DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

JAN 12 2005

TO: Wynethea Walker
Acting Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Vermont Medicaid School-Based Services for the Period October 2001 Through September 2002 (A-01-03-00004)

Attached is an advance copy of our final report on Vermont Medicaid school-based services. We will issue this report to the Vermont Medicaid agency within 5 business days. This report is one of a series of audits of costs claimed by States for Medicaid school-based health services. We are conducting these audits in response to concerns raised by officials from the Centers for Medicare & Medicaid Services (CMS) and the Office of Management and Budget. We suggest that you share this report with the Centers for Medicaid State Operations and any other components of CMS involved with Medicaid program integrity and provider issues.

Our objective was to determine whether costs that Vermont claimed for school-based child health services were allowable and adequately supported in accordance with Federal regulations and the Medicaid State plan.

Under Part B of the Individuals with Disabilities Education Act, school districts must prepare an individualized education plan (child's plan) for each child that specifies all special education and "related services" that the child needs. The Medicaid program pays for some of the school-based "health related services" included in the child's plan if the services are specified in Medicaid law and included in the Medicaid State plan. Examples of school-based services include physical therapy, speech pathology, occupational therapy, psychological services, and medical screening and assessment.

Of the 1,087 claims in our statistical sample, 240 were not allowable or adequately supported. The errors included:

- services not specified in the child's plan,
- services not billed at the appropriate level of reimbursement,
- unallowable services, and
- clerical errors.

These errors occurred because the school districts (known as local educational supervisory unions) and the State did not have controls in place to ensure that services billed were accurate and in accordance with services specified in the child's plan. As a result, we estimated that the State improperly claimed $1,463,395 in Federal funds for school-based services from October 2001 through September 2002.

We recommend that the State:

- refund $1,463,395 to the Federal Government,

- instruct the supervisory unions to review school-based service billings before submitting them for reimbursement to ensure that the services billed are specified in the child's plan and accurately reflect the type and amount of services provided, and

- establish periodic postpayment reviews to ensure that claims for services are in accordance with Federal regulations and State policies and procedures.

The State said that since our audit, it had made some significant improvements in the program that addressed our procedural recommendations. Although the State agreed with our findings for a number of the sampled claims, it believed that other erroneous claims identified in the audit were in compliance with program policies. As a result, the State believed that the dollar impact of the errors included in the report was substantially overstated. In this regard, the State provided specific comments disagreeing with our conclusions that overpayments were made for 111 of the 278 erroneous claims identified in our draft report.

After reviewing the State's comments and additional documentation that the State presented subsequent to the issuance of the draft report, we made adjustments for 38 claims. However, for the remaining 240 claims, we maintain our conclusions that payments for these claims did not meet Federal and State reimbursement requirements.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2689. Please refer to report number A-01-03-00004 in all correspondence.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

JAN 18 2005

Report Number: A-01-03-00004

Mr. Joshua Slen
Director
Office of Vermont Health Access
State of Vermont
103 South Main Street
Waterbury, Vermont 05671-1201

Dear Mr. Slen:

Enclosed are two copies of a Department of Health and Human Services (HHS), Office of Inspector General's (OIG) report entitled "Review of Vermont Medicaid School-Based Services for the Period October 2001 Through September 2002." A copy of this report will be forwarded to the action official name below for review and any action deemed necessary.

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

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

Please refer to report number A-01-03-00004 in all correspondence.

Sincerely yours,

Michael J. Armstrong

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Charlotte Yeh, M.D.
Regional Administrator
Centers for Medicare & Medicaid Services – Region I
Department of Health and Human Services
Room 2325, JFK Federal Building
Boston, Massachusetts 02203

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF VERMONT MEDICAID SCHOOL-BASED SERVICES FOR THE PERIOD OCTOBER 2001 THROUGH SEPTEMBER 2002

JANUARY 2005
A-01-03-00004

Office of Inspector General

http://oig.hhs.gov

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The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the department.

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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

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

OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

OBJECTIVE

Our objective was to determine whether costs that Vermont claimed for school-based child health services were allowable and adequately supported in accordance with Federal regulations and the Medicaid State plan. The State received about $16.3 million in Federal funding for school-based health services provided from October 2001 through September 2002.

SUMMARY OF FINDINGS

Of the 1,087 claims in our statistical sample, 240 were not allowable or adequately supported. The errors included:

- services not specified in the child's individualized education plan (child's plan),
- services not billed at the appropriate level of reimbursement,
- unallowable services, and
- clerical errors.

These errors occurred because the school districts (known as local educational supervisory unions) and the State did not have controls in place to ensure that services billed were accurate and in accordance with services specified in the child's plan.

