that our findings for the 300 sample items relate to 298 unique activity moments.

of the unsupported amount is $7,513 higher than the State agency's calculation and maintain that the State agency should refund the higher amount.

The State Agency Mistakenly Claimed Excess Costs for 1 Year

State Agency Comments

The State agency agreed that it claimed excess costs on the Form CMS-64 for 1 year and stated that it has submitted a prior period adjustment for the $19,607,699 that it claimed in error. The State agency stated that, on October 30, 2020, it provided documentation of the refund to OIG, and requested that we remove this finding from the report.

Office of Inspector General Response

We notified the State agency of our preliminary finding during the course of our audit and acknowledge that the State agency took action during the audit to refund the excess costs; however, it remains a reportable audit finding. We will clear the related recommendation as soon as CMS confirms that the funds were repaid.

THE STATE AGENCY DID NOT FOLLOW FEDERAL REQUIREMENTS

The State Agency Applied School Year 2013 Random Moment Time Study Results to School Year 2012 Without Adequate Justification

State Agency Comments

The State agency did not concur with our finding that it did not follow Federal requirements when it applied SY 2013 RMTS results to SY 2012 without adequate justification. The State agency stated that no significant difference existed between the time study period and the period to which the time study was applied. Further, the State agency did not agree with our observation (made during the exit conference) that available documentation indicated that there was a substantial change from SY 2012 to 2013 in direct services because interim payments increased. The State agency stated that there is no direct relationship between interim claiming activities and activities of health services providers. It also stated that CMS approved this approach.

Office of Inspector General Response

The State agency did not provide any documentation showing that no significant difference existed between SYs 2012 and 2013. Further, the available documentation indicated that a substantial change did exist as interim payments increased from $81 million to $99.5 million (23 percent increase). If this was *not* potentially caused by an increase in services, the State agency should provide an alternative reason for the increase. Finally, the State agency did not provide documentation indicating CMS's approval of its approach.

The State Agency Did Not Sample Moments During September

State Agency Comments

The State agency disagreed with our recommendation that it revise its certified public expenditures SSHSP to include September days worked in its RMTS. According to the State agency, CMS approved its RMTS implementation plan, which allowed the State agency to apply results from three quarters—from October through June—to the July through September quarter.

Office of Inspector General Response

Federal regulations require that *all* time worked be sampled. Since schools are in session during September, the State agency's RMTS should cover the days worked during that month. Therefore, its calculation of the annual direct medical percentage should include that period. We found no support that the State agency informed CMS that it planned to *not* sample days during which schools are in session. Therefore, we maintain that our recommendation is valid.

THE STATE AGENCY USED AN UNSUPPORTED COST ALLOCATION METHOD

State Agency Comments

The State agency agreed that documentation used to calculate IEP ratios is not available and cited the Federal law we noted in footnote 23 as well as New York State Education Law to support its assertion that it had limited access to the needed information. According to the State agency, it used a set of internal controls (e.g., desk reviews and reviews of student enrollment data on IEPs) to verify IEP ratios. It also stated that the school districts and counties certify the accuracy of the public expenditures used for matching purposes and included a sample certification statement. In addition, the State agency asserted that interim payments should be removed from the scope of the audit (which would reduce the amount of our financial recommendation regarding unsupported IEP ratios) because school districts incur costs and OIG favorably noted that the use of interim claims could also be used to specifically identify students enrolled in Medicaid. Finally, the State agency disagreed with our recommendation to develop an accurate, supportable method to identify Medicaid costs instead of unverifiable IEP ratios because CMS approved the use of IEP ratios to allocate costs to Medicaid.

