DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

TO: Thomas Scully
Administrator
Centers for Medicare and Medicaid Services

MAR 28 2003

FROM: Dennis J. Duquette
Acting Principal Deputy Inspector General

SUBJECT: Review of Medicaid School-Based Services Claimed During State Fiscal Year 2000 by Maryland's Medicaid Program (A-03-01-00224)

As part of the Office of Inspector General's self-initiated audit work, we are alerting you to the issuance within 5 business days of our final report entitled, "Review of Medicaid School-Based Services Claimed During State Fiscal Year 2000 by Maryland's Medicaid Program." A copy of the report is attached. This report is one in a series of reports in our multi-state initiative focusing on direct costs claimed for Medicaid school-based health services.

The objective of our review was to determine whether Medicaid costs claimed for school-based health services by Maryland's Department of Health and Mental Hygiene (DHMH) were reasonable, allowable, and adequately supported in accordance with the terms of applicable federal regulations and the state Medicaid plan.

We identified internal control weaknesses that need to be corrected to ensure that Maryland's school-based payment rates are based on actual costs of providing medical services and service providers appropriately submit and document Medicaid claims for school-based health care services. Our review of payments in 100 randomly selected recipient/months showed that DHMH billed the Medicaid program: 1) when providers were not qualified to render the service; 2) for services that were not approved in the state plan; 3) when the student was absent or the service did not occur with the appropriate participant; 4) for services that were not authorized or were in excess of the quantity authorized; 5) for transportation services when there was no authorized Medicaid service on the same day; and 6) for services that were insufficiently documented. Based on a projection of the statistical sample, we estimated overpayments to be approximately $20 million in federal Medicaid matching funds.

We recommended the DHMH:

1. Consult with the Centers for Medicare and Medicaid Services to develop new school-based payment rates based on actual medical costs.

2. Ensure school-based service providers adhere to federal and state Medicaid requirements for provider qualifications.

3. Develop and implement written policies and procedures requiring school-based service providers to document services delivered to Medicaid recipients.

4. Refund $19,954,944 federal share that was inappropriately paid by the Medicaid program.

5. Revise the state plan to eliminate all references to Medicaid coverage for section 504 services.

In a written response to our draft report, DHMH agreed with the findings and accepted the procedural recommendations related to its payment rates, provider qualifications, documentation requirements, and state plan revisions. However, DHMH strongly disagreed with our recommendation to reimburse federal Medicaid payments and requested that we do not proceed with this recommendation.

We are pleased that DHMH agreed with our procedural recommendations. We acknowledge DHMH's concerns relating to the reimbursement recommendation, however, we continue to recommend the financial adjustment. Where appropriate, we made changes to the report to reflect additional documentation provided as well as DHMH's comments. We summarized DHMH's comments and responded to those comments at the conclusion of the FINDINGS AND RECOMMENDATIONS section, and included the comments in their entirety as APPENDIX D to this report.

If you have any questions or comments about this report, please do not hesitate to call George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Audits, at (410) 786-7104 or Stephen Virbitsky, Regional Inspector General for Audit Services, Region III, at (215) 861-4501. To facilitate identification, please refer to report number A-03-01-00224 in all correspondence.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT SERVICES
150 S. INDEPENDENCE MALL WEST
SUITE 316
PHILADELPHIA, PENNSYLVANIA 19106-3499

MAR 31 2003

Report Number: A-03-01-00224

Mr. Nelson J. Sabatini
Secretary
Department of Health and Mental Hygiene
201 West Preston Street
Executive Suite 5th Floor
Baltimore, Maryland 21201

Dear Mr. Sabatini:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Review of Medicaid School-Based Services Claimed During State Fiscal Year 2000 by Maryland's Medicaid Program." A copy of this report will be forwarded to the action official noted 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, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (see 45 CFR part 5). As such, within 10 business days after the final report is issued, it will be posted to the Internet at http://oig.hhs.gov.

To facilitate identification, please refer to report number A-03-01-00224 in all correspondence relating to this report.

Sincerely yours,

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Ms. Sonia A. Madison
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150 S. Independence Mall West
Philadelphia, Pennsylvania 19106-3499

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF MEDICAID SCHOOL-BASED SERVICES CLAIMED DURING STATE FISCAL YEAR 2000 BY MARYLAND'S MEDICAID PROGRAM

JANET REHNQUIST
Inspector General

March 2003
A-03-01-00224

Notices

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

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

OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

Background

The Centers for Medicare and Medicaid Services (CMS) permits Medicaid payments for health-related services provided in school settings pursuant to the Individuals with Disabilities Education Act (IDEA). Under IDEA, local education agencies (LEA) prepare an Individualized Education Plan (IEP) for each child that specifies all special education and related services needed by the child. The Medicaid program will pay for some of the health-related services included in the IEP if they are among the services specified in Medicaid law and included in the state's Medicaid plan. In Maryland, the Department of Health and Mental Hygiene (DHMH) administers the Medicaid program. During state fiscal year (SFY) 2000, Maryland school-based health service providers claimed Medicaid costs totaling over $101 million.

Objective

The objective of our review was to determine whether Medicaid costs claimed for school-based health services by Maryland LEAs through the DHMH were reasonable, allowable, and adequately supported in accordance with the terms of applicable federal regulations and the state Medicaid plan. Our audit scope included Medicaid payments to Maryland's eight highest paid LEAs during SFY 2000, or the period July 1, 1999 through June 30, 2000.

Summary of Findings

In Maryland, reimbursements for Medicaid services delivered by school providers are made using fee-for-service rates based on cost. We identified internal control weaknesses that need to be corrected to ensure that Maryland's school-based payment rates are based on actual costs of providing medical services and service providers appropriately submit and document Medicaid claims for school-based health care services.

The fee-for-service rates used to bill for school-based health services were overstated because they included basic costs of special education that are not reimbursable under the Medicaid program. In addition, we found that the largest LEA subcontracted a significant amount of its school-based health services to private contractors at rates below what it charged the Medicaid program.

Our review of payments contained in 100 randomly selected recipient/months showed that the 8 LEAs billed the Medicaid program: 1) when providers were not qualified to render the service; 2) for services that were not approved in the state plan; 3) when the student was absent or the service did not occur with the appropriate participant; 4) for services that were not authorized or were in excess of the quantity authorized in the IEP; 5) for transportation services when there was no authorized Medicaid service on the same day; and 6) for services that were insufficiently documented. Relative to our review of the randomly selected recipient/months, we estimate that the eight LEAs were overpaid approximately $20 million in federal Medicaid matching funds.

Finally, Maryland's approved state plan included Medicaid coverage for school-based health services provided pursuant to a written individualized plan under section 504 of the Rehabilitation Act of 1973. The CMS, however, determined that Medicaid funding is not available for section 504 services.

Recommendations

We recommended the DHMH:

1. Consult with CMS to develop new school-based payment rates based on actual medical costs.

2. Ensure school-based service providers adhere to federal and state Medicaid requirements for provider qualifications.

3. Develop and implement written policies and procedures requiring school-based service providers to document services delivered to Medicaid recipients.

4. Refund $19,954,944 federal share that was inappropriately paid by the Medicaid program.

5. Revise the state plan to eliminate all references to Medicaid coverage for section 504 services.

Auditee's Comments and Office of Inspector General's Response

In written response to our draft report, DHMH agreed with the findings and accepted the procedural recommendations related to its payment rates, provider qualifications, documentation requirements, and state plan revisions. However, DHMH strongly disagreed with our recommendation to reimburse federal Medicaid payments and requested that we do not proceed with this recommendation.

