Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW JERSEY'S MEDICAID SCHOOL-BASED COST SETTLEMENT PROCESS COULD RESULT IN CLAIMS THAT DO NOT MEET FEDERAL REQUIREMENTS

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Office of Inspector General

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Report in Brief
Date: March 2022
Report No. A-02-20-01012

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

Why OIG Did This Audit

In July 2019, the Centers for Medicare & Medicaid Services (CMS) approved New Jersey's *Medicaid Administrative Claiming and Special Education Medicaid Initiative Cost Settlement Process Guide* (Process Guide). New Jersey has been using the methodology detailed in the Process Guide to claim Medicaid school-based costs since October 2011. In November 2019, OIG issued a report stating that the methodology did not meet Federal requirements. As of December 2021, New Jersey is seeking to use the Process Guide to claim additional Medicaid reimbursement for school-based costs for prior periods if CMS approves a related proposal by New Jersey to amend its Medicaid State plan. We initiated this audit because New Jersey has not corrected the deficiencies identified in our November 2019 report and seeks to use the Process Guide to claim additional funds for prior periods.

The objective of our audit was to determine whether New Jersey's CMS-approved Process Guide complied with Federal requirements.

How OIG Did This Audit

To achieve our objective, we reviewed New Jersey's Process Guide and CMS's letter approving the Process Guide. We also reviewed Federal requirements, CMS documents, and information provided by New Jersey.

New Jersey's Medicaid School-Based Cost Settlement Process Could Result in Claims That Do Not Meet Federal Requirements

What OIG Found

New Jersey's methodology for claiming Medicaid school-based costs, as described in the Process Guide, does not comply with Federal requirements. Specifically, the Process Guide's methodology for conducting random moment time studies (RMTSs) (1) does not meet Federal requirements for statistical sampling, (2) defines one Medicaid administrative activity code as including activities not necessary for the administration of the Medicaid State plan, and (3) does not ensure that RMTS responses and Medicaid cost allocation ratios are supported. In designing its Process Guide, New Jersey did not address deficiencies identified during our prior audit of its school-based program, follow CMS guidance, and ensure that its Medicaid cost allocation ratios could be supported. Therefore, if CMS does not work with New Jersey to address the deficiencies identified in this report, Medicaid claims submitted for reimbursement by New Jersey school districts will not meet Federal requirements and the risk of improper payments could increase by tens of millions of dollars per year.

What OIG Recommends

We recommend that CMS direct New Jersey to revise the Process Guide to ensure that New Jersey's methodology for claiming Medicaid school-based health care services costs complies with Federal requirements. The detailed recommendations are listed in the body of the report.

In written comments on our draft report, CMS concurred with our recommendations. CMS also indicated that it is in the process of developing updated guidance to ensure that time studies used by States to claim Medicaid Federal reimbursement for school-based administrative and health service programs are valid, reliable, and auditable.

The final report can be found at https://oig.hhs.gov/oas/reports/region2/A22001012.asp.

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INTRODUCTION

WHY WE DID THIS AUDIT

In July 2019, the Centers for Medicare & Medicaid Services (CMS) approved the New Jersey Department of Human Services' (State agency's) *Medicaid Administrative Claiming and Special Education Medicaid Initiative Cost Settlement Process Guide* (Process Guide).[1] The State agency has been using the methodology detailed in the Process Guide to claim Medicaid school-based costs since October 2011. In November 2019, the Office of Inspector General (OIG) issued a report stating that the methodology did not meet Federal requirements.[2] As of December 2021, the State agency is seeking to use the Process Guide to claim additional Medicaid reimbursement for school-based costs for prior periods if CMS approves a related proposal by the State agency to amend its Medicaid State plan. We initiated this audit because the State agency has not corrected the deficiencies identified in our November 2019 report and seeks to use the Process Guide to claim additional funds for prior periods.[3]

OBJECTIVE

The objective of our audit was to determine whether the State agency's CMS-approved Process Guide complied with Federal requirements.

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, 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 Jersey, the State agency administers the Medicaid program.