As a result, we estimated that the State improperly claimed $1,463,395 in Federal funds for school-based services from October 2001 through September 2002.

RECOMMENDATIONS

We recommend that the State:

- refund $1,463,395 to the Federal Government,
- instruct the supervisory unions to review school-based service billings before submitting them for reimbursement to ensure that the services billed are specified in the child's plan and accurately reflect the type and amount of services provided, and
- establish periodic postpayment reviews to ensure that claims for services are in accordance with Federal regulations and State policies and procedures.

STATE'S COMMENTS

The State said that since our audit, it had made some significant improvements in the program that addressed our procedural recommendations. Although the State agreed with our findings for a number of the sampled claims, it believed that other erroneous claims identified in the audit were in compliance with program policies. As a result, the State believed that the dollar impact of the errors included in the report was substantially overstated. In this regard, the State provided specific comments disagreeing with our conclusions that overpayments were made for 111 of the 278 erroneous claims identified in our draft report. Appendix C contains the full text of the State's comments.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State's comments and additional documentation that the State presented subsequent to the issuance of the draft report, we made adjustments for 38 claims. However, for the remaining 240 claims, we maintain our conclusions that payments for these claims did not meet Federal and State reimbursement requirements.

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INTRODUCTION

BACKGROUND

Nationwide School-Based Services

Title XIX of the Social Security Act (the Act) established the Medicaid program in 1965 to provide medical assistance to certain individuals and families with low income and resources. Medicaid is a jointly funded Federal and State entitlement program administered by the States. CMS administers Medicaid at the Federal level.

The Medicaid program, recognizing the important role that school health services can play in a child's development, has supported school-centered health care as an effective method of providing eligible children with access to essential medical care. In this regard, the Individuals with Disabilities Education Act authorized Federal funding to States for programs that affect Medicaid payments for health-related services provided in schools.

Under Part B of the Individuals with Disabilities Education Act, school districts must prepare a child's plan for each child that specifies all special education and "related services" that the child needs. The Medicaid program pays for some of the "health related services" included in the child's plan if they are specified in Medicaid law and included in the Medicaid State plan. Examples of school-based services include physical therapy, speech pathology, occupational therapy, psychological services, and medical screening and assessment.

Vermont School-Based Services

In Vermont, the Agency of Human Services, Office of Vermont Health Access is responsible for the overall administration of the school-based service program. The Vermont Equal Education Opportunity Act of 1997 requires equal educational opportunities for all children in the State, including children with disabilities. Pursuant to the Act and the provisions of the Individuals with Disabilities Education Act, local supervisory unions are responsible for furnishing special education and related services as defined in a child's plan.

Under the Vermont school-based service program, the local educational supervisory union prepares the child's plan, provides the services specified in the child's plan, and bills the State for reimbursement. The services are reimbursed on the basis of statewide bundled rates that vary depending on the number of units of service that the supervisory union provides. The number of units of service provided to the child determines the level of care at which the claim is billed. The State has established four levels of care (1 through 4) in which the greater the number of units of service provided, the higher the level of care and the related reimbursement that the State may claim for Federal funding. The supervisory unions are allowed additional outlier payments if the services provided to the child exceed 42 units per month.

During the period October 2001 through September 2002, the State claimed about $16.3 million in Federal funds for the 43,577 school-based direct services that the supervisory unions provided.

Law and Policy

Section 1903(c) of the Act requires the Secretary to pay for services furnished to children with disabilities, covered under the Individuals with Disabilities Education Act, and supported by a child's plan or a family plan. A comprehensive discussion of section 1903(c) and other school-based policies is included in the CMS guidance entitled "Medicaid and School Health: A Technical Assistance Guide" (CMS Technical Assistance Guide), dated August 1997.

To obtain reimbursement for school-based services, a provider must have an agreement with the State delineating the responsibilities of all parties. In addition, the State defines and explains its school-based service policies and procedures through periodic provider notices and meetings with local provider personnel. For program guidance during the audit period, local supervisory unions relied on these notices and the "Dr. Dynasaur/Medicaid School Health Related Services Program" manual, which was revised in September 2001. The manual provided a compilation of guidelines, including those related to student eligibility and services eligible for reimbursement, requirements for completing a child's plan, and instructions for billing for services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether costs that Vermont claimed for school-based child health services were allowable and adequately supported in accordance with Federal regulations and the Medicaid State plan.

Scope

Our audit covered payments made for Vermont Medicaid school-based services provided during the period October 2001 through September 2002. The State received about $16.3 million in Federal funding for school-based child health services provided during the period. Our review of internal controls was limited to obtaining an overall understanding of the policies and procedures governing school-based services in Vermont.