We are pleased that DHMH agreed with our procedural recommendations. We acknowledge DHMH's concerns relating to the reimbursement recommendation, but we continue to recommend a financial adjustment. Where appropriate, we made changes to the report to reflect additional documentation provided as well as DHMH's comments. The DHMH's comments and the Office of Inspector General's response are summarized at the conclusion of the FINDINGS AND RECOMMENDATIONS section, and DHMH's complete response is included as APPENDIX D to this report.

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INTRODUCTION

Background

The Medicaid program established by title XIX of the Social Security Act provides medical assistance to needy people. Each state Medicaid program is administered by the state in accordance with an approved state plan. While the state has considerable flexibility in designing its state plan and operating its Medicaid program, it must comply with broad federal requirements administered by the Centers for Medicare and Medicaid Services (CMS). In Maryland, the Department of Health and Mental Hygiene (DHMH) administers the Medicaid program.

The Federal Government and states share in the cost of the program. States incur expenditures for medical assistance payments to medical providers who furnish care and services to Medicaid-eligible individuals. The Federal Government pays its share of medical assistance expenditures to a state according to a defined formula. The federal share of medical costs, referred to as federal financial participation (FFP), ranges from 50 percent to 83 percent, depending on each state's relative per capita income. The FFP rate in Maryland is 50 percent.

The Individuals with Disabilities Education Act (IDEA) authorized federal funding to states for health-related services provided in school settings. Under Part B of IDEA, local education agencies (LEA) must prepare an Individualized Education Plan (IEP) for each child that specifies all special education and related services needed by the child. The Medicaid program can pay for some of the health-related services specified in an IEP if: 1) the services are medically necessary and coverable under a Medicaid coverage category such as speech therapy and physical therapy; 2) all other federal and state regulations are followed, including those for provider qualifications, comparability of services, and the amount, duration, and scope provisions; and 3) the services are included in the state plan or available under Medicaid's early and periodic screening, diagnostic, and treatment benefit.

Maryland's state Medicaid plan includes payment based on cost for school-based health services delivered by or through LEAs--primarily local school systems--to students with special needs pursuant to an IEP. Based on an agreement with DHMH, school-based health services are rendered under the auspices of the Maryland State Department of Education (MSDE). The state's share of Medicaid costs for school-based health services is provided through public funds from MSDE. The MSDE provided its special education appropriation budget as support for the state's share of Medicaid services provided. In general, billing and reimbursement of services were as follows:

- LEAs billed DHMH for services using fee-for-services rates based on cost.
- DHMH entered the claim into its Medicaid Management Information System as a voucher only payment. The voucher, but no payment, was provided to the LEA.
- DHMH totaled the vouchers monthly for each LEA.
- DHMH reported the Medicaid expenses to CMS and collected the FFP.
- DHMH transferred the FFP to MSDE.

- MSDE retained a small administrative fee and transferred the remaining FFP to the LEAs.

Therefore, the LEAs billed for the full costs of the medical services but received only the federal share. Health-related services provided in school include: speech-language pathology and audiology services, ongoing case management, social work services, initial and annual/periodic IEP review, physical and occupational therapy, psychological services, nursing and nutrition services, and transportation.

Objective, Scope, and Methodology

We conducted our audit in accordance with generally accepted government auditing standards. The objective of our review was to determine if Medicaid costs claimed by DHMH for school-based health services were reasonable, allowable, and adequately supported in accordance with applicable federal regulations and the state Medicaid plan. Specifically, we determined whether: 1) school-based payment rates were supported and reasonable and 2) school-based health services were provided and adequately supported.

To accomplish our audit objective, we:

- Reviewed federal and state laws, regulations, guidelines, and state Medicaid plan pertaining to the Medicaid program and school-based health services.

- Held discussions with various officials from CMS, DHMH, MSDE, and the eight LEAs.

- Obtained an understanding of internal controls relative to payment rates and billing process, provider eligibility, and health service provider contracts with one LEA.

- Selected a random sample of 100 recipient/months representing paid Medicaid claims totaling $16,537 FFP for the period July 1999 through June 2000. The sample was selected from the 8 highest reimbursed LEAs comprising a population of 247,417 recipient/months with payments totaling $40,745,650 FFP.

- Obtained and analyzed supporting documentation for the sampled claims for Medicaid reimbursement from the eight LEAs including: student IEPs; provider qualifications; billing records; attendance records; and documentation such as progress notes and contact and trip logs to support the nature, amount, and duration of the services provided.

Our review covered school-based service costs paid during the period July 1, 1999 through June 30, 2000. During this period, DHMH paid 70 school-based providers over $101 million for school-based services. Reimbursements to the eight highest paid LEAs selected for detailed review represented 80 percent of the state's total FFP reimbursements for school-based services for this period.

We performed our field work at DHMH and MSDE offices in Baltimore, Maryland, and the eight LEA offices located throughout Maryland during the period August 2001 through April 2002.

FINDINGS AND RECOMMENDATIONS

Our review found that the fee-for-service rates used to bill for school-based health services were overstated because they included the basic costs of education that would not be reimbursable under the Medicaid program. In addition, contrary to the state Medicaid plan, we found that the largest LEA subcontracted a significant amount of its school-based health services to private contractors at rates below what it charged the Medicaid program. Our review of payments contained in 100 randomly selected recipient/months showed that the 8 LEAs billed the Medicaid program: 1) when providers were not qualified to render the service; 2) for services that were not approved in the state plan; 3) when the student was absent or the service did not occur with the appropriate participant; 4) for services that were not authorized or in excess of the quantity authorized in the IEP; 5) for transportation services when there was no authorized Medicaid service on the same day; and 6) for services that were insufficiently documented. Relative to our review of the randomly selected months, we estimate that the eight LEAs were inappropriately overpaid at least $19,954,944 FFP. Finally, we found that, contrary to CMS policy, Maryland's state plan included Medicaid coverage for school-based health services under section 504 of the Rehabilitation Act of 1973.

PAYMENT RATES OVERSTATED

Maryland's state Medicaid plan specified that reimbursement for services delivered by school providers or LEAs in school-based settings was based on cost. In the early 1990s, MSDE used cost data to develop the following fee-for-service school-based rates:

School-Based Health Service Rates

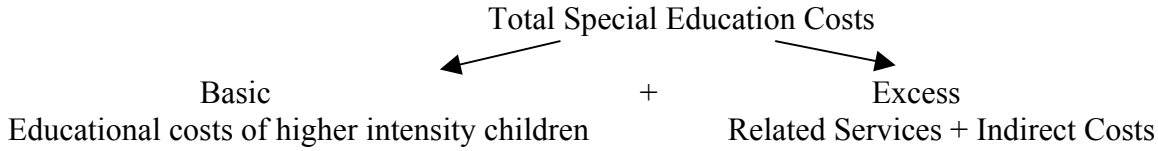
Service	Rate per Service
Health Services	
Audiology	$82
Nursing	$82
Nutrition	$82
Occupational Therapy	$82
Physical Therapy	$82
Psychiatry	$82
Psychology	$82
Social Work	$82
Speech	$82
Service Coordination	
Initial IEP	$500
Ongoing Case Management	$150
IEP Review	$275
Transportation	$12.50 each way

We reviewed available documentation to support development of MSDE's school-based health services rates. Our review found that the health services and service coordination rates were overstated because they included the basic costs of education that would not be reimbursable under the Medicaid program. We also found that the largest LEA subcontracted a significant amount of its school-based health services to private contractors at rates below what it charged the Medicaid program.