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[1] The State agency refers to this document as the Implementation Guide.

[2] *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 (Nov. 8, 2019). As part of its oversight activities, OIG is conducting a series of audits of Medicaid school-based costs claimed by States that used contractors to claim these costs.

[3] Among other recommendations, we recommended that the State agency revise its methodology to comply with Federal requirements. In its comments on our draft report, the State agency asserted that it had worked in good faith with CMS to develop a revised methodology to claim school-based Medicaid costs in compliance with Federal requirements. However, CMS approved the Process Guide prior to the issuance of our final report.

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

Section 1903(c) of the Social Security Act (the Act) permits Medicaid payment for certain covered health care services that are provided by schools under the Individuals with Disabilities Education Act (IDEA). IDEA requires schools to provide special education and related services for children with disabilities. 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. Among other requirements, the health care services must be specified in each child's individualized education plan (IEP) or, for children under age 3, the individualized family service plan to be covered by Medicaid.[4]

A State agency may also claim Federal Medicaid funds for school-based activities necessary for the "proper and efficient administration" of its State plan (the Act § 1903(a)(7)). These administrative activities are functions other than providing direct health care services to Medicaid beneficiaries and may include Medicaid outreach, assistance with processing Medicaid applications, and assisting beneficiaries with receiving access to Medicaid services.

CMS-Approved Process Guide

The methodology described in the CMS-approved Process Guide[5] contains the policies and procedures that New Jersey school districts must follow for the State agency to receive Federal Medicaid reimbursement if CMS approves the State agency's proposal to amend its Medicaid State plan. The methodology includes the design of random moment time studies (RMTSs) used to estimate health care services and administrative costs, and ratios to allocate health care services and administrative costs to Medicaid. By using this methodology, school districts would claim Medicaid costs based on their actual costs. As of December 2021, CMS is reviewing an amendment to the State agency's Medicaid State plan that utilizes statistics resulting from the Process Guide.[6] The State agency has prepared calculations showing that the Process Guide's methodology would allow it to claim up to tens of millions of dollars of additional Federal funding per year,[7] and it seeks to retroactively claim these amounts to 2011.

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[4] An IEP is a written plan that is designed to meet a disabled child's special education and related services needs.

[5] CMS approved the Process Guide in July 2019 with an effective date of Oct. 1, 2016.

[6] If approved, the proposed State Plan Amendment would allow the State agency to claim school districts' actual costs of school-based health care services through certified public expenditures (CPE). The CPE method allows use of funds certified as actual expenditures as the State share to receive matching Federal Medicaid funds. Currently, the State agency is approved to claim Federal Medicaid funds for school-based health care services based on a fee schedule.

[7] In our report *New Jersey Claimed Hundreds of Millions in Unallowable or Unsupported Medicaid School-Based Reimbursement*, A-02-15-01010 (Nov. 27, 2017), we reported that the State agency improperly claimed $80 million for 4 years based on the unapproved State Plan Amendment.

Random Moment Time Studies and Cost Allocation Ratios

RMTSs must reflect all of the time used and activities performed (whether allocable or allowable under Medicaid) by employees participating in a school-based health program. RMTSs are used to identify the portion of the direct medical service time allowable and reimbursable under Medicaid. The State agency contracts with Public Consulting Group (PCG) to perform RMTSs, code RMTS participant responses, and assist with calculating and allocating costs for school-based health care services and administrative activities.

The RMTSs determine health care costs for all students (i.e., students enrolled or not enrolled in Medicaid). The portion of health care costs that Medicaid may reimburse is determined by the ratios of Medicaid-eligible students to the total number of students in each school district. According to the Process Guide, the State agency uses two ratios: the IEP ratio[8] for special education health care services costs included in an IEP and the Medical Plan (MP) ratio[9] for other Medicaid-eligible health care services costs included in a Medical Plan of Care.[10] Both ratios are calculated by identifying the total number of students (including those not enrolled in Medicaid) that have IEPs or MPs recommending Medicaid-eligible health care services.