We performed our fieldwork at the Agency of Human Services, Office of Vermont Health Access in Waterbury, VT, the Vermont Department of Education in Montpelier, VT, and the administrative offices of the eight supervisory unions selected for review.

Methodology

On the basis of a statistical sample, we selected claims data from 8 of the 60 local supervisory unions for services provided during the period October 1, 2001, through September 30, 2002. We selected the eight supervisory unions through probability-proportional-to-size sampling methodology. From each of the 8 supervisory unions, we randomly selected a statistical sample from 5 strata, each containing up to 30 paid claims, for each level of care (1 through 4) and outliers. If a supervisory union had fewer than 30 paid claims in any of the 5 strata, we selected all paid claims in that stratum for review. In total, our sample included 1,087 claims totaling $591,940 in Federal payments.

In reviewing the sample claims, we compared paid school-based service claim data that the State provided with documentation supporting the claimed services at the local supervisory unions. Specifically, we determined whether the reviewed services were:

- authorized by the Medicaid State plan,
- specified in the child's plan,
- accurately billed at the appropriate level of care, and
- adequately documented in the child's case file.

We conducted our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Based on a statistical sample of 1,087 claims paid for the period October 2001 through September 2002, we estimated that the State received unallowable Federal reimbursement of at least $1,463,395. We found that the State claimed unallowable Federal funding of $105,009 for school-based services included in 240 of the 1,087 claims, as follows:

- $39,522 for 109 claims for services not specified in the child's plan,
- $12,744 for 42 claims for services not billed at the appropriate level of reimbursement,
- $21,012 for 42 claims for unallowable services, and
- $31,731 for 47 claims with clerical errors.

These errors occurred because the State and the local supervisory unions did not have procedures and controls in place to ensure that services billed were accurate and in accordance with services specified in the child's plan.

SERVICES NOT SPECIFIED IN THE CHILD'S PLAN

Federal and State Requirements

The Act permits Medicaid payment for school health services provided to children that were identified in a child's plan or a family plan. Under Part B of the Individuals with Disabilities Education Act, school districts must prepare, for each child, a plan that specifies all needed special education and related services.

According to the CMS Technical Assistance Guide for school-based services:

> Under Part B of IDEA [Individuals with Disabilities Education Act], school districts must prepare an IEP [individualized education plan, or child's plan] for each child which specifies all special education and "related services" needed by the child. The Medicaid program can pay for some of the "health related services" required by Part B of IDEA in an IEP, if they are among the services specified in the Medicaid law.

The Vermont Medicaid manual for school-based health related services stated, "In order for a service to be billable under the School-Based Health Service program, the student must be receiving services identified in the State Medicaid Plan in accordance with his or her IEP . . . ." However, additional State instructions allow supervisory unions to bill for more hours of service than those specified in the child's plan. For the additional hours provided, the monthly billing form must explain the change, and the child's plan must be revised for subsequent billings.

Sample Errors

In 109 claims, we found overpayments of $39,522 that included billings for more units of service than specified in the child's plan or for services that were not included in the child's plan. The following are examples of these situations.

- A supervisory union claimed 30 hours for personal care services, but the child's plan specified only 10 hours per week. The billing form did not explain the additional hours claimed. On the basis of the child's plan, we adjusted the number of hours and reduced the level of care from 4 to 2.

- A supervisory union billed for 30 hours of developmental assistive therapy service provided by a professional and 30 hours of the same service provided by a paraprofessional. The child's plan specified that a paraprofessional was to provide 27.5 hours of this service per week. On the basis of the child's plan, we eliminated the professional services and reduced the level of care from 4 to 2.

For the 109 claims found with these types of errors, we recalculated the allowable reimbursement for the claims by eliminating the services not specified by the child's plan and determining the appropriate reimbursement at a lower level of care.

SERVICES NOT BILLED AT APPROPRIATE LEVEL OF REIMBURSEMENT

Federal and State Requirements

The CMS Technical Assistance Guide provides that:

> States may place appropriate limits on the coverage of Medicaid services based on such criteria as medical necessity or utilization control. For example, states may place a reasonable limit on the number of covered physician visits or may require prior authorization to be obtained before service delivery to ensure that the provision of the services is warranted . . . .

State billing instructions dated April 2001 and September 2001 noted that the child's plan must be specific as to the provider of services, type of setting (i.e., group versus one-on-one), and frequency and duration of the services. The billing forms also noted that the number of units that were billable should be adjusted depending on the size of the group. For example, a professional's time for providing certain services to a group of two to six children should be reduced to 50 percent of the total units of service provided to account for the group service. Similarly, a paraprofessional's time for providing certain services to a group of two to four children should be reduced to 16.5 percent or 33 percent of the number of units of service provided, depending on the type of service.