Education Costs Included in Rates

The MSDE included the cost of education, the primary function of the schools and not a reimbursable cost under the Medicaid program, in its calculation of the health services and service coordination rates.

Documentation provided by MSDE in support of the $82 health services rate showed that the rate included total special education costs. Special education costs included basic and excess costs as shown below.



The basic educational costs of higher intensity children reflected the costs to educate the more disabled population. The excess costs included: (1) the related services costs defined as medical and non-medical costs associated with additional services provided beyond the classroom teacher to supplement the education process and (2) the indirect costs of the special education program.

Similar to the health services rate, MSDE included special education costs in its calculation of the service coordination rates. Specifically, the health services rate, a key component used in the calculation, included special education costs. Those costs relate to the primary mission of the special education departments of the schools.

Including basic educational costs in school-based health services rates resulted in the Medicaid program supplementing the cost of education. Medicaid funds were intended to pay for health care services and not basic education costs. Therefore, the rate setting process should recognize only Medicaid reimbursable costs and exclude any costs related to non-Medicaid activities (i.e., education) performed by the provider.

We recalculated the health services rate by removing only the basic educational costs, which resulted in a new rate of $62, or a potential cost savings of $20 per billable health service. However, we did not have sufficiently detailed documentation to perform any other recalculations and available documentation related to very old cost data. Under the circumstances, we believe that the most appropriate course of action would be for MSDE and DHMH to develop new school-based rates using current healthcare cost data, excluding education costs.

Contracted Services Cost

The largest LEA subcontracted a significant amount of its school-based health services to private contractors at rates below what it charged the Medicaid program. This practice was contrary to the CMS approved state plan that specified that reimbursement for services delivered by school providers of LEAs in school settings were based on cost.

The LEA awarded over $9 million in contracts to various consultants to provide school-based speech therapy, occupational therapy, physical therapy, and social work services. According to the contracts, the consultants were to bill the LEA monthly for services provided using rates specified in the contracts. Only the LEA was authorized to submit billings to third party payers (primarily Medicaid) for services provided by the consultants. The LEA billed the Medicaid program for the services using the flat rate of $82 per service per individual. As shown below, the rate used to bill the Medicaid program was always higher than the contracted rates that varied by contractor, service type, and whether the service was provided in an individual or group setting.

Medicaid Rate Compared to Contract Rates

Health Service	Medicaid School-based Rate	Contract Rates *
Speech Therapy	$82	$51 – 70
Occupational Therapy	$82	$58 – 74
Physical Therapy	$82	$67
Social Work Services	$82	$38
* The contracted provider rates were based on per class hour of individual/group or related service hours. The ranges for speech and occupational therapies represented rates for two contracted providers.		

By using the higher fixed rate of $82 per service to bill Medicaid, the LEA was not in compliance with the state plan that stated that reimbursement for school-based services are based on cost. The LEA's actual cost was the amounts paid to the consultants to provide the services based on the contracted rates.

REVIEW OF MEDICAID CLAIMS

As part of our review of the appropriateness of Medicaid payments for school-based health services, we reviewed payments totaling $16,537 FFP for a random sample of 100 recipient/months made to 8 LEAs during the period July 1999 through June 2000.

We found that payments contained in 71 of the 100 recipient/months reviewed, the LEAs received payments of $9,887 FFP for school-based health services when: 1) the provider was not qualified to render the service (16 sample units); 2) the service provided was not approved in the state plan (17 sample units); 3) the student was absent or the service was not with the appropriate person (14 sample units); 4) the service was not authorized on the IEP (4 sample units); 5) the transportation service did not have the requisite Medicaid covered service (8 sample units); and 6) the service was not sufficiently documented (54 sample units).

The individual sample units total more than 71 because some sample units had more than 1 error condition. While some sample units had more than one condition, we did not question more than 100 percent of the claim (APPENDIX A). As a result, we estimate that Maryland's eight largest LEAs were overpaid at least $19,954,944 FFP (APPENDIX B).

Providers Not Qualified

For 16 sample units, Maryland received reimbursement for services when the health service providers were not qualified based on federal and state Medicaid requirements. The 16 sample units contained speech and/or case management services.

According to federal and state Medicaid regulations and the state plan, in order to provide direct speech services, a speech-language pathologist must be licensed or under the direction of a speech-language pathologist who is certified by the American Speech Language Hearing Association (ASHA) or meets the education and supervised work experience requirements necessary for the ASHA certification.

According to the state regulations for case managers, Code of Maryland Regulations (COMAR) 10.09.52.03(c)(3), a speech pathologist can also be a case manager; however, the speech pathologist must have a master's degree and be either licensed by the state or certified by MSDE. Additionally, an education professional, such as a special education teacher, can also be a case manager but must be certified by MSDE.

The following examples illustrate the lack of qualifications for the providers rendering speech and/or case management services:

- Eight sample units contained speech services that were rendered by speech pathologists that were not qualified because they were not licensed or ASHA certified. Also, the LEAs did not provide sufficient documentation to show that the provider was under the supervision of a qualified speech provider or that the supervisor was a qualified speech provider.

- Two sample units contained speech and case management services that were rendered by the same speech therapist. This provider was not qualified to render either service because she was not licensed or ASHA certified and did not hold a master's degree.

- Six sample units contained case management services rendered by special education teachers who were not qualified on the date of service because they were not MSDE certified.

For the 16 sample units that contained services provided by unqualified providers, we identified $2,098 FFP in error.

Written Case Management

For 17 sample units, the LEA billed for *written* case management, which was not an approved Medicaid service.

According to the state plan, case management was defined as at least one contact *in person* or *by phone* with the participant or the participant's parent. In 1998, Maryland changed its state regulation definition for case management to "at least one contact…in person, by telephone, or by written progress notes or log with the participant or the participant's parent." However, DHMH did not submit a state plan amendment to CMS requesting approval to add written case management as a Medicaid service. The following are examples of LEAs billing for case management when there was no contact in person or by phone with the recipient or parent:

- For one sample unit, the LEA's billing form indicated that the case management service consisted of a written note sent home to the parent regarding the child's progress. Also, the LEA did not provide a case management log or a copy of the written note to support the billing form.

- For another sample unit, the LEA provided an encounter form on which the case manager circled "report/letter," "other," and "monitor progress" to describe the case management service rendered.

- Another sample unit contained an encounter form that stated the type of service rendered was "Ongoing Service Coordination," place of service indicated "home" via "progress sheet." The LEA also provided the case manager's service coordination record; however, this document stated that the service rendered was a "written" progress note. No other documentation was provided to support the service.

The 17 unallowable written case management services resulted in errors of $1,125 FFP.

Service Not With the Student

For 14 sample units, we found that the student or the student's parent did not participate in the service as required by the state regulations and the state plan.

State regulations for transportation, COMAR 10.09.25.04A(3), provides Medicaid coverage for transportation services when provided to a child who was transported to or from a Medicaid covered service. Similarly, the state regulations for health services, COMAR 10.09.50.06(B), states providers may not bill the Medicaid program if the participant is not present. Finally, the state regulations, COMAR 10.09.52.04C(2)(a) and D(1)(b), and the state plan for case management services, states that an ongoing case management service or IEP review includes at least one contact with the student or the student's parent.

