DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Offices of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

AUG 1 1 2006

Report Number: A-07-05-03063

Ms. Laura Howard
Assistant Secretary for Health Care Policy
Kansas Department of Social and Rehabilitation Services
915 SW Harrison
DSOB, 10th Floor
Topeka, Kansas 66612

Dear Ms. Howard:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General (OIG) final report entitled "Review of Kansas's Mental Health Center Medicaid Administrative Cost for the Quarters Ended December 31, 2002, and March 31, 2003." A copy of this report will be forwarded to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. 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.

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If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, ext. 274 (e-mail patrick.cogley@oig.hhs.gov), or your staff may contact Greg Tambke, Audit Manager, at (573) 893-8338, ext. 30 (greg.tambke@oig.hhs.gov). Please refer to report number A-07-05-03063 in all correspondence.

Sincerely yours,

Patrick J. Cogley
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Thomas Lenz
Regional Administrator, Region VII
Centers for Medicare & Medicaid Services
Richard Bolling Federal Building, Room 227
601 East 12th Street
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF KANSAS'S MENTAL HEALTH CENTER MEDICAID ADMINISTRATIVE COST FOR THE QUARTERS ENDED DECEMBER 31, 2002, AND MARCH 31, 2003

Daniel R. Levinson
Inspector General

August 2006
A-07-05-03063

Office of Inspector General

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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

BACKGROUND

The Medicaid program, a jointly funded Federal and State program, pays medical assistance costs for persons with limited income and resources. Each State administers its Medicaid program in accordance with a State plan approved by the Centers for Medicare & Medicaid Services (CMS) to ensure compliance with applicable Federal requirements.

Section 1903(a)(7) of the Social Security Act (the Act) permits Federal reimbursement for the cost of a Medicaid activity if necessary for the proper and efficient administration of the State plan.

In Kansas, the Department of Social and Rehabilitation Services (State agency) administers the Medicaid program. The State agency contracted with MAXIMUS, Inc. (MAXIMUS) to develop and administer the Mental Health Administrative Claiming (MHAC) program. The purpose of the MHAC program is to obtain Medicaid reimbursement for costs associated with administrative activities performed at the local level by mental health centers (MHC).

The State agency received a total of $3,060,098 in Federal reimbursement for Medicaid reimbursements for MHC administrative activities for the quarters that ended December 31, 2002, and March 31, 2003.

OBJECTIVE

Our objective was to determine whether the State agency claimed MHC Medicaid administrative costs for the quarters that ended December 31, 2002, and March 31, 2003, in accordance with applicable Federal requirements.

SUMMARY OF FINDINGS

The State agency did not claim MHCs Medicaid administrative costs for the quarters that ended December 31, 2002, and March 31, 2003, in accordance with applicable Federal requirements. Specifically,

- The State agency used a statistically invalid random moment time study to allocate costs because it had inadequate oversight and the system did not have adequate capacity to process all of the time studies.

- The State agency inappropriately claimed 75-percent Federal reimbursement instead of 50 percent for activities that did not require skilled professional medical personnel expertise because of a weakness in the claim calculator.

- The State agency's claim for the quarter that ended March 31, 2003, was calculated by MAXIMUS with transposed time study percentages because the State agency had inadequate oversight to ensure claimed amounts were accurate.

- The State agency included improper amounts reported by some of the MHCs because it had inadequate oversight and did not adequately train staff at the MHCs.

Because the random moment time study was invalid, we were unable to determine what portion (if any) of the State agency's claim for Medicaid reimbursement was allowable. Therefore, we set aside the $3,060,098 of Federal reimbursement the State agency received for the quarters that ended December 31, 2002, and March 31, 2003, for CMS adjudication.

RECOMMENDATION

We recommend that the State agency work with CMS to resolve the $3,060,098 in Federal reimbursement that we set aside.

AUDITEE'S COMMENTS

The State agency concurred with the findings and the recommendation. The State Agency agreed to work with CMS to resolve the $3,060,098 that we set aside, and stated that it would continue efforts to ensure that its MHC Medicaid administrative costs comply with all Federal requirements.