Sample Errors

In 42 claims, we found overpayments of $12,744 representing services that were billed at amounts greater than the authorized level of reimbursement. These claims included billings for one-on-one services when the child's plan specified that the services were to be provided in a group setting within the classroom. For these claims, we recalculated the allowable reimbursement by applying the group service factor to determine the total number of allowable units.

Other claims included billings for professional services, although the child's plan specified that a paraprofessional should provide the services. The professional service hours were billed at a greater number of units than paraprofessional services would have been billed. This resulted in increasing the level of care and the related reimbursement for the claims. We recalculated the reimbursement at the paraprofessional level.

For both of these claim situations, our recalculations resulted in reducing the allowable number of units of service and the related reimbursement for the claims.

UNALLOWABLE SERVICES

Federal and State Requirements

Section 1905(a) of the Act lists the mandatory and optional services that a State may cover in its Medicaid program. In order for Medicaid to reimburse for health services in

the schools, the services must be included among those listed in the Act and included in the State's Medicaid plan or be available under the Early and Periodic Screening, Diagnostic and Treatment program.

According to State instructions, certain services are not allowable for reimbursement under the school-based program. These include guidance counseling, vocational training, recreational services, and services that are normally provided by other Medicaid providers. In addition, paraprofessional support identified "as needed" is not billable to Medicaid, as the time required for the service must be clearly stated.

Sample Errors

Our review identified 42 claims that had overpayments of $21,012 because the claims included unallowable services. We removed these services and recalculated the appropriate amount of reimbursement for the claims in question at a lower level of care.

CLERICAL ERRORS

In 47 sample claims, we found overpayments of $31,731 resulting from clerical errors, such as incorrect mathematical calculations and billing for a higher level of care than what should have been billed. We found other claims that were not adjusted to reflect the student's less than full-time attendance at school for the month. According to State reimbursement rates, the reimbursement for these claims should have been reduced to 50 or 75 percent of the total allowable reimbursement, based on the number of days the student attended school during the month.

For these errors, we recalculated the allowable reimbursement amount at the appropriate lower level of care.

INADEQUATE MONITORING OF BILLING PROCESS

The above overpayments were the result of inadequate procedures that the supervisory unions and the State used to monitor the billing process. At the supervisory union level, the Medicaid billing clerks did not routinely verify the monthly billings to the child's plan to ensure that the services billed were authorized on the plans and billed at the appropriate amounts based on provider type and service setting. We also noted that the billing clerks did not always adjust the billed amounts to account for less than full-time attendance by the students. In addition, the supervisory unions did not provide documentation to support billings for services beyond the amount specified in the child's plan.

The State did not have adequate procedures to monitor and review the supervisory unions' billings to ensure that claims were billed in accordance with Federal payment requirements and State policies and instructions.

IMPACT ON STATE MEDICAID REIMBURSEMENT

According to our projection of a statistical sample, at least $1,463,395 in Federal funds that the State claimed for school-based services provided during the period October 2001 through September 2002 did not qualify for Medicaid reimbursement. This estimate represents the lower limit of the 90-percent confidence level. The details of our statistical sampling estimates and schedules of the sample items reviewed for the eight supervisory unions are included in Appendixes A and B.

RECOMMENDATIONS

We recommend that the State:

- refund $1,463,395 to the Federal Government,

- instruct the supervisory unions to review school-based service billings before submitting them for reimbursement to ensure that the services billed are specified in the child's plan and accurately reflect the type and amount of services provided, and

- establish periodic postpayment reviews to ensure that claims for services are in accordance with Federal regulations and State policies and procedures.

STATE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

State Comments

In its written comments on the draft report dated June 17, 2004 (see Appendix C), the State indicated that since the audit period, it had made some significant changes and improvements to the program that addressed the Office of Inspector General (OIG) procedural recommendations. Specifically, the State noted that it had (1) implemented new documentation requirements to identify the services, the dates the services were provided, and the number of hours of service provided; (2) incorporated new policies and procedures in a revised Policy Manual that specified that supervisory unions must bill at the lowest level listed on the child's plan; and (3) implemented an enhanced training and postpayment audit process to monitor the program.

The State also agreed with OIG's findings for a number of the sample claims. However, the State believed that other sample claim errors identified in the audit were billed appropriately and in compliance with program policies as they existed during the 2001-02 school year. As a result, the State believed that the dollar impact of the errors included in the report was substantially overstated. In this regard, the State provided additional documentation and comments disagreeing with our conclusions that overpayments were made for 111 of the 278 sample claims identified in our draft report.