The LEAs did not adhere to those requirements when they billed for the following claims:

- An LEA billed for an IEP review session. However, the IEP did not indicate that the parent or student was involved or was contacted by the case manager or the IEP team.

- An LEA billed for a transportation service. However, the transportation log indicated the child was absent on the date of service.

- An LEA billed for an ongoing case management service, but the billing form indicated that the case manager met with the teacher and not with the student or the student's parent.

The 14 unallowable sample units that were for services that did not occur with the student or the student's parent resulted in errors of $620 FFP.

Service Not Authorized on the IEP

We found four sample units that contained health-related and transportation services billed to Medicaid that were not authorized on the IEP.

For an LEA to bill for medical and transportation services, the state plan and state regulations require that the service be specifically listed or authorized, and delivered in accordance with the IEP. The LEAs did not comply with those requirements when billing Medicaid for the following services:

- Two sample units contained transportation services that were not authorized on the IEP. In these cases, the specialized transportation section of the IEP form indicated that transportation services were not needed.

- The other two sample units contained health services that were not delivered in accordance with the IEP. For one sample unit, the LEA billed for more services during 1 week than was authorized in the IEP. On the other sample, the date of service was in June 1999, however, the IEP authorized the service to begin in September 1999. Therefore, the service was not authorized in the IEP at the time it was rendered.

For the four sample units that included services that were not authorized on the IEP, we identified $214 FFP in error.

No Authorized Medicaid Service

For eight sample units, we did not find an authorized Medicaid service billed on the same date of service a transportation service was billed.

The CMS's *Medicaid and School Health: A Technical Assistance Guide* (CMS Guide) stated that the Medicaid program can pay for transportation when: 1) the child receives transportation to obtain a Medicaid-covered service (other than transportation) and 2) both the Medicaid-

covered service and the need for transportation are included in the child's IEP. Additionally, the state plan provides for Medicaid coverage for transportation services under IDEA. To qualify, the child must have an IEP and both the medical service and transportation service must be included on the child's IEP. Finally, state regulations for transportation at COMAR 10.09.25.04A(03), provide that transportation services are covered if the student was transported to or from a Medicaid-covered service.

The LEAs, however, could not support that a Medicaid-covered service was provided when a transportation service was billed on the same date of service for eight sample units. The following examples highlight the types of errors found with the transportation services:

- For one sample unit, we determined that *written* case management was an unallowable service according to the state plan. Therefore, the correlating transportation service billed on the same date of service was also unallowable.

- For another sample unit, a Medicaid service was not billed the same day a transportation service was billed. The provider's billing documents did not indicate that a medical service was rendered.

- For another sample unit, the student attended a non-public school and the LEA billed for transportation services on behalf of the non-public school. However, the school could not provide documentation to show that a Medicaid service was rendered on the same days that transportation was billed.

For the eight sample units that the LEAs could not support that an authorized Medicaid service was provided on the same date of service when transportation was billed, we identified $362 FFP in error.

Insufficient Documentation

For 54 sample units, the LEAs did not provide sufficient supporting documentation for the Medicaid services billed. Specifically, the LEAs did not provide sufficient documentation for 17 transportation sample units, 16 health service sample units, 13 case management sample units, and 8 combined case management, health service, and/or transportation sample units. The lack of documentation ranged from missing IEPs to insufficient support for case management, health services, and transportation because the LEAs did not provide progress reports, case notes, or trip logs to describe the nature or extent of the services provided.

The Medicaid program can cover school health-related services included in a child's IEP if federal and state regulations, including documentation standards, are met. Federal guidance pertaining to documentation required providers to maintain specific information about all specific services and supporting documentation be available when a claim is filed. The MSDE had written policies and procedures in place for public schools requiring the providers to document services delivered to Medicaid recipients. These policies did not specifically cover documentation of the nature and extent of the services rendered, unlike MSDE's policies for non-public schools. However, the provider agreement between MSDE and the LEA specifically required the LEA to maintain records to fully describe the nature and extent of services. We

considered the following federal and state regulations and guidelines to determine whether a service was sufficiently documented to support that a Medicaid service was actually rendered.

Section 1903(c) of the Social Security Act permits Medicaid payment for medical services provided to children under IDEA that were included on a child's IEP. The CMS Guide states that a school must keep records that detail client specific information regarding all specific services provided for each individual recipient of services and retain those records for review.

The CMS *State Medicaid Manual* (SMM) section 2500.2 states that supporting documentation includes as a minimum the following: date of service; name of recipient; Medicaid number; name of the provider agency and person providing the service; nature, extent, or units of service; and the place of service. The SMM section 2497.1 requires that expenditures are allowable only to the extent that, when a claim is filed, adequate supporting documentation exists in readily reviewable form to assure compliance with applicable federal requirements.

During the Medicaid provider application process between MSDE and the LEA, the LEA agreed to:

> **"…maintain adequate records which fully describe the nature and extent of all goods and services provided and rendered, including but not limited to, charts, laboratory test results, medication records, and appointment books for a minimum of six (6) years and to provide them upon request to the Department and/or its designee."**

Finally, state regulations for non-public schools, COMAR 13A.09.10.12(G)(3), states that the provider shall document the student's progress in the achievement of IEP goals and objectives and shall provide a copy of the IEP progress documentation to the local school system for each student. Further, a school shall maintain documentation of each related service session provided. The documentation shall contain the following information: student's name; date of service of related service session; length of time of each session; IEP goal or objective being implemented; and notes regarding progress.

During our field work, we asked the LEAs for documentation supporting all sampled services. We suggested that sufficient supporting documentation could take the form of a progress or clinical note, contact log, or a trip log (as appropriate). Stated another way, we asked for documentation that would fully describe the nature and extent of the service provided. After our exit conference, we provided DHMH with a detailed listing of the service units in question. In response to this listing, DHMH provided letters from service providers related to 25 sample units questioned. The letters, which were signed subsequent to the completion of audit field work, typically stated that the service provider certified to providing the service to the student on the dates of service in question. The service providers did not provide additional documentation to support their statements. We did not accept any of the letters as sufficient documentation to support a service was rendered.

Transportation Services

For 17 sample units with transportation services, the LEAs did not submit trip logs, driver qualifications, and/or a completed IEP. In a May 1999 letter to the state Medicaid Directors, CMS stated that the requirements for documentation of each transportation service must be maintained for purposes of an audit trail. The CMS suggested this might be in the form of a trip log. The letter also stated the federal guidance that transportation services may be claimed when a child receives a medical service and transportation on a particular day, and the transportation must be identified in the IEP.

The LEAs did not adhere to these requirements as described below:

- For 15 sample units, the LEAs did not provide trip logs or similar documentation that would support that the child received specialized transportation on the date of service.

- For one sample unit, the LEA did not provide a completed IEP to support the authorization for transportation services.

- For one sample unit, the LEA did not provide support that the child received a medical service. Additionally, the LEA did not provide a driver's license to support the driver's qualifications.

Health Services

The DHMH did not provide sufficient documentation for 16 sample units with health services. Ten of the samples were for speech services, 2 for psychological services, 2 for social work services, and 2 for multiple services.