Office of Inspector General Response

Internal controls are not a substitute for documentation to support Medicaid reimbursement, as Federal rules require sufficient tracing of funds and appropriate audit of records if payment is based on costs of services (45 CFR § 75.302, 42 CFR § 447.202). The State agency believes the IEP ratios are accurate based on the internal controls set in place yet it informed us that, when

IEP ratios are greater than 1—an impossible result—its response is to cap the ratio at 1 (i.e., 100 percent of students with IEPs were enrolled in Medicaid). Also, while the districts and counties certify their costs and allocations, they do not specifically certify the accuracy of the figures used to calculate IEP ratios. Finally, while we agree that districts and counties incurred costs for providing services to Medicaid-enrolled students, CMS's approval of the methodology does not excuse the State agency from providing documentation to support its IEP ratios. Because the State agency is unable to provide documentation to support IEP ratios, it should develop an alternate method to identify Medicaid costs. We encourage the State agency to work with CMS to develop an alternate method that supports past cost allocations. For future years, we maintain our recommendation for the State agency to develop an accurate, supportable method to identify Medicaid costs instead of unverifiable IEP ratios, such as the specific identification method school districts and counties currently use for contractor and tuition health care costs.

OTHER MATTERS: THE STATE AGENCY PAID SCHOOL DISTRICTS AND COUNTIES THE FULL AMOUNT OF THEIR INTERIM CLAIMS

During our audit, we found that the State agency paid school districts and counties the full amount of their interim claims using a Medicare fee schedule. During our audit period, the State agency paid them 75 percent of the amount Medicare would have paid for the same services. However, after our audit period, in 2017, the State agency increased its payments to 100 percent of the Medicare amount.

We commend the State agency for its use of interim payments because it encourages school districts to identify services provided to students enrolled in the Medicaid program. By specifically identifying services provided to Medicaid-enrolled students and claiming for these services, districts and counties certify that Medicaid service documentation standards are met. Also, by specifically identifying Medicaid services, the State agency does not need to rely on IEP ratios to allocate health services costs to its Medicaid program. If the State agency can ensure that interim payment rates are sufficient to encourage schools to identify Medicaid services, it could eliminate its use of unsupportable IEP ratios to allocate these costs.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed $439,238,640 in Federal Medicaid payments for school-based health services provided in New York State from October 1, 2011, through June 30, 2016.[32] Of this amount, $154,606,543 was paid based on RMTSs used to statistically estimate the portion of school costs for providing health care. We reviewed a stratified random sample that included 298 RMTS moments coded as a Medicaid-eligible health service.[33] The remaining $284,632,097 was paid based on specific health care costs identified by school districts.

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the claims data obtained from the State agency for our audit period. We established reasonable assurance of the completeness of these data by reconciling them to the State agency's reimbursement claims on the Form CMS-64 and to the cost reports submitted by school districts to PCG. We reviewed the random moment sampling methodology and data files used to support the sampling, as well as the coding of the 298 unique random moments included in our sample.

During our audit, we did not review the overall internal control structure of the State agency, its contractor, or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective.

We performed fieldwork at the State agency's office in Albany, New York, and at various school districts throughout New York.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- discussed New York's State Medicaid plan with CMS officials;
- held discussions with State agency officials to gain an understanding of its SSHSP;
- obtained and reviewed documents from the State agency and PCG that were used to calculate the SSHSP costs, including RMTS results and school district cost reports;

[32] Our scope did not include New York City school district services.

[33] Our sample was composed of combinations of activity moments and school districts. Because the sample unit was a combination of an activity moment and a school district, it was possible for the same activity moment to appear multiple times within the sample. Within our sample, 2 activity moments were selected multiple times. As a result, the 300 items in our sample corresponded to 298 unique activity moments.