OIG Response

After reviewing the State's documentation and comments disagreeing with 111 sample claim errors, we believe that our conclusions were correct for most of the overpayments. However, we reconsidered our conclusions for 38 claims and agree that no overpayments occurred. We adjusted our sample projection to account for the changes to these claims.

The State's comments included detailed discussions of each of the four categories of errors in the report. The following sections provide the State's comments and OIG's response.

Services Not Specified in the Child's Plan

State Comments

The State indicated that it had identified several instances in which OIG compared the claim to the wrong child's plan and other instances in which OIG may have misinterpreted the State billing policy. The response noted that "OIG identified a large number of instances where case management was billed in excess of hours listed on the IEP." The State contended that "State policy affords SUs [supervisory unions] the latitude to bill additional case management hours over and above what is listed on the IEP. . . . Therefore, the State disagrees with OIG's findings regarding all of these cases." The State agency provided specific comments disagreeing with our conclusions for 42 claims in this category.

OIG Response

On the basis of our review of the additional State documentation, we reconsidered our conclusions for eight claims and agree that they were allowable. We adjusted the number and amount of overpayments, as well as our sample projection of total overpayments, for these claims. However, for the remaining 34 claims that the State contested, we believe that our conclusions are correct.

As noted in our report, the CMS Technical Assistance Guide and the Vermont Medicaid manual for school-based services state that to be reimbursed under the Medicaid program, services must be identified on the child's plan. The CMS Technical Assistance Guide further states that "Health-related services coverable under an IEP. . . are still subject to the Medicaid requirements for coverage of services including amount, duration and scope. . . ." The CMS Technical Assistance Guide also describes billing requirements for documenting services as follows: "Relevant documentation included dates of service, who provided the service, where the service was provided . . . length of time for service. . . ."

We believe that these Federal and State requirements do not give the State the latitude to allow supervisory unions to bill for more services than included in the approved plan.

Services Not Billed at Appropriate Level of Reimbursement

State Comments

The State indicated that OIG inappropriately applied program policies that were not in effect during the audit period. The response stated that:

> The OIG relied on a 2002-2003 SBHS Bulletin, which states that "Medicaid only allows the LOWEST LEVEL of services listed on the IEP to be Billed." State policies in effect during the 2001-2002 school year did not require SUs to bill at the lowest level of service identified on the IEP. SUs were permitted to bill at the higher level of service even if the IEP, for example, listed the service as "paraprofessional or professional."

The State's additional documentation identified 43 such claims that it believed should be considered allowable.

OIG Response

We revised our conclusions for 29 of these claims and now consider them to be allowable. However, the remaining 14 claims had other errors that made the billings unallowable. We determined that 11 of the claims had clerical errors in the billing and that the other 3 claims billed for services not specified in the child's plan. As a result, we reclassified these 14 claims into these error categories. We adjusted the error amounts to reflect these changes for the projection of the sample results.

Unallowable Services

State Comments

The State's comments discussed the fact that services provided in schools frequently include both medical and educational components. Accordingly, the State created a separate category of service, developmental and assistive therapy, to reimburse these services. The response went on to state that "The OIG disallowed billing for specific services because the IEP did not provide a medical justification for the service . . . ." The State disagreed with our conclusions for 15 claims in this category.

OIG Response

We did not question any claims merely because they included developmental and assistive therapy services. As noted in our report, the disallowances in this category were due to the fact that services were not billable for reimbursement under the Vermont school-based program, not to a lack of medical justification.

However, following our review of the State's additional documentation, we have reconsidered our conclusion for one of these claims and now believe that the payment for

that claim was allowable. We have adjusted our statistical projection to account for the claim. However, we stand by our conclusions that overpayments were made for the remaining 14 claims.

Clerical Errors

State Comments

The State noted that "Approximately 84 percent . . . of the overpayments identified by OIG in this category . . . are attributed to claims for one child. We are concerned that the OIG's findings with regard to a single case can have such a large impact on its overall findings." The response went on to state that "In this case, the child received care from a Communications Facilitator which was billed at the professional level; OIG determined that the services . . . should have been billed at the paraprofessional level." The response concluded by stating that "We agree with a number of the clerical errors identified by OIG and will defer to OIG and CMS as to whether the error rate (removing the case discussed above), is within a range of reasonableness." The State disagreed with our conclusions for 11 claims included in this category.

OIG Response

Following our review of the State's additional documentation, we adjusted the amount of overpayment in two claims. However, we still considered these claims to be overpayment errors and adjusted the error amounts for these claims in our revised projection of the sample.