How We Conducted This Audit

To achieve our objective, we reviewed the State agency's Process Guide and CMS's letter approving the Process Guide (dated July 5, 2019).

CMS's internal controls are not significant to the objective of our audit because our objective was to determine if the State agency's Process Guide complied with Federal requirements.

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.

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[8] The IEP ratio is calculated by dividing the number of Medicaid-eligible students that have an IEP containing a reimbursable direct medical health care service by the total number of students (including those not enrolled in Medicaid) that have IEPs containing reimbursable direct medical health care services.

[9] The MP ratio is calculated by dividing the number of Medicaid-eligible students with a medical plan that includes a reimbursable direct medical health care service by the total number of students with a medical plan that includes a reimbursable direct medical health care service.

[10] Prior to Dec. 2014, CMS policy generally prohibited Medicaid reimbursement for school health services provided free to all students unless it was included in an IEP. In a State Medicaid Director's Letter dated Dec. 15, 2014, CMS withdrew this "free care" policy. However, CMS stated that, if a State agency prefers to cover services provided free of charge, it must comply with all Medicaid requirements, including obtaining CMS approval.

Appendix A contains the details of our audit scope and methodology, Appendix B contains a list of related audits, and Appendix C includes both the CMS Guide and the State agency's Process Guide's definition and description of the code used to indicate the performance of Medicaid administrative services.

FINDINGS

The State agency's methodology for claiming Medicaid school-based costs, as described in the Process Guide, does not comply with Federal requirements. Specifically, the Process Guide's methodology for conducting RMTSs (1) does not meet Federal requirements for statistical sampling, (2) defines one Medicaid administrative activity code as including activities not necessary for the administration of the Medicaid State plan, and (3) does not ensure that RMTS responses and Medicaid cost allocation ratios are supported. In designing its Process Guide, the State agency did not address deficiencies identified during our prior audit of its school-based program, follow CMS guidance, and ensure that its Medicaid cost allocation ratios could be supported.[11] Therefore, if CMS does not work with the State agency to address the deficiencies identified in this report, Medicaid claims submitted for reimbursement by New Jersey school districts will not meet Federal requirements and the risk of improper payments could increase by tens of millions of dollars per year.

RANDOM MOMENT TIME STUDY METHODOLOGY DOES NOT MEET FEDERAL REQUIREMENTS FOR STATISTICAL SAMPLING

Random Moment Time Studies Do Not Sample the Entire School Year

Federal regulations require RMTS results to be applied to the sample period and the entire time period involved must be covered by the sample.[12] CMS's *Medicaid School-Based Administrative Claiming Guide* (CMS Guide)[13] provides the following example of how to apply this requirement: "If the regular school year begins in the middle of a calendar quarter (that is, the end of August or sometime in September), the first time study for that school year should include all days from the beginning of the school year."

RMTSs described in the Process Guide do not sample during September even though most New Jersey schools are in session for most of the month. Instead, the Process Guide states that RMTSs are conducted for three of the four Federal fiscal year quarters (October 1 through

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[11] *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 (Nov. 8, 2019).

[12] 45 CFR § 75.430(i)(5).

[13] 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 Oct. 27, 2021.

December 31, January 1 through March 31, and April 1 through June 30). The State agency does not conduct a time study for the fourth quarter (July 1 through September 30). Instead, it applies the average RMTS percentages for the three quarters prior to July through September to the fourth quarter's costs. As a result, the RMTSs described in the Process Guide do not meet statistical sampling standards because moments that could change the resulting RMTS percentages would not be included in the sampled time period. This could lead to increased costs claimed from the Federal government.[14]

The State Agency Interprets a CMS-Required Provision Added to the Process Guide Differently Than CMS Intended

Federal regulations require RMTS results to be statistically valid.[15] To ensure the accuracy of RMTS responses, CMS required the State agency to include a provision in the Process Guide to allow the State agency 3 working days to obtain responses.[16] CMS's provision stated in the Process Guide, reads: "The time study questionnaire or survey forms are not kept open more than three (3) school days after the end of the time study period." CMS officials stated that the provision was intended to ensure that responses must be received within 3 working days of the date of the sampled moment. Moments received outside the response window are deemed non-responses and are coded as non-Medicaid, potentially decreasing Medicaid reimbursement.[17]