- held discussions with the State agency and PCG regarding school district cost reports;

- conducted site visits at various school districts to better understand their role and responsibilities in the claiming process;

- reviewed final net settlements from the State agency that were used to claim costs for services provided from October 1, 2011, through June 30, 2016;

- reconciled Medicaid interim claims reported on the cost settlement summaries from the State agency to the interim claims from the State agency's Medicaid Data Warehouse claimed for Federal reimbursement by the State agency;

- reconciled interim claims reported on the Form CMS-64 to interim claims from the State agency's Medicaid Data Warehouse;

- reconciled the final net settlement reported on the State agency's cost settlement report to the amount reported as school-based health services on Form CMS-64;

- selected a stratified random sample that included 298 moments that were coded as Medicaid-eligible;[34]

- reviewed the stratified random sample and, for each sample item:

    - determined if coding was supported by documentation provided;

    - determined the cost effect of any unsupported code on its corresponding school district for the sample item;

    - calculated the related unallowable claim amount for Federal reimbursement; and

    - estimated the total amount of overpayment for Medicaid school-based health services related to incorrect or unsupported activity moment coding;[35]

- discussed the issue of intergovernmental agreement costs not netting to zero with State agency officials and PCG; and

- discussed our results with State agency officials and PCG.

[34] Each item in our sample corresponded to a unique combination of an activity moment and a school district. See Appendix C for details on our sample design.

[35] See Appendix D for our sample results and estimates.

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Florida Received Unallowable Medicaid Reimbursement for School-Based Services	A-04-18-07075	11/24/2020
Nebraska Claimed Unallowable School-Based Administrative Costs Because of Improper Coding of Random Moment Timestudy Responses	A-07-19 -03234	08/14/2020
New Jersey Improperly Claimed Tens of Millions for Medicaid School-Based Administrative Costs Based on Random Moment Sampling That Did Not Meet Federal Requirements	A-02-17-01006	11/08/2019
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	12/06/2018
New Jersey Claimed Hundreds of Millions in Unallowable or Unsupported Medicaid School-Based Reimbursement	A-02-15-01010	11/27/2017
Texas Improperly Received Medicaid Reimbursement for School-Based Health Services	A-06-14-00002	08/14/2017

APPENDIX C: SAMPLE DESIGN AND METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of the combination of annual school district and county cost pools to which PCG's RMTS results were applied to allocate costs, from October 1, 2011, through June 30, 2016; with the quarterly RMTS moments coded as Medicaid-eligible used to calculate the Medicaid costs for the corresponding cost pools.

PCG provided RMTS results data and school district/county cost data via Excel files. The files detailed cost report data containing 4,527 cost pools submitted by school districts/counties to which RMTS results were applied. We also obtained Excel files containing 20,709 moments coded as Medicaid-eligible health services. The 4,527 cost pools were comprised of two categories: "Therapy" and "All Other Personnel." Based on the 20,709 moments coded as Medicaid-eligible health services, the State agency claimed $154,606,543 in Federal Medicaid payments.

To create the sampling frame, we joined the cost pools and corresponding moments in such a manner that each moment was listed once for each cost pool that the moment could influence. The resulting sampling frame consisted of 10,244,131 cost pool-RMTS Medicaid-eligible health service moment combinations.

SAMPLE UNIT

The sample unit was defined as the combination of an RMTS moment and a school district cost pool.

SAMPLE DESIGN AND SAMPLE SIZE

We selected 300 sample items which corresponded to 298 unique activity moments.[36] The sample was based on the following stratified design:

- 20 items from Stratum 1, which included moments with a potential impact less than or equal to $11.39 on an "All Other Personnel" cost pool;

- 20 items from Stratum 2, which included moments with a potential impact greater than $11.39 and less than or equal to $32.47 on an "All Other Personnel" cost pool;

[36] The coding of a moment from one school district could impact reimbursements associated with other school districts in the same cost pool. Our sample was composed of combinations of activity moments and school districts. For each sample item, we examined the impact of any errors in the coding of the activity moment on the reimbursement for the school district that was part of that sample item. Because the sample unit was a combination of an activity moment and a school district, it was possible for the same activity moment to appear multiple times within the sample. Within our sample, 2 activity moments were selected multiple times. As a result, the 300 items in our sample corresponded to 298 unique activity moments.