During our review of the claims involving the communications facilitator, the supervisory union's Medicaid billing clerk informed us that this individual should have been billed at the paraprofessional level. The billing clerk indicated that the claims were to be resubmitted at the appropriate level of service. Thus, we believe that our conclusions for these claims were correct.

The claims for the communications facilitator were included in the outlier stratum for the Franklin Northwest supervisory union. This stratum had only 28 paid claims. Because the stratum contained fewer than 30 claims, we reviewed all 28 claims. We added the amount determined in error for these claims to the overall sample projection amounts at face value. Therefore, these claims do not have an adverse effect on the sample projection.

APPENDIXES

APPENDIX A

SAMPLING METHODOLOGY

POPULATION

The sample population consisted of the total number of school-based service claims paid for services provided during the period October 2001 through September 2002. In this population, 60 local supervisory unions were paid for 43,577 claims related to services provided during this period. The State agency paid claims based on the level of care (LOC) provided to the recipient. There are 4 levels of care and, in addition, separate outlier payments are made for claims that have more than 42 units of service during a month. Thus, the sample population included the following:

	Number of Paid Claims
LOC 1	21,671
LOC 2	9,840
LOC 3	4,833
LOC 4	5,555
Outliers	1,678
Total	**43,577**

SAMPLE DESIGN

We used a multistage sample based on probability proportional to size, weighted by the number of claims paid to each supervisory union. The first stage consisted of a random selection of supervisory unions with probability of selection proportional to the number of paid school-based claims. The second stage consisted of five strata (LOC 1, LOC 2, LOC 3, LOC 4, and outliers) for each supervisory union selected in the first stage. The third stage consisted of up to 150 individual paid claims (30 paid claims from each of the 5 strata) selected from each stratum using a simple random sample. If a stratum had fewer than 30 paid claims, we selected all claims in that stratum for review.

PROJECTION OF RESULTS

The point estimate of the projection of the sample was $3,752,925 ($2,366,594 Federal share), with a precision of plus or minus $1,432,285 ($903,199 Federal share) at the 90-percent confidence level. The lower limit of the projection was $2,320,640 ($1,463,395 Federal share) and the upper limit was $5,185,210 ($3,269,793 Federal share). According to OIG policies and procedures, the number of errors found in 17 strata was not sufficient to be considered in our projection. (See Appendix B.) For 7 strata that had fewer than 30 paid claims in their universe, OIG policy required that we review all claims in the strata and add the error amounts identified for these claims to the total sample projection amount.

APPENDIX B

SUMMARY RESULTS OF SAMPLE

Supervisory Union	LOC	Number of Sample Items	Number of Non-Errors	Number of Errors	Error Amount
SU02 Addison Northwest	LOC1	30	29	1	$45.53
SU02 Addison Northwest	LOC2	30	29	1	209.43
SU02 Addison Northwest	LOC3	30	30	0	0.00
SU02 Addison Northwest	LOC4	30	30	0	0.00
SU02 Addison Northwest	Outliers	30	20	10	635.68
SU03 Addison Central	LOC 1	30	26	4	546.33
SU03 Addison Central	LOC 2	30	19	11	3,890.29
SU03 Addison Central	LOC 3	30	19	11	7,942.42
SU03 Addison Central	LOC 4	30	22	8	11,100.38
SU03 Addison Central	Outliers	23	5	18	2,286.01
SU10 Milton	LOC 1	30	29	1	273.17
SU10 Milton	LOC 2	30	26	4	1,072.32
SU10 Milton	LOC 3	30	20	10	6,599.97
SU10 Milton	LOC 4	30	23	7	11,159.69
SU10 Milton	Outliers	0	0	0	0.00
SU21 Franklin Northwest	LOC 1	30	30	0	0.00
SU21 Franklin Northwest	LOC 2	30	16	14	4,364.07
SU21 Franklin Northwest	LOC 3	30	22	8	5,497.94
SU21 Franklin Northwest	LOC 4	30	21	9	14,084.44
SU21 Franklin Northwest	Outliers	28	12	16	37,088.35
SU35 Orleans Southwest	LOC 1	30	29	1	182.11
SU35 Orleans Southwest	LOC 2	30	22	8	2,227.56
SU35 Orleans Southwest	LOC 3	30	28	2	1,015.46
SU35 Orleans Southwest	LOC 4	30	28	2	1,445.36
SU35 Orleans Southwest	Outliers	6	6	0	0.00
SU 36 Rutland Northeast	LOC 1	30	29	1	182.11
SU 36 Rutland Northeast	LOC 2	30	22	8	2,452.88
SU 36 Rutland Northeast	LOC 3	30	25	5	3,698.91
SU 36 Rutland Northeast	LOC 4	30	28	2	4,487.93
SU 36 Rutland Northeast	Outliers	13	7	6	2,420.44
SU48 Windham Southeast	LOC 1	30	30	0	0.00
SU48 Windham Southeast	LOC 2	30	22	8	2,546.50
SU48 Windham Southeast	LOC 3	30	22	8	4,818.81
SU48 Windham Southeast	LOC 4	30	18	12	17,569.50
SU48 Windham Southeast	Outliers	30	14	16	3,706.50
SU52 Windsor Southeast	LOC 1	30	25	5	644.22
SU52 Windsor Southeast	LOC 2	30	20	10	2,855.02
SU52 Windsor Southeast	LOC 3	30	18	12	7,859.48
SU52 Windsor Southeast	LOC 4	14	13	1	1,613.06
SU52 Windsor Southeast	Outliers	13	13	0	0.00
Total		**1,087**	**847**	**240**	**$166,521.87**
Federal Share					**$105,008.69**