The State agency's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We commend the State agency for working with CMS to resolve the $3,060,098 in Federal reimbursement that we set aside. We also commend the State agency for taking corrective action to insure that its MHC Medicaid administrative costs comply with all Federal requirements.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program pays medical assistance costs for persons with limited income and resources. Each State administers its Medicaid program in accordance with a State plan approved by the Centers for Medicare & Medicaid Services (CMS) to ensure compliance with Federal requirements.

The Federal and State Governments share the cost of the Medicaid program. Section 1903(a)(7) of the Act permits Federal reimbursement for the cost of a Medicaid activity if necessary for the proper and efficient administration of the State plan. Federal reimbursement, or Federal share, of State Medicaid expenditures is 50 percent of allowable costs. However, the Federal share is 75 percent of allowable skilled professional medical personnel costs. To receive the enhanced rate, skilled medical professionals must meet specific education and licensure requirements and perform activities requiring the use of their professional training and expertise. The activities must be directly related to the administration of the Medicaid program and cannot include direct medical assistance. States submit expenditures for reimbursement on the Standard Form CMS-64, "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" (CMS-64 report).

Kansas Mental Health Administrative Claiming Program

In Kansas, the Department of Social and Rehabilitation Services (State agency) administers the Medicaid program. The State agency contracted with MAXIMUS, Inc. (MAXIMUS) to develop Kansas's Mental Health Administrative Claiming (MHAC) program. The purpose of the MHAC program is to obtain Medicaid reimbursement for costs associated with administrative activities performed at the local level by mental health centers (MHC). Medicaid did not reimburse the State agency for these MHC administrative costs prior to implementation of the MHAC program.

MAXIMUS developed the "Kansas Mental Health Administration Claiming Handbook" (MHAC Handbook) to provide guidance to the MHCs participating in the MHAC program. The MHAC Handbook provides instructions for calculating administrative costs by using random moment time studies, costs associated with administrative time, and Medicaid utilization data.

The random moment time study is a sampling method that is supposed to capture a given moment in time that represents the actions that a time study pool participant performs related to his or her job. Each of the sample participants selects a given code from a preprinted time study form. Participants are given training to help them determine which code is applicable for whatever activity they are performing. The codes include direct patient care; billable targeted case management services; outreach services for Medicaid and other services; facilitating applications for Medicaid and other services; referral, coordination, and monitoring of medical services; program planning; training; general administration; and not working.

Some of the services are not reimbursable under the MHAC program because they are reimbursable under other Medicaid programs. However, all time must be accounted for in order to allocate the expenses.

Generally, the MHAC program methodology is composed of the following processes: (1) MHCs report costs to MAXIMUS, (2) MAXIMUS utilizes the statewide time study results and allocates the cost to the proper codes, (3) those services that benefit Medicaid and non-Medicaid beneficiaries are adjusted by the specific MHC Medicaid eligibility rate, and (4) MAXIMUS reports the results to the State agency and the State agency submits the amount on the Standard Form CMS-64 report. See Appendix A for a step-by-step description of the MHAC claim calculator process.

The statewide time study for the quarter that ended December 31, 2002, began on November 14, 2002, and ended on December 31, 2002. The MHCs incurred expenses for the entire quarter, from October 1, 2002, through December 31, 2002, with the exception of one MHC.

CMS's Conditional Approval

On March 30, 2005, CMS informed the State agency that it had conditionally approved the agency's proposal to claim Federal reimbursement beginning October 1, 2002, for the costs of MHC administrative activities as described in the MHAC Handbook. CMS's conditional approval consisted of six conditions, one of which was that CMS must approve any change to the language of the conditional agreement. See Appendix B for a list of the six conditions.

Claim Amounts

The State agency submitted claims and received a total of $3,060,098 in Federal reimbursement for MHC administrative activities for the quarters that ended December 31, 2002, and March 31, 2003. The $3,060,098 was allocated as shown in Table 1:

Table 1: Allocation of Federal Reimbursement to the State Agency

	Quarter That Ended 12/31/2002	Quarter That Ended 3/31/2003	COMBINED
Claimed Federal Reimbursement	$1,174,428	$1,885,670	$3,060,098
Federal Reimbursement Allocation:			
MAXIMUS Contract[1]	76,338	122,569	198,907
Participating MHCs[2]	782,389	1,256,210	2,038,599
Retained by the State Agency[3]	315,701	506,891	822,592
Total	**$1,174,428**	**$1,885,670**	**$3,060,098**

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed MHC Medicaid administrative costs for the quarters that ended December 31, 2002, and March 31, 2003, in accordance with applicable Federal requirements.