- 20 items from Stratum 3, which included moments with a potential impact greater than $32.47 and less than or equal to $70.52 on an "All Other Personnel" cost pool;

- 20 items from Stratum 4, which included moments with a potential impact greater than $70.52 on an "All Other Personnel" cost pool;

- 55 items from Stratum 5, which included moments with a potential impact less than or equal to $13.53 on a "Therapy" cost pool;

- 55 items from Stratum 6, which included moments with a potential impact greater than $13.53 and less than or equal to $31.63 on a "Therapy" cost pool;

- 55 items from Stratum 7, which included moments with a potential impact greater than $31.63 and less than or equal to $112.88 on a "Therapy" cost pool; and

- 55 items Stratum 8, which included moments with a potential impact greater than $112.88 on a "Therapy" cost pool.

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered each stratum within the sampling frame. After generating the random numbers for each stratum, we selected the corresponding frame items for our sample.

ESTIMATION METHODOLOGY

We determined the effect of any unsupported codes on their corresponding cost pools for the sample item and calculated the related unallowable claim amount for Federal reimbursement. We used the OIG/OAS statistical software to estimate the total amount of overpayments for Medicaid costs at the lower limit of the two-sided 90-percent confidence interval. We also used this program to calculate the corresponding point estimate and upper limit.[37]

[37] The estimate was calculated based on the 300 sample items. Although the sample of cost pool-moment combinations contained two activity moments that appeared twice, each sample item was associated with a separate portion of the payments made to the State.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Stratum	Frame Count[38]	Sample Size	Unique Activity Moments	Unsupported Moments
1	1,176,017	20	20	7
2	260,095	20	20	7
3	103,528	20	20	7
4	32,664	20	19	9
5	6,235,644	55	55	36
6	1,665,186	55	55	30
7	645,471	55	54	35
8	125,526	55	55	38
Total	**10,244,131**	**300**	**298**	**169**

Estimated Unallowable Medicaid School-Based Administrative Claims Related to Unsupported Activity Moment Coding
(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	$85,564,116
Lower Limit	$77,152,491
Upper Limit	$93,975,742

[38] The frame count refers to the number of unique school district and RMTS moment combinations in the sampling frame.

APPENDIX E: STATE AGENCY COMMENTS

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

April 21st, 2021

Ms. Brenda Tierney
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: A-02-18-01019

Dear Ms. Tierney:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-18-01019 entitled, "New York Improperly Claimed $439 Million In Medicaid Funds for Its School-Based Health Services Based on Certified Public Expenditures."

Thank you for the opportunity to comment.

Sincerely,

Theresa Egan
Deputy Commissioner for Administration

Enclosure

cc: Diane Christensen
Frank Walsh
Brett Friedman
Geza Hrazdina
Daniel Duffy
Erin Ives
Timothy Brown
Amber Rohan
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Collin Gulczynski
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Lori Conway
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New York State Department of Health
Comments on the Department of Health and Human Services Office of Inspector General Draft Audit Report A-02-18-01019 entitled, "New York Improperly Claimed $439 Million in Medicaid Funds for Its School-Based Health Services Based on Certified Public Expenditures"

The following are the responses from the New York State Department of Health (Department) to Draft Audit Report A-02-18-01019 entitled, "New York Improperly Claimed $439 Million in Medicaid Funds for Its School-Based Health Services Based on Certified Public Expenditures" by the Department of Health and Human Services, Office of Inspector General (OIG).

Recommendation #1:

Refund to the Federal Government or provide documentation of such refund, totaling $97,998,292. Specifically:

- Refund to the Federal Government $77,152,491 related to random moments that could not be supported as Medicaid-eligible health services.
- Refund to the Federal Government $1,238,102 for intergovernmental agreement payments that the State agency did not support that it did not double-claim.
- Refund to the Federal Government or provide documentation of the refund to the Centers for Medicare & Medicaid Services (CMS) of $19,607,699 for excess costs claimed on the Form CMS-64 for 1 year.