In addition to the federal and state documentation requirements previously discussed, speech pathologists should adhere to guidelines established by their professional association, ASHA. Specifically, members of ASHA and pathologists who have an ASHA certification should follow ASHA's clinical recordkeeping guidance. This guidance required that a clinical record include patient identifying information, client history, assessment(s) of the client's current status, a treatment plan, and documentation of treatment. The treatment documentation should include treatment reports with summaries of the assessment and treatment plan, the number of times treatment was rendered and the length of sessions, objective measures of client performance in terms that relate to the treatment goals, and changes in prognosis.

Maryland's Medicaid COMARs also required documentation of speech services, as well as other health services such as psychology and social work. Specifically, COMAR 10.41.02.04(H) required that speech language licensees maintain adequate records of professional services rendered and products dispensed and shall allow access to these records when appropriately authorized. The COMAR 10.42.03.03(A)(5), related to social workers, required the licensee to maintain documentation in the client's record which accurately reflected the services provided and indicated the time and date of the services. Finally, COMAR 10.36.05.07(C) required a

psychologist to keep records of a patient's condition and assessment results and provide timely evaluation or treatment reports to a client's insurance company or another concerned party.

The following examples highlight the insufficient documentation for health services:

- For nine speech sample units, the providers submitted "billing forms" that included the child's name, the date, and a number representing the amount of time the student received service. The forms did not fully describe the nature and extent of the services rendered and did not include a treatment report or a measure of the student's performance as it related to the IEP goals. The billing form did not represent an adequate record of professional services rendered, as required by the COMAR 10.41.02.04(H). The Office of Inspector General (OIG) discussed with CMS officials the use of this form as speech service documentation. The officials stated that this is not sufficient documentation because it does not describe the specific services provided to the recipient, as required by the CMS Guide. Subsequent to the completion of our field work, many of the speech providers submitted letters that stated they performed the services. These providers did not submit documentation as required by the provider agreement, ASHA guidance, or COMAR 10.41.02.04(H).

- For one social work sample unit, the LEA provided as support a billing form that included a social work code defined as "social work service." The social worker did not supply additional documentation with her letter to accurately reflect the services provided.

- For one sample unit containing psychological services, the billing form included the child's identifying information, the date of service, and codes representing "psychological services" and "individual psychology." The LEA did not provide additional documentation and the psychologist provided only a letter stating he performed the services.

Case Management Services

Of the 13 case management services with insufficient documentation, the LEAs: submitted an incomplete case management billing form or service log (7 sample units); did not provide an IEP (4 sample units); and did not provide documentation to prove a billable service (2 sample units).

Generally for case management services, the LEAs submitted a case management billing form or service log that included the child's name and a date of service. According to the state plan, case management was defined as at least one contact *in person* or *by phone* with the participant or the participant's parent. The state plan description of ongoing case management services included implementing the IEP by referring the participant to direct service providers and assisting the participant in gaining access to services specified in the IEP. We questioned billing forms that did not minimally identify the contact type, person, and a description of the service.

The following examples highlight the insufficient documentation for case management services:

- For seven sample units, the billing forms provided by the LEA were not complete for purposes of identifying the participant (either the student or parent) or nature and extent of the service, beyond "case management" or its billing code. For these forms, we could not verify whether a billable service, as defined in the state plan, occurred.

- For four sample units, the LEAs did not provide an IEP to verify that case management is a reimbursable service.

Combined Services

The LEAs did not provide sufficient documentation for eight sample units containing more than one service type.[1] Seven sample units contained case management and a health service or services and one sample unit contained transportation and a health service. We questioned the documentation based on the criteria previously discussed.

The following examples highlight the insufficient documentation for combined services:

- For one sample unit, the provider billed for case management using a billing form that merely indicated "CM" on the date of service. The form did not identify what service was provided or with whom. The same provider billed for speech services by including a number representing the length of service next to the recipient's name. The provider did not submit additional documentation to describe the nature and extent of either service.

- For one sample unit, the provider billed for a social work service and transportation. The LEA did not provide an IEP in effect for the date of service and the social work billing form included a code defined as "social work service." The social worker submitted a letter stating she provided the services, but did not provide additional documentation to accurately reflect the services provided.

For the 54 sample units where sufficient documentation was not provided, we identified $5,468 FFP in error.

SECTION 504 SERVICES

During our review, we found that CMS approved Maryland's state plan, which included Medicaid coverage for school-based health services and service coordination services provided, pursuant to a written individualized plan under section 504 of the Rehabilitation Act of 1973. Section 504 services are similar to those provided to children pursuant to an IEP under IDEA but are normally provided to less disabled children who do not qualify for IDEA services.

[1] Some sample units had more than one type of service, but we only questioned the sample as one unit. Therefore, we did not report these units in the previous insufficient documentation sections.

The CMS, however, in a March 1, 2000 memorandum to its Associate Regional Administrators, stated that Medicaid funding is not available for section 504 services. The CMS stated that the Medicare Catastrophic Coverage Act amended section 1903(C) of the Social Security Act to permit Medicaid to pay before education agencies for services provided to Medicaid eligible children pursuant to an IEP under IDEA. According to CMS, the exception is very specific and does not extend to section 504 services.

We asked the eight LEAs whether they had billed Medicaid for section 504 services. Six of the eight stated that they did not. One LEA stated that in the past they used their IEP form to document services needed for section 504 students, and the last LEA was unable to determine whether or not they billed Medicaid for section 504 services.

CONCLUSIONS AND RECOMMENDATIONS

Based on our review, we identified internal control weaknesses that need to be corrected to ensure that Maryland's school-based payment rates are based on actual costs of providing medical services and service providers appropriately submit and document Medicaid claims for school-based health care services.

We found that the fee-for-service rates used to bill for school-based health services were overstated because they included the basic costs of education. Also, the largest LEA subcontracted a significant amount of its school-based health services to private contractors at a lower cost than was billed to the Medicaid program. Our review of payments contained in randomly selected months for 100 recipients showed that the 8 highest paid LEAs billed the Medicaid program: 1) when providers were not qualified to render the service; 2) for services that were not approved in the state plan; 3) when the student was absent or the service did not occur with the appropriate participant; 4) for services that were not authorized or were in excess of the quantity authorized in the IEP; 5) for transportation services when there was no authorized Medicaid service on the same day; and 6) for services that were insufficiently documented. We estimate that the eight LEAs were inappropriately overpaid at least $19,954,944 FFP. Finally, we found that, contrary to CMS policy, Maryland's state plan included Medicaid coverage for school-based health services under section 504 of the Rehabilitation Act of 1973.

We recommended the DHMH:

1. Consult with CMS to develop new school-based payment rates based on actual medical costs.

2. Ensure school-based service providers adhere to federal and state Medicaid requirements for provider qualifications.

3. Develop and implement written policies and procedures requiring school-based service providers to document services delivered to Medicaid recipients.

4. Refund $19,954,944 federal share that was inappropriately paid by the Medicaid program.

5. Revise the state plan to eliminate all references to Medicaid coverage for section 504 services.

DHMH'S COMMENTS

In response to our draft report, DHMH agreed with the findings and accepted the procedural recommendations related to its payment rates, provider qualifications, documentation requirements, and state plan revisions. However, DHMH strongly disagreed with our recommendation to reimburse federal Medicaid payments and requested that we not proceed with this recommendation.

For the findings accepted, DHMH stated that it completed or is in the process of taking corrective actions. Specifically, DHMH is formulating a new school-based payment rate system based on actual costs using OMB Circular A-87 cost principles. Additionally, DHMH formed an Interagency Team to monitor all school systems annually to ensure proper provider qualifications, worked with CMS to develop documentation standards, and amended its state plan to remove any section 504 references.