State of Vermont
Agency of Human Services
Department of Prevention, Assistance, Transition, and Health Access
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June 17, 2004

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Department of Health and Human Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203

Dear Mr. Armstrong:

This letter serves as the State of Vermont's formal response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Report entitled "Review of Vermont Medicaid School-Based Services for the Period October 2001 - September 2002."

The State of Vermont would like to thank the OIG for its efforts. We view the results and recommendations highlighted by the OIG as another opportunity for the State to improve on its revised School-Based Health Services (SBHS) program that has continuously evolved since its inception in 1998. The State has made some significant changes and quality improvements to the program since the 2001 - 2002 school year, which are discussed in detail below.

First, all billed services must now include a documentation log that identifies the service, the date the service was provided and the number of hours. The implementation of this process was due in part to recommendations from the CMS Regional Office and the results of internal reviews. Since the program began, we have been careful in our efforts to strike a balance between overburdening staff with additional paperwork and ensuring that documentation is adequate to support Medicaid claiming activities. We believe the implementation of documentation logs has improved the accuracy and quality of Medicaid claims.

Second, the State implemented new policies and procedures, which were not in place during the 2001 – 2002 school year. IEPs frequently define a range for service delivery, such as "one-on-one or group" or "professional or paraprofessional." IEPs were drafted

in this manner to afford greater flexibility in matching service delivery to children's needs, recognizing that these needs change over time. As of the 2002 – 2003 school year, the State revised the Policy Manual such that SUs must bill at the lowest level of service listed on the IEP, even if the services actually were provided at a higher level.

Third, the State is in the process of re-organizing departmental responsibilities, in conjunction with implementation of enhanced training and audit processes. Starting with the 2004 -2005 school year, the newly-created Audit Unit within OVHA will assume complete responsibility for oversight and auditing of school-based claims. This new post-payment review process will include periodic reviews of a random sample of claims from each SU. The audits will compare the child's claim to his/her IEP. The audit teams will document and report back to the SU any significant errors or trends, and if necessary, require the SU to develop a corrective action plan. The audit teams will monitor the effectiveness of the corrective actions as a part of its next scheduled audit.

Vermont believes that its Medicaid reimbursement program for school-based health services is a rational and fair methodology that equitably reimburses providers for medically necessary services. As with any program, the State accepts the fact that there are areas for improvement and embraces the opportunity to improve program performance.

We appreciate the opportunity to review OIG's documentation in support of the findings presented in its report. We agree with OIG's findings in a number of cases and will take the necessary steps, through additional training and oversight, to ensure that the incidence of these types of errors diminishes. However, we also believe that a number of the errors identified by OIG were in fact billed appropriately and in compliance with program polices as they existed in the audit period (2001-2002). As a result, we believe the dollar impact of the errors identified by OIG is substantially overstated. The following sections outline the State's response to each of the four categories of errors identified by the OIG.

Service not authorized in the IEP

The State identified a number of issues related to the errors delineated by OIG in this category. We identified several instances in which OIG compared the claim to the wrong IEP and in other cases we believe OIG may have misinterpreted State billing policy.

OIG identified a large number of instances where case management was billed in excess of the hours listed on the IEP. The State's billing manual, in effect during the 2001 – 2002 school year, lists case management as the only service that can be billed even when it is not listed on the IEP. Further, State policy affords SUs the latitude to bill additional case management hours over and above what is listed on the IEP. These policies are still in effect today under the current reimbursement manual. Therefore, the State disagrees with OIG's findings regarding all of these cases.