Response #1:

- *Refund to the Federal Government $77,152,491 related to random moments that could not be supported as Medicaid-eligible health services.*

The Department disagrees with the audit finding that the sampled activity moments were either miscoded or unsupported. As a result, the Department asserts that a refund is not warranted for the identified claims. The Department notes that the OIG sampled 300 moments out of a total universe of approximately 70,000 moments that occurred from October 2012 through June 2016 (0.43%). Based on its review, the OIG has then found that 166 out of the 300 moments were coded in error, for a claims-based error rate of approximately 55%.

Based on these findings, the Department engaged coding experts from the Public Consulting Group—a leading public sector management consulting firm that supports School Supportive Health Services Programs (SSHSPs) across the country— to review each of those 166 moments identified by the OIG as potentially miscoded or unsupported. The results of this external expert review found that 163 of those 166 moments were coded correctly, with the remaining three moments being potentially correctly coded, but unsupported based on a lack of available documentation. Additionally, four (4) of the 166 moments sampled by the OIG were duplicates, reflecting possible problems with the OIG's sample design and selection methodology. Accordingly, the claims-level error rate from the sample was merely one (1) percent of the 300 moments that were sampled by the OIG.

As to the three unsupported moments, additional inquiry could have yielded additional information sufficient to support a reimbursable moment, further reducing the error rate. In addition, had OIG

considered the context in which these services are delivered, it likely would not have considered these moments unsupported. While the services provided in schools are medical in nature, they are coordinated to compliment the educational needs of a student. Medical providers often incorporate the subjects and tools that are being used in the classroom into their therapy session with the child. For example, the OIG cites where a "licensed speech language therapist stated she was 'identifying similes and metaphors' with four special education students because these goals were 'related to the English Language Arts Curriculum'." But the goals that students have on their Individualized Education Programs (IEPs) and Individualized Family Service Plans (IFSPs) are specifically designed because the child has a disability that creates an adverse effect and educational need that prevents them from being able to receive a Free and Appropriate Public Education in the same way a child without that disability would. Use of similes and metaphors by a Licensed Speech Language Therapist as part of a therapy session does not diminish the fact that they were still providing Speech Language Services that are eligible for reimbursement. Delivery of the service can serve both health-related and educational purposes simultaneously.

Similarly, an Occupational Therapist may indicate that they were working with a student on writing the letter 'B' because the development of fine motor skills like writing was defined in the goals of the student's IEP or IFSP. Like the Speech Therapy example provided above, the activity of the Occupational Therapist using writing the letters of the alphabet as part of the therapy session is consistent with the Occupational Therapy services that are eligible for reimbursement, while also complementing the educational needs of the child.

Additional examples of other faulty conclusions by the OIG as to coding, drawn from the list of moments identified by the OIG as being incorrectly coded as a direct service, are identified in the chart below:

Job_Title	Who was with you?	What were you doing?	Why were you performing this activity?	Special Ed student?	Part of IEP?
Speech and Language Therapist	A student	Speech therapy, one-on-one session with a preschool age child. Therapy focused on language, listening and vocabulary development.	It was the student's scheduled speech therapy time as mandated on the student's Individualized Education Plan. I see this student 5 days per week, 3 individual sessions and 2 groups.	Yes	Yes
Speech and Language Therapist	3 6th grade students from a collab classroom	We started reviewing irregular nouns, singular and plural, as well as adjectives. We were using cards with words and pictures.	All three students worked in previous sessions on the identification and use of irregular nouns and adjectives and in this session we reviewed it to make sure that they retained the information.	Yes	Yes
Speech and Language Therapist	A student	I was doing speech and language therapy with this student. We were working on verbs, identification of farm animals and sound production.	I was performing this activity because this student gets Speech and Language Therapy per his IEP at that time. We were working on speech and language objectives towards meeting long term goals.	Yes	Yes

The OIG also identified moments as incorrectly coded to the direct service activity code when the respondent noted that they were completing session notes after the session. But the Implementation Guide plainly states that activity Code 4b for direct services includes "Providing health/mental health services as covered in the student's IEP" such as "Paperwork associated with the delivery of the direct care service, as long as the student/client is not present. Such paperwork could include the preparation of progress notes, translation of session notes, or completion of billing activities."