Contrary to CMS's intent, the State agency stated that it interprets the provision to allow it to obtain RMTS responses up to 3 days after the end of the sampled quarter. If the State agency applies its interpretation of CMS's provision, it may accept RMTS responses weeks or months after the sampled moment, potentially creating unreliable (e.g., a response based on a participant's memory of a moment that occurred 3 months earlier) results and avoiding these responses from being coded as non-Medicaid.

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[14] Based on past experiences of auditing the State agency's school-based claims, OIG concludes that omitting September from the moment sampling population would likely increase the costs to the Federal Government because schools require time at the beginning of each school year to initiate health care services and generally prepare care plans in the spring to be effective for the following school year.

[15] 45 CFR § 75.430(i)(5).

[16] In its communications with the State agency related to the RMTS and the State agency's proposed amendment to its State Plan, CMS explained its reasoning as follows: "Please note that CMS has revised our administrative claiming policy in consultation with the Division of Cost and Allocation and input from the Office of the Inspector General to request that participants be notified at the exact time and date of their assigned moment and not 5 days beforehand as previously permitted. Participants should have no more than 2 working days to respond to their RMTS moment. Participants should no longer have access to the RMTS moment after 2 working days. This CMS change in policy is an excellent control that will enhance the reliability of the RMTS percentages and eliminate bias." After receiving feedback from the State agency, CMS subsequently approved a window of 3 working days.

[17] The Process Guide states that "if an 85% response rate is not met, ALL non-responses will be coded to the Non-Medicaid Activity Code." Process Guide, p. 36 (emphasis in original).

The State Agency Interprets the Process Guide to Allow It to Substitute Sampled Personnel and Vacant Positions

Federal regulations require RMTS results to be statistically valid and adhere to statistical sampling standards.[18] Changes to the sample may compromise its representativeness or distort the RMTS results.[19] Also, the State agency agreed to a CMS request that the State agency not add or delete RMTS participants after the close of a sampled quarter.

The State agency interprets its Process Guide to allow it to substitute sampled personnel and vacant positions to respond to staff turnover. According to the State agency, sampling is done by position—not by identified personnel. However, the Process Guide states that participants are to be selected from a "staff list," which is defined as a "list of names." Further, "names" are to be selected for the sample and moments are matched with "individuals." If the State agency substitutes sampled personnel and vacant positions as part of its RMTS methodology, it will not comply with the statistical sampling methodology CMS approved in the Process Guide. Such unauthorized changes to a sample may compromise its representativeness or distort the RMTS results.[20] Therefore, it may incorrectly estimate health care services costs, resulting in an incorrect claim for Federal Medicaid reimbursement.

THE PROCESS GUIDE'S DEFINITION OF ONE MEDICAID ADMINISTRATIVE ACTIVITY CODE INCLUDES ACTIVITIES NOT NECESSARY FOR THE ADMINISTRATION OF THE STATE PLAN

A State agency may claim Federal Medicaid funds for activities necessary for the "proper and efficient administration" of its Medicaid State plan (42 CFR § 433.15). The CMS Guide states that "Medicaid does not pay for the administrative activities associated with the development of the IEP" and that "Medicaid does not pay for the IEP team meetings or for costs related to attendance at those meetings by medical professionals."[21] The CMS Guide provides a model coding system to assist State agencies in claiming only Medicaid-allowable administrative activities which excludes these unallowable activities.

The State agency's Process Guide defines one of its RMTS administrative codes as including activities not necessary for the proper and efficient administration of the Medicaid State plan. Specifically, the State agency's definition for the code includes the development of IEPs and attendance at IEP meetings—activities not included in CMS's model language for the code and not reimbursable as stated in the CMS Guide. If the State agency adheres to the definition in its

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[18] 45 CFR § 75.430(i)(5).