The DHMH, however, questioned the validity of the sampling errors stating that subsequent to the audit exit conference it obtained additional documentation from the local school districts to respond to issues raised by OIG and provided the additional documentation to OIG. The DHMH responded that the audit demonstrated that most of the sample errors were the result of documentation inadequacies and not whether services were provided. The DHMH believes that available documentation demonstrated that the services were provided as intended to students but conceded that local documentation of services and oversight monitoring could have been improved.

The DHMH questioned our statistical sampling methods used to determine the amount of the recommended financial adjustment but did not identify specific concerns. Finally, DHMH commented that OIG had inaccurate information related to contract rates used by one LEA for speech therapy services.

The complete text of DHMH's comments is included in APPENDIX D.

OIG'S RESPONSE

We are pleased that DHMH has begun to address our procedural recommendations and encourage DHMH's efforts to improve the school-based program. Although we acknowledge DHMH's concerns relating to the financial adjustment recommendation, as discussed below, we continue to recommend a financial adjustment.

We considered the additional documentation DHMH provided subsequent to the audit exit conference. Where appropriate, we made changes in the report to reflect the additional documentation provided as well as DHMH's written comments. Much of the subsequent documentation, however, was not sufficient to cause us to modify our overall conclusions**.** For example, for several sample errors due to speech therapy services provided by unqualified providers, DHMH provided letters signed by two county school system central office supervisors

as support that the services were provided under the direction of a qualified speech pathologist. According to federal and state Medicaid regulations and the Maryland state plan, speech services must be provided by or under the direction of a properly qualified speech pathologist. The DHMH defines speech pathologist supervision requirements in the COMAR. Specifically, COMAR 10.41.11.07(D)(2) states that supervising speech-language pathologists shall maintain ongoing contact with all clients seen by the assistant by participating in speech services including not less than one in-person contact a month per client. Additionally, COMAR 10.41.11.07(D)(4) requires supervisors to maintain documentation of ongoing supervision. The letters, signed in May 2002 (after the completion of our audit field work and exit conference), stated that the supervisors "provide support, assistance and clinical supervision" to speech pathologists employed by the county's public schools and the providers in question rendered services in fiscal year 2000 under the direction of these supervisors. The letters, however, did not demonstrate that the named central office staff maintained ongoing contact with the client or participated in the delivery of services that would have required at minimum one in-person client contact per month. Further, the supervisors did not provide documentation to support ongoing supervision. Therefore, the additional documentation provided was not sufficient for us to conclude that the unqualified speech providers were under the direction of a qualified speech pathologist, and we continued to report these sample units as errors.

Additionally, for some sample errors due to lack of supporting documentation, DHMH provided letters from service providers stating that they actually performed the billed service. For example, a speech pathologist attested that, although her clinical notes were no longer available, she provided the services to the student on the dates selected for audit. The provider did not submit any additional documentation to support her statement. Neither the letter, nor the billing form submitted to the school district, included a note or description of the nature or extent of the services. Therefore, we continued to find the services were not sufficiently documented.

As DHMH indicated in its response, it did provide IEPs for two sample units. We modified our findings, but the sample units remained in error because the service providers were not qualified.

The DHMH is correct that the majority of the sample errors identified during the audit were due to insufficient supporting documentation for the Medicaid services billed. For most of the errors in this category, the only documentation provided was a billing form that listed the service billed. The documentation for case management and speech therapy services billed did not include progress, case, or clinical notes to describe the nature and extent of the service or how the service contributed toward achieving IEP goals. The documentation for transportation services did not include transportation logs. Accordingly, for those sample units we concluded that the documentation provided was insufficient to support that a Medicaid service was actually rendered.

Because DHMH did not specify its concerns related to our statistical sampling method, we cannot respond to its general comment. However, to improve the claims review report format, we modified the alignment of the dollars by error type. Those modifications did not change the overall results of our findings because the sampling methodology did not account for or project errors by type.

Finally, we based our contract rate analysis on therapy service rates in effect during our audit period, as provided by the LEA during our site visit. The purpose of our discussion was to emphasize that the $82 service rate billed was not based on cost as specified in the approved state plan. We recommended that DHMH consult with CMS to revise its service rates and DHMH agreed with this recommendation. Our recommended financial adjustment did not include amounts related to the contract rate analysis.

OTHER MATTERS

CASE MANAGEMENT SERVICES

For 17 of the 100 randomly selected months, we found that case management was the only medical service included in the students' IEPs.

Section 1905(a)(19) of the Social Security Act authorizes Medicaid reimbursement for case management services. Section 1915(g)(2) defines case management services as services that will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services. The state plan description of ongoing case management services includes the following activities: implementing the IEP by referring the participant to direct service providers; assisting the participant in gaining access to services specified in the IEP; providing linkage to agreed-upon direct service providers; and discussing with direct service providers the services needed and available for the participant.

For each of the 17 sample units, the only Medicaid medical service billed was the $150 monthly ongoing case management service. All other services prescribed in the IEPs for those individuals were educational in nature. Therefore, the Medicaid program paid the entire cost of case management services related to implementing IEPs that authorized only educational services. We estimate that the eight LEAs received about $3.2 million in Medicaid FFP when ongoing case management was the only medical service included in the students' IEPs (APPENDIX C).

The CMS considers case management to be a medical service; therefore, we are not questioning these services. We are reporting this condition to alert CMS to the extent of Maryland's Medicaid billings where case management is the only authorized Medicaid service.