One such example, drawn from the list of moments identified by the OIG as being incorrectly coded as a direct service is provided below:

Job_Title	Who was with you?	What were you doing?	Why were you performing this activity?	Special Ed student?	Part of IEP?
Licensed Occupational Therapist	I was alone.	Completing Medicaid notes in Clear Track for students seen throughout the school day.	As part of my job responsibility.	Yes	Yes

In light of these examples, we respectfully suggest that the OIG reconsider its findings regarding these moments before finalizing its report.

- *Refund to the Federal Government $1,238,102 for intergovernmental agreement payments that the State agency did not support that it did not double-claim.*

The Department has reviewed all Intergovernmental Agreement transactions for the periods covering the 2011-12 through the 2015-16 claiming periods and agrees with the return of $1,230,589 for Intergovernmental Agreement payments that were not correctly offset. For the 2014-15 period, the Department identified that the Intergovernmental Agreement Tuition Costs did not reflect the application of the applicable revenue offsets for a total of $1,078,759 of the $1,230,589. The Department also identified a small number of transactions across the remaining periods covered by the audit with a value of $151,830 federal share where the revenue offsets did not equal the amount of the expanse claimed. The Department will refund $1,230,589 to CMS.

- *Refund to the Federal Government or provide documentation of the refund to the Centers for Medicare & Medicaid Services (CMS) of $19,607,699 for excess costs claimed on the Form CMS-64 for 1 year.*

As a result of revising the IEP ratio calculation, the Department has already submitted a prior period adjustment on the January - March 2019 CMS-64 report, adjusting the claim from $11 million per quarter ($44 million per year) to $6 million per quarter ($25 million per year). On October 30, 2020, the Department provided documentation to the OIG that the $19M was previously refunded. Accordingly, the Department requests that this finding be removed from the final audit report as this finding has already been remediated.

Recommendation #2:

Refund $32,267,478 to the Federal Government or provide documentation to CMS to establish that it met an exception to use School Year (SY) 2013 random moment time studies (RMTS) to allocate costs for SY 2012.

Response #2:

Based on contemporaneous records (e-mail correspondence regarding drafts of the methodology) it is the Department's position that CMS approved the use of this approach. No significant differences existed between the time study period and the period to which the time study was applied to claim costs. The tables below demonstrate that the (Random Moment Time Study) RMTS percentages consistently fall within a range of less than 3%.

Direct Service - Therapy	2011 – 12	2012-13	2013-14	2014-15	2015-16
October – December	55.57%	55.57%	53.76%	54.96%	52.92%
January – March	50.84%	50.84%	53.35%	50.72%	52.91%
April – June	42.41%	42.41%	47.39%	44.57%	45.84%
Annual	**49.44%**	**49.44%**	**51.44%**	**50.31%**	**50.62%**
Direct Service – All Other	2011 – 12	2012-13	2013-14	2014-15	2015-16
October – December	17.50%	17.50%	14.18%	13.01%	11.01%
January – March	12.18%	12.18%	14.02%	10.55%	12.15%
April – June	12.67%	12.67%	13.22%	10.66%	11.08%
Annual	**14.10%**	**14.10%**	**13.80%**	**11.43%**	**11.41%**

During the exit conference, the OIG stated that increased interim claiming levels during the 2012-13 school year over the 2011-12 school year was evidence that the direct medical service related activities performed by SSHSP eligible clinicians would also be greater in the 2012-13 school year and, therefore, it is not reasonable to apply to the 2011-12 school year costs.