[19] See *Florida Agency for Health Care Administration*, DAB No. 2808, p.16 (July 27, 2017).

[20] See previous footnote.

[21] CMS Guide, p. 56. However, a medical professional's development of a care plan for Medicaid-eligible health care services may be an allowable health care service. Such development of a care plan, though, would be coded as a health care service, not an administrative activity.

Process Guide and CMS approves the State agency's proposal to amend its Medicaid State plan, the State agency may make unallowable claims for Federal Medicaid reimbursement. (Appendix C includes both the CMS Guide and the State agency's Process Guide definitions of this code.)

THE PROCESS GUIDE DOES NOT ENSURE THAT RANDOM MOMENT TIME STUDY RESPONSES AND MEDICAID COST ALLOCATION RATIOS ARE SUPPORTED

The Process Guide Does Not Ensure That Random Moment Time Studies Collect Enough Information for the State Agency to Support Its Claims

For claims to be eligible for Medicaid reimbursement, Federal regulations require documentation to be maintained to assure that the claims comply with applicable Federal requirements and that documentation be made available for audits and examinations.[22] Also, the CMS Guide indicates that, in conducting RMTSs, State agencies should collect students' names or case numbers, or use some comparable procedure that provides adequate documentation.

The methodology described in the Process Guide does not ensure that the State agency collects enough information to support whether an RMTS participant's time was part of a Medicaid-eligible health care service or a Medicaid administrative activity. In prior audits of coding by the State agency's contractor, OIG found many instances where the absence of student identifying information prevented the State agency from obtaining service documentation that might have supported the codes.[23] Specifically, the Process Guide does not require the RMTSs to collect the name of the student or other identifying information. Rather, the RMTSs collect general information about participants' activity. Without identifying information on students, the associated records cannot be reviewed to substantiate the service or activity reported. Therefore, if the State agency follows its Process Guide, it will not be able to support its claims for Federal Medicaid reimbursement, which increases the risk for improper payments by tens of millions of dollars per year.

The Allocation Ratios Detailed in the Process Guide Are Calculated Based Partially on Records of Students Not Enrolled in Medicaid

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

[22] 42 CFR § 433.32, 45 CFR § 75.364.

[23] *New York Improperly Claimed $439 Million in Medicaid Funds for Its School-Based Services Based on Certified Public Expenditures,* A-02-18-01019 (Jul. 20, 2021)*; 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 (Nov. 8, 2019).

their expenditures.[24] In order to be allowable, costs must be allocable to Medicaid (i.e., chargeable or assignable to Medicaid in accordance with relative benefits received).[25] Also, State Medicaid agencies must assure appropriate audit of records if payment is based on costs of services.[26]

The IEP and MP allocation ratios detailed in the Process Guide are calculated based, in part, on records of students not enrolled in Medicaid. Federal privacy requirements[27] do not allow the State agency to review IEPs or MPs of students not enrolled in Medicaid,[28] which would be required to audit the school districts' allocation ratios. Therefore, the State agency will be unable to verify the total number of students (including those not enrolled in Medicaid) that had IEPs and MPs recommending Medicaid-eligible health care services (i.e., the denominator used in each school district's IEP and MP ratios). Without verification, an audit of the ratios is not possible. If the State agency follows its Process Guide and continues to use these allocation ratios, it will not be able to support its claims for Federal Medicaid reimbursement and may increase the risk for improper payments by tens of millions of dollars per year.

CONCLUSION

We provided our preliminary findings to the State agency for informal comments. In written comments, the State agency disagreed with our findings and stressed that CMS had approved the Process Guide and that the methodology was consistent with those used by other States.[29] After considering the State agency's comments, we maintain that our findings are valid. Specifically, the Process Guide's RMTS does not meet Federal requirements for statistical sampling, its definition of a Medicaid administrative activity includes activities not necessary for the administration of the State plan, and it does not ensure that RMTS responses and Medicaid cost allocation ratios are supported. Therefore, if the Process Guide is not revised, the State agency's cost settlement process will result in school-based claims for Medicaid reimbursement that do not meet Federal requirements, which increases the risk of improper payments by tens

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[24] 45 CFR § 75.302.