APPENDICES

SCHEDULE OF SAMPLE ITEMS

Sample	A		B		C		D		E		F		TOTALS	
Number	Error	Dollars	Error	Dollars	Error	Dollars	Error	Dollars	Error	Dollars	Error	Dollars	Error	Dollars*
1	-	-	-	-	-	-	-	-	-	-	-	-	0	0
2	-	-	-	-	-	-	-	-	-	-	-	-	0	0
3	-	-	-	-	-	-	-	-	-	-	Y	75	1	75
4	-	-	Y	75	-	-	-	-	-	-	-	-	1	75
5	Y	198	-	-	-	-	-	-	-	-	-	-	1	198
6	-	-	-	-	-	-	-	-	-	-	-	-	0	0
7	-	-	Y	75	-	-	-	-	-	-	Y	75	1	150
8	-	-	-	-	-	-	-	-	-	-	Y	12.5	1	12.5
9	-	-	Y	75	-	-	-	-	-	-	-	-	1	75
10	Y	164	-	-	-	-	-	-	Y	50	Y	12.5	1	226.5
11	Y	198	Y	-	-	-	-	-	-	-	-	-	1	198
12	-	-	-	-	-	-	-	-	-	-	-	-	0	0
13	-	-	Y	75	Y	41	Y	82	Y	25	Y	100	1	323
14	-	-	Y	75	-	-	-	-	-	-	Y	275	1	350
15	-	-	-	-	-	-	-	-	-	-	-	-	0	0
16	Y	75	-	-	-	-	-	-	-	-	Y	82	1	157
17	-	-	Y	75	-	-	-	-	-	-	Y	150	1	225
18	-	-	Y	75	-	-	-	-	-	-	Y	212.5	1	287.5
19	-	-	-	-	-	-	-	-	-	-	-	-	0	0
20	-	-	-	-	-	-	-	-	-	-	-	-	0	0
21	-	-	-	-	-	-	-	-	-	-	-	-	0	0
22	-	-	Y	75	-	-	-	-	-	-	-	-	1	75
23	-	-	-	-	-	-	-	-	-	-	-	-	0	0
24	-	-	-	-	Y	41	-	-	-	-	-	-	1	41
25	-	-	-	-	-	-	-	-	-	-	-	-	0	0
26	-	-	-	-	-	-	-	-	-	-	-	-	0	0
27	-	-	-	-	-	-	-	-	-	-	-	-	0	0
28	-	-	-	-	-	-	-	-	-	-	Y	75	1	75
29	-	-	Y	75	-	-	-	-	-	-	Y	-	1	75
30	-	-	Y	75	-	-	-	-	-	-	-	-	1	75
31	-	-	-	-	-	-	-	-	-	-	-	-	0	0
32	Y	164	-	-	-	-	-	-	-	-	Y	137.5	1	301.5
33	-	-	-	-	-	-	-	-	-	-	-	-	0	0
34	-	-	-	-	-	-	-	-	Y	12.5	Y	25	1	37.5
35	-	-	Y	75	-	-	-	-	-	-	-	-	1	75
36	-	-	-	-	Y	12.5	-	-	-	-	Y	-	1	12.5
37	-	-	-	-	Y	75	-	-	-	-	Y	492	1	567
38	-	-	-	-	-	-	-	-	-	-	Y	50	1	50
39	-	-	-	-	-	-	-	-	-	-	Y	75	1	75
40	Y	82	-	-	-	-	-	-	-	-	Y	41	1	123
41	-	-	-	-	-	-	-	-	-	-	Y	123	1	123
42	Y	75	Y	-	-	-	-	-	-	-	Y	-	1	75
43	-	-	-	-	-	-	-	-	-	-	-	-	1	75
44	-	-	-	-	-	-	-	-	-	-	Y	123	1	123
45	-	-	-	-	-	-	-	-	-	-	Y	50	1	50
46	-	-	-	-	Y	75	-	-	-	-	Y	41	1	116
47	-	-	-	-	-	-	-	-	-	-	Y	157	1	157
48	-	-	-	-	-	-	-	-	-	-	Y	160.5	1	160.5
49	Y	123	-	-	Y	137.5	-	-	-	-	Y	164	1	424.5
50	-	-	-	-	-	-	-	-	-	-	Y	123	1	123
51	-	-	-	-	-	-	-	-	-	-	Y	137.5	1	137.5
52	Y	75	-	-	-	-	-	-	-	-	Y	-	1	75
53	-	-	-	-	-	-	-	-	-	-	-	-	0	0
54	-	-	-	-	-	-	-	-	-	-	-	-	0	0
55	-	-	-	-	-	-	-	-	-	-	Y	239	1	239
56	-	-	-	-	-	-	-	-	-	-	Y	82	1	82
57	Y	75	-	-	Y	-	-	-	-	-	Y	164	1	239
58	-	-	-	-	-	-	-	-	-	-	-	-	0	0
59	-	-	-	-	-	-	Y	12.5	-	-	Y	-	1	12.5
60	-	-	-	-	-	-	-	-	-	-	Y	280	1	280
61	Y	75	-	-	Y	-	-	-	-	-	Y	-	1	75

SCHEDULE OF SAMPLE ITEMS

Sample	A		B		C		D		E		F		TOTALS	
Number	Error	Dollars	Error	Dollars	Error	Dollars	Error	Dollars	Error	Dollars	Error	Dollars	Error	Dollars*
62	-	-	-	-	-	-	-	-	-	-	-	-	0	0
63	-	-	-	-	-	-	-	-	-	-	-	-	0	0
64	-	-	Y	75	-	-	-	-	-	-	-	-	1	75
65	-	-	-	-	-	-	-	-	-	-	Y	157	1	157
66	-	-	-	-	Y	75	-	-	-	-	Y	41	1	116
67	-	-	-	-	-	-	-	-	-	-	-	-	0	0
68	-	-	-	-	-	-	-	-	-	-	-	-	0	0
69	Y	137.5	-	-	-	-	-	-	-	-	-	-	1	137.5
70	-	-	-	-	-	-	-	-	-	-	-	-	0	0
71	-	-	-	-	-	-	-	-	-	-	Y	164	1	164
72	Y	246	-	-	Y	-	-	-	-	-	-	-	1	246
73	-	-	-	-	-	-	-	-	-	-	Y	75	1	75
74	-	-	-	-	-	-	-	-	-	-	-	-	0	0
75	-	-	-	-	-	-	-	-	-	-	Y	123	1	123
76	-	-	-	-	-	-	-	-	-	-	-	-	0	0
77	Y	164	-	-	Y	-	-	-	-	-	Y	75	1	239
78	-	-	-	-	-	-	-	-	-	-	Y	75	1	75
79	-	-	-	-	-	-	Y	82	-	-	-	-	1	82
80	-	-	-	-	-	-	-	-	-	-	Y	25	1	25
81	-	-	-	-	-	-	Y	37.5	-	-	-	-	1	37.5
82	-	-	-	-	-	-	-	-	-	-	Y	239	1	239
83	-	-	-	-	Y	75	-	-	-	-	-	-	1	75
84	-	-	-	-	-	-	-	-	-	-	-	-	0	0
85	-	-	-	-	-	-	-	-	-	-	-	-	0	0
86	-	-	-	-	-	-	-	-	Y	50	Y	-	1	50
87	Y	123	-	-	-	-	-	-	-	-	-	-	1	123
88	-	-	-	-	Y	75	-	-	-	-	-	-	1	75
89	-	-	-	-	-	-	-	-	Y	12.5	Y	-	1	12.5
90	-	-	Y	75	-	-	-	-	Y	112.5	Y	41	1	228.5
91	-	-	-	-	-	-	-	-	-	-	Y	75	1	75
92	-	-	-	-	-	-	-	-	-	-	Y	41	1	41
93	-	-	-	-	-	-	-	-	-	-	-	-	0	0
94	-	-	-	-	-	-	-	-	-	-	Y	321	1	321
95	-	-	-	-	Y	12.5	-	-	-	-	-	-	1	12.5
96	-	-	Y	75	-	-	-	-	Y	25	Y	82	1	182
97	-	-	-	-	-	-	-	-	-	-	-	-	0	0
98	-	-	-	-	-	-	-	-	-	-	Y	75	1	75
99	-	-	Y	75	-	-	-	-	Y	75	Y	125	1	275
100	Y	123	-	-	-	-	-	-	-	-	-	-	1	123
TOTAL	16	$2,097.5	17	$1,125	14	$619.5	4	$214	8	$362.5	54	$5,468	82	$9,886.5

*While some sample units had more than one condition, we did not question more than 100 percent of the claim.

Error Code Legend:

Error Code:

A: Provider not qualified

B: Written case management

C: Participant not present (health related services and transportation)/Service with teacher or related staff (case management service)

D: Services not authorized on IEP/Services exceeded amount authorized

E: No authorized MA service on date billed

F: Insufficient documentation for CM, health related and transportation (i.e., no IEP/no progress notes/no trip log)

APPENDIX B

RESULTS OF STATISTICAL SAMPLE

Sample Size	100
Value of Sample	$ 16,537
Number of Errors	71
Value of Errors	$ 9,887
Population Size	247,417
Value of Population	$ 40,745,650

Point Estimate	$ 24,460,882
2-Sided Confidence Level	90 %
Lower Confidence Limit	$ 19,954,944
Upper Confidence Limit	$ 28,966,820
Sample Precision	+/- 18.42 %

Based on our statistical sample, we are 95 percent confident that the amount overpaid is at least $19,954,944 (federal share).