In order to support the use of this approach, which was approved by CMS, the Department and its vendor completed an analysis to compare the annual interim claiming levels to the annual direct medical services percentages generated through the RMTS. This analysis shows that there is no direct relationship between interim claiming activities of the Local Education Agencies (LEAs) and the activities of the SSHSP-eligible clinicians participating in the RMTS. As the table below shows, as interim claiming levels increased over the five-year period covered by this audit, the direct medical service percentages from the RMTS for both cost pools remain relatively consistent. For example, as the interim claiming levels increased from $100.8M to $115.7M from 2013-14 to 2014-15, the direct medical service percentages across the two cost pools decreased (51.44% to 50.31% for the therapy cost pool and 13.80% to 11.43% for the all other cost pool).

	2011-12	2012-13	2013-14	2014-15	2015-16
Total Interim Payments	$ 81,317,758	$ 99,534,981	$ 100,868,098	$ 115,717,861	$ 137,520,013
Direct Medical Service RMTS % - Therapy		49.44%	51.44%	50.31%	50.62%
Direct Medical Service RMTS % - All Other		14.10%	13.80%	11.43%	11.41%
Annual Change in Interim Claiming		22%	1%	15%	19%
Annual Change in Direct Service % - Therapy			4%	-2%	1%
Annual Change in Direct Service % - All Other			-2%	-17%	0%

Accordingly, the Department asserts that the use of the 2012-13 RMTS results to allocate costs in the 2011-12 cost report, as approved by CMS, was supported and reasonable.

Recommendation #3:

Refund $308,972,870 to the Federal Government or provide documentation that it can reasonably support, under the circumstances, its allocation of health services costs to Medicaid without using unverifiable individualized education plan (IEP) ratios.

Response #3:

The OIG sought to verify that the IEP ratios used to calculate the claims are accurate by requesting that the Department provide personally identifiable information (PII) from school districts that is not available to the Department under federal and state law. Instead, the claiming methodology approved by CMS as part of numerous State Plan Amendments (SPAs) (SPAs #11-39-A, 11-39-B, 16-0019, 16-0020, 17-0027, 17-0028) utilizes a set of internal controls to verify the IEP ratios. The Department believes it has adequately demonstrated the accuracy of the IEP ratios based on these CMS-approved internal controls being in place to verify this information. These controls include:

- A comparison of the IEP ratio denominator to the public Student Enrollment Data including percentage of students that are classified as disabled (i.e., have an IEP);
- A desk review process that requires all LEAs to reconfirm the data reported for the IEP denominator; and
- A requirement that any LEAs with an IEP Ratio that is one standard deviation above or below the statewide average to review and validate the IEP Ratio denominator a final time.

As articulated in the SSHSP Cost Reporting Guide issued by the Department, which was reviewed and approved by CMS as part the SPA process, "[f]ollowing the completion of the annual cost report and prior to submission, the LEA will be required to certify the public expenditures used for matching purposes to draw down federal funds related to the Medicaid Direct Service Program. In addition to certifying the accuracy of the public expenditures used for matching purposes, LEAs must also certify that all interim claims, have to the best of their ability and knowledge, been submitted through the Medicaid Management Information System (MMIS)."

Sample Certified Public Expenditure (CPE) form:

CERTIFICATION STATEMENT BY OFFICER OF THE PROVIDER INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED HEREIN MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.
1. All expenditures presented should be allowable in accordance with federal and the State Plan Amendment (SPA) agreement requirements.
2. I have examined this statement, the accompanying supported exhibits, the allocation of expenses and services, and the worksheets for the above indicated reporting period and to the best of my knowledge and believe they are true and correct statements prepared from our books and records in accordance with applicable instructions.
3. The expenditures included in this statement are based on the actual cost recorded expenditures.
4. The required amount of state and/or local funds were available and used to pay for total computable allowable expenditures included in this statement, and such state and/or local funds were in accordance with all applicable federal requirements for the non-federal share match of expenditures (including that the funds were not Federal funds in origin, or are Federal funds authorized by Federal law to be used to match other Federal funds, and that the claimed expenditures were not used to meet matching requirements under other Federally funded programs).
5. Federal matching funds are being claimed on this report in accordance with the cost report instructions provided by the New York State department of Health, Office of Health Insurance Programs effective for the above indicated reporting period.
6. I am the officer authorized by the referenced government agency to submit this form and I have made a good faith effort to assure that all information reported is true and accurate.
7. I understand that this information will be used as a basis for claims for Federal funds, and possibly State funds, and that a falsification and concealment of a material fact may be prosecuted under Federal or State civil or criminal law.