[25] 45 CFR §§ 75.403(a), 75.405.

[26] 42 CFR § 447.202.

[27] 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 the U.S. Department of Health and Human Services and the U.S. Department of Education, and the regulations cited therein.

[28] 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.

[29] We provided a copy of the State agency's comments to CMS.

of millions of dollars per year. Further, the State agency may seek to claim these additional amounts retroactively to 2011.

RECOMMENDATIONS

To ensure that the State agency complies with Federal requirements and does not claim unallowable costs, we recommend that the Centers for Medicare & Medicaid Services direct the State agency to revise the Process Guide to incorporate the following changes:

- include days worked during September in RMTSs,
- obtain RMTS responses within 3 days after the date of the sampled moment,
- prohibit the substitution of sampled personnel,
- revise the definition of the RMTS code described in the report to include only activities necessary for the proper and efficient administration of the Medicaid State plan,
- require the collection of information (e.g., student names or case numbers) to support whether an RMTS participant's time was part of a health care service or a Medicaid administrative activity, and
- develop a method for allocating health care services costs to Medicaid that does not require it to rely on IEP and MP ratios (e.g., require a school district to determine whether an RMTS moment is for a health care service or administrative activity performed for a student enrolled in Medicaid).

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations. CMS also indicated that it is in the process of developing updated guidance to ensure that time studies used by States to claim Medicaid Federal reimbursement for school-based administrative and health service programs are valid, reliable, and auditable. CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding technical comments, are included as Appendix D.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We limited our review to the State agency's Process Guide and CMS's letter approving the Process Guide (dated July 5, 2019). Accordingly, there was no audit period.

CMS's internal controls are not significant to the objective of our audit because our objective was to determine if the design of the RMTSs described in the State agency's Process Guide follow the guidance set forth by Federal requirements.

We performed audit work from February 2020 through December 2021.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal criteria,

- obtained and analyzed documentation of all communication on the Process Guide between CMS and the State agency,

- discussed our findings with State agency, PCG, and CMS officials to obtain their perspectives; and

- determined if IEP and MP allocation ratios, as described in the Process Guide, can be supported by documents subject to audit.

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
New York Improperly Claimed $439 Million in Medicaid Funds for Its School-Based Services Based on Certified Public Expenditures	A-02-18-01019	7/20/2021
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: CMS AND STATE AGENCY PROCESS GUIDE
ACTIVITY CODE DESCRIPTIONS

CODE 9B (CMS Guide)

REFERRAL, COORDINATION, AND MONITORING OF MEDICAID SERVICES –
School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of medical (Medicaid covered) services. Referral, coordination and monitoring activities related to services in an IEP are reported in this code. Activities that are part of a direct service are not claimable as an administrative activity. Furthermore, activities that are an integral part of or an extension of a medical service (e.g., patient follow-up, patient assessment, patient counseling, patient education, patient consultation, billing activities) should be reported under Code 4, Direct Medical Services. Note that targeted case management, if provided or covered as a medical service under Medicaid, should be reported under Code 4, Direct Medical Services. Activities related to the development of an IEP should be reported under Code 3, School Related and Educational Activities. Include related paperwork, clerical activities, or staff travel necessary to perform these activities.

1. Identifying and referring adolescents who may be in need of Medicaid family planning services.

2. Making referrals for and/or coordinating medical or physical examinations and necessary medical/dental/mental health evaluations.

3. Making referrals for and/or scheduling EPSDT[30] screens, interperiodic screens, and appropriate immunization, but NOT to include the state-mandated health services.

4. Referring students for necessary medical health, mental health, or substance abuse services covered by Medicaid.

5. Arranging for any Medicaid covered medical/dental/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/mental health condition.

6. Gathering any information that may be required in advance of medical/dental/mental health referrals.

7. Participating in a meeting/discussion to coordinate or review a student's needs for health-related services covered by Medicaid.