Also, OIG's findings of errors and its adjustments to the number of hours claimed appear to be arbitrary. For example, one case included five hours of case management; OIG

disputed the number of hours and made an adjustment to permit one hour of billable time. Based on our review of this particular case, the IEP clearly identifies the complexity of the child's needs. Further, the IEP delineates all of activities required of the case manager on a daily and weekly basis, clearly justifying five, if not more, hours of case management.

The State conservatively estimates that one-third of the total overpayments identified by OIG in this category were related to the above case management issues.

Services not billed at the lowest level of service

The State believes that the majority of errors identified by OIG in this category were due to OIG's inappropriate application of program policies that were not in effect during the audit period. The State believes a large percentage of the $29,400 in overpayments identified by the OIG were in fact not errors.

The OIG relied on a 2002 – 2003 SBHS Bulletin, which states that "Medicaid only allows the LOWEST LEVEL of services listed on the IEP to be billed." State policies in effect during the 2001 - 2002 school year did not require SUs to bill at the lowest level of service identified on the IEP. SUs were permitted to bill at the higher level of service even if the IEP, for example, listed the service as "paraprofessional or professional."

This policy was changed for the 2002 – 2003 school year and SUs must now bill at the lowest level listed on the IEP. This policy is clearly articulated in the 2003 – 2004 billing manual and the State has conducted several state-wide training sessions to communicate this policy change. The State will monitor compliance with this policy through its enhanced oversight and audit process.

Unallowable Services

The State does not agree with a number of the errors identified by OIG in this category. The Vermont SBHS program allows for the reimbursement of services that are designed to overcome a child's physical, cognitive or behavioral deficit. However, we recognize that services provided in schools frequently include both a medical and educational component.

The State worked closely with CMS during development of the SBHS program in order to address the fact that many special education services have both a medical and educational purpose, and that the line between treatment and education frequently is blurred. The State and CMS agreed that, rather than attempting to the very difficult task of dissecting these types of complex, evolving services, all such services would be reimbursed at fifty percent of the level of other services.

A separate category of service, Developmental and Assistive Therapy, was created to reimburse these services. This approach recognizes that some services may be predominantly medical in nature and others primarily educational. The policy to only

reimburse half of the time spent providing these services seems to be a rational and equitable solution.

Also, the OIG disallowed billing of specific services because the IEP did not provide a medical justification for the service. The State billing policies do not require the IEP to include a medical justification for each service listed in the IEP. However, Vermont policies require SUs to obtain physician review and signature that the services being provided are medically appropriate. Further, we are unaware of a Federal Medicaid law that requires medical justification to be specified in the IEP on a service-specific basis.

Should Vermont's billing policies be found to be inconsistent with Medicaid laws or regulations, we will make any policy changes necessary to come into compliance.

Clerical Errors

Approximately 84 percent, or $21,321, of the overpayments identified by OIG in this category (and 18 percent of the overpayments identified by OIG for the entire audit) are attributed to claims for one child. We are concerned that the OIG's findings with regard to a single case can have such a large impact on its overall findings.

In this case, the child received care from a Communications Facilitator which was billed at the professional level; OIG determined that the services provided by the Communications Facilitator should have been billed at the paraprofessional level.

Communications Facilitators, due to their high demand, frequently are paid salaries at rates significantly higher than the salaries of paraprofessionals. The underlying goal of the LOC reimbursement system is to equitably reimburse SUs for the cost of providing services. Since the inception of the program, the State has had a number of policy issues arise concerning the appropriate reimbursement rate for certain, specialized types of staff.

The State's policy manual in effect during the 2001 – 2002 school year did not provide guidance on this issue and the State would not have identified this case as an inappropriate claim. The State believes that its billing policy was ambiguous at this point in time. The billing manual has subsequently been amended and now clearly instructs the SUs to bill this service as personal care at the paraprofessional level.

We agree with a number of the clerical errors identified by OIG and will defer to OIG and CMS as to whether the error rate (removing the case discussed above), is within a range of reasonableness. Regardless of the reasonableness of the error rate, the State has undertaken measures that will reduce the clerical error rate.

We would like to thank you for the opportunity to respond to the results of this audit. The State looks forward to further discussing these issues with the OIG or CMS and would appreciate any input regarding policies and approaches to improve program performance.

Respectfully,

Joshua Slen, Director
Office of Vermont Health Access

CC: Charles Smith, Secretary, Agency of Human Services
Bill Talbot, CFO, Department of Education
Bruce Greenstein,
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ACKNOWLEDGMENTS

This report was prepared under the direction of Michael J. Armstrong, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

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For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.