As a further explanation, and as referenced above, the Department does not have access to the specific PII requested by the OIG for verification purposes based on limitations in federal law and State Education Law. Specifically, the federal Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) prohibits the sharing of students' PII without the consent of the parent, subject to enumerated exceptions. None of these exceptions, as enumerated under 34 C.F.R. § 99.31, apply to the sharing of PII with the Department or OIG directly for purposes of validating Medicaid claims related to SSHSP or for audit responses generally. In particular, 34 C.F.R. § 99.31(a)(3), which contemplates disclosures to other governmental entities, neither includes the Department nor HHS as authorized entities capable of receipt of this PII. Similarly, Section 2-D of the New York Education Law imposes similar restrictions on the sharing of PII on students by school districts, consistent with the prohibitions of federal law. The Department has not found an exception to disclosure of PII for audit purposes as part of this statute or any regulations promulgated by the State Education Department in this regard.

To the extent the OIG believes that the Department's conclusion as to its interpretation of FERPA and/or State Education Law is incorrect, we ask it to render an opinion that supports this assertion, such that it can be presented by the Department to the school districts, or provide us with a methodology (if utilized and effective through similar audits with other states) to validate such claims. Otherwise, the Department believes it is reasonable and sufficient to rely on the internal controls approved by CMS through the periodic SPAs on the SSHSP, as referenced above.

Finally, the Department notes that the disallowed payments include all SSHSP interim claims reimbursed to school districts for direct medical services provided to only Medicaid eligible children. Interim claims are reimbursed at a Medicaid fee schedule amount, which is benchmarked to 75% of the Medicare fee for similar services. The Department disagrees with inclusion of interim claims in this audit. Including these claims in their entirety implies that school districts incurred no costs in providing the medically necessary services they offered. This is clearly inaccurate; school districts do incur costs in providing medical services. In fact, the OIG audit report specifically commends the Department for "use of interim payments because it encourages school districts to identify services provided to students enrolled in the Medicaid program." The report further acknowledges that the Department increased interim fees to 100% of Medicare fees, which further reduces the need for the Department to "rely on IEP ratios to allocate health services costs to its Medicaid program." Based on the OIG's recognition and acknowledgement of the need for interim payments, the Department believes that all interim payments should be eliminated from the scope of this audit report.

Recommendation #4:

Ensure that its contractor (1) collects sufficient information so the State agency can validate the contractor's coding of sampled moments and (2) correctly offsets and supports intergovernmental agreement transactions.

Response #4:

The Department understands the recommendations and agrees to conduct the necessary follow-up with time study respondents to collect additional information when the initial responses do not allow for the appropriate coding of moments. The collection of this additional information will support the validation of the contractor's coding of sampled moments. The Department will also include, in subsequent CPE claims, documentation sufficient to clearly display that the claim correctly offsets and supports intergovernmental agreement transactions.

Recommendation #5:

Revise its certified public expenditures School Supportive Health Services Program (SSHSP) to (1) include September days worked in its RMTS and (2) develop an accurate, supportable method to identify Medicaid costs instead of unverifiable IEP ratios.

Response #5:

The Department disagrees with these recommendations. The RMTS Implementation Guide issued by the Department and approved by CMS only requires the sample period to cover the three quarters from October through June each school year. On February 18, 2015, CMS sent the Department a letter approving the time study methodology and specifying that annual direct medical percentages will be calculated by averaging three quarters of time study data. The Department is confident that its allocation of school-related health services costs to Medicaid were determined in accordance with the CMS-approved SPAs and claiming methodology.