RESULTS OF CASE MANAGEMENT ANALYSIS

Sample Size	100
Value of Sample	$ 16,537
Number of Non-Zero Items	17
Value of Non-Zero Items	$ 1,275
Population Size	247,417
Value of Population	$ 40,745,650

Point Estimate	$ 3,154,567
2-Sided Confidence Level	90 %
Lower Confidence Limit	$ 1,991,621
Upper Confidence Limit	$ 4,317,512
Sample Precision	+/- 36.87%

Based on our statistical sample, we estimate that the eight LEAs received about $3,154,567 (federal share) when ongoing case management was the only medical service included in the students' IEPs.

DHMH's RESPONSE

Nov-25-2002 02:46pm From-OPDF FINANCE 4103337789 T-011 P.002/005 F-147

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Parris N. Glendening, Governor - Georges C. Benjamin, M.D., Secretary

November 25, 2002

Stephen Virbitsky, Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services
140 S. Independence Mall West
Suite 316
Philadelphia, PA 19106-3499

Re: A-03-01-00224 Review of Medicaid School-Based Services Costs

Dear Mr. Virbitsky:

Thank you for allowing the Maryland State Department of Health and Mental Hygiene (DHMH) the opportunity to respond to the draft report, entitled "Review of Medicaid School-Based Services Costs during State Fiscal Year 2000 Claimed by Maryland's Medicaid Program."

OIG's report contains five recommendations:

1. Consult with CMS to develop new school-based payment rates based on actual costs using the cost principles established under OMB Circular A-87.

2. Ensure school-based service providers adhere to federal and state Medicaid requirements for provider qualifications.

3. Develop and implement written policies and procedures requiring school-based services providers to document services delivered to Medicaid recipients.

4. Refund $23,058,214 federal share that was inappropriately paid by the Medicaid program.

5. Revise the state plan to eliminate all references to Medicaid coverage for section 504 services.

DHMH's RESPONSE

The State of Maryland has completed or is in the process of completing recommendations one, two, three and five. However, we strongly disagree with recommendation number four. The reason for our disagreement should become evident as you read our response.

In response to the recommendations, and to enhance the efficiency of the reimbursement system, Maryland developed, provided training, and implemented a revised monitoring process that includes review with a detailed monitoring instrument. We are requiring school systems to develop a self-monitoring process and report the results to the state. Also, to accurately address each of the recommendations, Maryland Local Medical Assistance Coordinators participated in a two day seminar in the beginning of October 2002. Specific information from the OIG audit was shared, training was provided to correct past practices and additional recommendations were made related to corrective strategies for each of the audit findings. Feedback obtained during the seminar yielded the following:

- In response to recommendation number one, Maryland is formulating a new school-based payment rate system based on actual costs using the cost principles established under OMB Circular A-87.

- In response to recommendation number two, Maryland has formed an Interagency Team that will be responsible for monitoring all school systems annually to ensure proper provider qualifications.

- In response to recommendation number three, Maryland has requested guidance from the Centers for Medicare and Medicaid Services (CMS) for documentation that meets the federal requirements. On November 22, 2002, we provided to CMS a protocol for documenting cases and services for their comments.

- In response to recommendation number five, Maryland submitted an amended state plan to CMS on June 30, 2002, eliminating all references to Medicaid coverage for Section 504 services. On September 20, 2002, CMS agreed to the State Plan Amendment retroactive to April 2002.

While we accept the recommendations to improve the Medicaid reimbursement system, and have implemented steps to address them, Maryland strongly disagrees with recommendation number four that it should reimburse $23,058,214 of federal Medicaid payments. We have concerns about the validity of many sample errors found by the OIG that result in the financial penalty, as well as the statistical sampling methods that the OIG used to determine the reimbursement amount.

Because of Maryland's concerns about the validity of the sampling errors, after the April 18, 2002 exit conference with the OIG auditors, Maryland contacted the local school districts determined to have had sample errors. Maryland requested additional documentation from the local school districts to respond to the issues raised by OIG. Additional information was provided and Maryland submitted it to the OIG on May 17, 2002.

Maryland believes that many of the sample errors can be accounted for and should be

DHMH's RESPONSE

excluded in light of additional documentation provided by the local school districts. For example:

- Maryland obtained additional documentation from local school districts supporting the qualifications of service providers and case managers and provided it to the OIG.

- Maryland recently received information from a local school district demonstrating that contract rates for various speech therapy services (i.e., assessment, group therapy, individual therapy, and home visits) as determined by OIG were inaccurate. The actual payments made to physicians were above the rates billed to the Medicaid program.

- Communication sample errors occurred because Maryland revised its regulations to allow written contact with parents in addition to phone and person-to-person contact. Maryland did not revise the state plan at the time however, because it viewed the change as a minor technical one. In most instances written notes to the parents, report/letter, or progress sheets document communication with students' families.

- In response to the OIG's audit, a State Plan Amendment was sent to CMS in June 2002. CMS agreed to the State Plan Amendment retroactive to April 2002.

The largest area of sample errors resulted from documentation errors. Sources of information, including communication logs, written verification, and attendance reports demonstrate that services were provided although the service was not documented in the requested format, i.e., clinical notes. Existing documentation identified the date of service, the child's name, the type of service and the provider. Through additional review and contacts with the local school systems, Maryland has received written confirmation from a number of service providers that the billed service did occur. Additionally, in early 2002 Maryland requested guidance from CMS on documentation, specifically regarding how to adequately describe the nature and extent of the service.

The OIG identified sample errors for several health related services that were provided but were not identified on students' Individualized Education Program (IEP) documents. However, in at least two sample errors the IEPs included the listed service. Maryland acknowledges that the IEPs reviewed by the auditors could have been provided more promptly upon request by the OIG. Maryland has taken steps to ensure that the local school systems will provide appropriate documentation that describes the nature and extent of the service in the future and assure that it is timely provided upon request.

The audit demonstrates that most of the sample errors were the result of documentation inadequacies, and not whether services were provided. In the vast number of samples reviewed the identified service was provided to the student and the Medicaid money was used appropriately. Available documentation demonstrates that the services were provided as

DHMH's RESPONSE

intended to students, but local documentation of services and oversight monitoring could have been improved. As stated previously, we have taken steps to address this issue.

We request that the OIG not proceed with recommendation number four since we believe that the services were appropriately provided. We also request that OIG consider the impact of a reimbursement of this magnitude on the provision of services. Like most other states, Maryland is experiencing increasing costs for the provision of special education and related services and dwindling financial resources. A reimbursement of $ 23, 058, 214 will burden the provision of special education and related services to students with disabilities in Maryland. Reimbursement will have to be made from future funding allocation that would otherwise by used by local school districts to provide necessary special education and related services to students. Maryland will have to withhold millions of dollars of special education funding to the local school districts to make the reimbursement, without another revenue source to make up for this reduction. This will have a catastrophic effect on the provision of necessary services to students while the reimbursement is made.

Maryland thanks you for the opportunity to respond to the draft findings. Please do not hesitate to contact Kenneth Smoot, (410) 767-5186 with any questions or concerns you may have.

Sincerely,

Georges C. Benjamin, M.D.
Secretary

cc: Nancy S. Grasmick
Carol Ann Baglin
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