[30] Early and Periodic, Screening, Diagnostic and Treatment

8. Providing follow-up contact to ensure that a child has received the prescribed medical/dental/mental health services covered by Medicaid.

9. Coordinating the delivery of community based medical/dental/mental health services for a child with special/severe health care needs.

10. Coordinating the completion of the prescribed services, termination of services, and the referral of the child to other Medicaid service providers as may be required to provide continuity of care.

11. Providing information to other staff on the child's related medical/dental/mental health services and plans.

12. Monitoring and evaluating the Medicaid service components of the IEP as appropriate.

13. Coordinating medical/dental/mental health service provision with managed care plans as appropriate.

CODE 9B (State agency's Process Guide)
OIG Note: Number 8 is not included in the CMS Guide (above)

Code 9.b. - Referral, Coordination and Monitoring of Medicaid Services–
School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of medical (Medicaid covered) services. Referral, coordination and monitoring activities related to services in an IEP are reported in this code. Activities that are part of a direct service are not claimable as an administrative activity. Furthermore, activities that are an integral part of or an extension of a medical service (e.g., patient follow-up, patient assessment, patient counseling, patient education, patient consultation, billing activities) should be reported under Code 4A - Direct Medical Services - Not Covered as IDEA/IEP Services, 4B- Direct Medical Services - Covered as IDEA/IEP Services or 4C- Direct Medical Services – Covered on a Medical Plan of Care, Not Covered as IDEA/IEP service. Examples include:

1. Identifying and referring adolescents who may be in need of Medicaid family planning services.

2. Making referrals for and/or coordinating medical or physical examinations and necessary medical/dental/mental health evaluations.

3. Making referrals for and/or scheduling EPSDT screens, interperiodic screens, and appropriate immunization, but NOT to include the state-mandated health services.

4. Referring students for necessary medical health, mental health, or substance abuse services covered by Medicaid.

5. Arranging for any Medicaid covered medical/dental/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/mental health condition.

6. Gathering any information that may be required in advance of medical/dental/mental health referrals.

7. Participating in a meeting/discussion to coordinate or review a student's needs for health-related services covered by Medicaid.

8. Developing, coordinating, and monitoring the medical portion of the IEP for a student, which includes the medical portion of the actual IEP meetings with the parents, time spent developing the medical services plan on the IEP, and writing of the medical service goals of the IEP. (If appropriate, this would also refer to the same activities performed in support of an Individualized Family Service Plan or other medical plan.)

9. Providing follow-up contact to ensure that a child has received the prescribed medical/dental/mental health services covered by Medicaid.

10. Coordinating the delivery of community based medical/dental/mental health services for a child with special/severe health care needs.

11. Coordinating the completion of the prescribed services, termination of services, and the referral of the child to other Medicaid service providers as may be required to provide continuity of care.

12. Providing information to other staff on the child's related medical/dental/mental health services and plans.

13. Monitoring and evaluating the Medicaid service components of the IEP and/or medical plan as appropriate.

14. Coordinating medical/dental/mental health service provision with managed care plans as appropriate.

APPENDIX D: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: February 3, 2022

TO: Amy J. Frontz
Deputy Inspector General for Audit Services

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: New Jersey's Medicaid School-Based Cost Settlement Process Could Result in Claims That Do Not Meet Federal Requirements, A-02-20-01012

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS takes seriously its responsibilities to protect taxpayer funds by conducting thorough oversight of the Medicaid expenditures claimed by states. Because Medicaid is jointly funded by states and the Federal Government, and is administered by states within Federal guidelines, both CMS and states have key roles as stewards of the program and work together closely to carry out these responsibilities.

Schools deliver a broad range of educational, social, and medical services to students with disabilities, some of which may be covered by Medicaid. As OIG notes, current statute[1] allows Medicaid payment for health-related services that are specified in each child's individualized education plan, generally without the child having to leave school. State Medicaid agencies may also be reimbursed for the administrative activities that support school-based health services for children eligible for Medicaid. In 2003, CMS issued the Medicaid School-Based Administrative Claiming Guide[2] (the Guide) to inform schools, state Medicaid agencies, and other interested parties on the appropriate methods for claiming federal reimbursement for the costs of Medicaid administrative activities performed in the school setting. The Guide notes that while some or all of the costs of these administrative activities may be reimbursable under Medicaid, an appropriate claiming mechanism must be used.

In order to properly identify and categorize the Medicaid administrative activities performed by school or school district employees, states must develop an allocation methodology. The allocation methodology, which may use random moment sampling (RMS), contemporaneous time sheets, or other quantifiable measures of employee effort, is often referred to as a time study. States have the flexibility to design a time study that best meets the needs of their Medicaid program, as long as the applicable federal requirements are met. For example, time studies must only allocate allowed cost, be statistically valid, appropriately capture all time allocated to billable and non-billable activities, and account for no more than 100 percent of staff

[1] Section 1903(c) of the Social Security Act
[2] https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/medicaidbudgetexpendsystem/downloads/schoolhealthsvcs.pdf

time. In addition, time studies must comport with the state's approved public assistance cost allocation plans for administrative costs, and the Medicaid state plan for direct service costs.

CMS conducts multiple activities to oversee Medicaid expenditures and verify that federal financial participation matches states' actual expenditures. For example, on a quarterly basis, states must submit to CMS their Medicaid expenditures and include supporting documentation such as invoices, cost reports, and eligibility records. CMS then reviews these expenditures and works with states to resolve any questionable expenditures to ensure that the appropriate amounts are spent and that higher matching rates are reported correctly. Additionally, In response to prior OIG recommendations,[3] CMS is in the process of developing updated guidance to ensure that the time studies used by states to claim Medicaid federal reimbursement for school-based administrative and health service programs are valid, reliable and auditable. CMS also intends to use this guidance to remind states of their obligations to maintain and retain adequate documentation to validate Random Moment Time Studies (RMTSs) responses and support the school-based health services costs claimed.

The OIG's recommendations and CMS's responses are below.

OIG Recommendation
CMS should direct the State agency to revise the Process Guide to include days worked during September in RMTSs.

CMS Response
CMS concurs with this recommendation. CMS will work with the state to update their Process Guide to include days worked during September in the RMTS.

OIG Recommendation
Obtain RMTS responses within 3 days after the date of the sampled moment

CMS Response
CMS concurs with this recommendation. CMS will work with the state to update their Process Guide so that RMTS responses are obtained within 3 days after the date of the sampled moment.

OIG Recommendation
Prohibit the substitution of sampled personnel

CMS Response
CMS concurs with this recommendation. CMS will work with the state to update their Process Guide to prohibit the substitution of sampled personnel.

OIG Recommendation
Revise the definition of the RMTS code described in the report to include only activities necessary for the proper and efficient administration of the Medicaid State plan

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[3] https://oig.hhs.gov/oas/reports/region7/71804107.pdf

CMS Response
CMS concurs with this recommendation. CMS will work with the state to revise the definition of the RMTS code described in the OIG's report, Code 9B, to include only activities necessary for the proper and efficient administration of the Medicaid State plan. CMS will work with the state to ensure that the Process Guide is updated to reflect the revised definition of Code 9B.

OIG Recommendation
Require the collection of information (e.g., student names or case numbers) to support whether an RMTS participant's time was part of a health care service or a Medicaid administrative activity

CMS Response
CMS concurs with this recommendation. CMS will work with the state to update their Process Guide to require the collection of information necessary to support whether an RMTS participant's time was part of a health care service or a Medicaid administrative activity.

OIG Recommendation
Develop a method for allocating health care services costs to Medicaid that does not require it to rely on IEP and MP ratios (e.g., require a school district to determine whether an RMTS moment is for a health care service or administrative activity performed for a student enrolled in Medicaid)

CMS Response
CMS concurs with this recommendation. CMS will work with the state to develop a method for allocating health care services costs to Medicaid that does not require it to rely on IEP and MP ratios, and will ensure that the Process Guide is updated to reflect the new method for allocating health care services costs to Medicaid.