Scope

We reviewed the State agency's MHC Medicaid administrative costs claimed for the quarters that ended December 31, 2002, and March 31, 2003. The State agency claimed these administrative costs as prior period adjustments on its CMS-64 reports for the quarters that ended December 31, 2004, and March 31, 2005.

We selected three MHCs (the Wyandot Center for Community Behavioral Health, COMCARE of Sedgwick County, and Valeo Behavioral Health) and reviewed their supporting documentation for the costs reported.

Our objective did not require an understanding or assessment of the State agency's or each MHC's overall internal control structure. We limited our review to how the MHCs accumulated data and the controls the State agency and MAXIMUS use to review quarterly reported financial data and supporting documentation for consistency, appropriate placement of information into categories, conformance with Office of Management and Budget (OMB) Circular A-87 guidelines, and overall integrity.

[1]The State agency's contract with MAXIMUS specifies that 6.5 percent of any Federal reimbursement will be paid to MAXIMUS for services rendered.
[2]Participating MHCs received 66.62 percent of the Federal reimbursement.
[3]The State agency retained 26.88 percent of the Federal reimbursement amount for program oversight.

We performed fieldwork at the State agency in Topeka, Kansas; the Wyandot Center for Community Behavioral Health in Kansas City, Kansas; COMCARE of Sedgwick County in Wichita, Kansas; and Valeo Behavioral Health in Topeka, Kansas.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance, including section 1903 of the Act, OMB Circular A-87, the MHAC Handbook, and CMS's conditional approval;

- interviewed officials and reviewed policies with the State agency, MAXIMUS, and three MHCs to understand how the Federal reimbursement for the Kansas MHAC was calculated;

- reconciled amounts claimed for Federal reimbursement to account detail information for three MHCs;

- interviewed MHC staff and reviewed training records and skilled professional licenses for staff using codes reimbursed at the enhanced rate at the three MHCs visited;

- reviewed 104 expense items to determine whether they were allowable for reimbursement;

- reviewed 603 time study documents to determine whether (1) participants correctly coded and completed them, and (2) the State agency and MAXIMUS properly administered them;

- reviewed 828 work schedules to determine whether each moment of time had an equal chance of being selected to represent the cost to be allocated; and

- reviewed the random moment time study sampling methodology to determine if the sample selected during the audit period was statistically valid.

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

FINDINGS AND RECOMMENDATION

The State agency did not claim MHCs Medicaid administrative costs for the quarters that ended December 31, 2002, and March 31, 2003, in accordance with applicable Federal requirements. Specifically,

- The State agency used a statistically invalid random moment time study to allocate costs because it had inadequate oversight and the system did not have adequate capacity to process all of the time studies.

- The State agency inappropriately claimed 75-percent Federal reimbursement instead of 50 percent for activities that did not require skilled professional medical personnel expertise because of a weakness in the claim calculator.

- The State agency's claim for the quarter that ended March 31, 2003, was calculated by MAXIMUS with transposed time study percentages because the State agency had inadequate oversight to ensure claimed amounts were accurate.

- The State agency included improper amounts reported by some of the MHCs because it had inadequate oversight and did not adequately train staff at the MHCs.

Because the random moment time study was invalid, we were unable to determine what portion (if any) of the State agency's claim for Medicaid reimbursement was allowable. Therefore, we set aside the $3,060,098 of Federal reimbursement the State agency received for the quarters that ended December 31, 2002, and March 31, 2003, for CMS adjudication.

STATISTICALLY INVALID TIME STUDY USED

Criteria: Sampling Methodology Must Be Statistically Valid

According to OMB Circular A-87, Attachment B, section 11(h)(6)(a)(i)(ii)(iii), the sampling universe must include all of the employees whose salaries and wages are to be allocated based on sample results; and the entire time period involved must be covered by the sample; and the results must be statistically valid and applied to the period being sampled.

The MHAC Handbook, chapter 2, states that: "It is important to note that 100% of MHC staff time is considered during MHAC time studies but only certain staff activities are actually eligible for Medicaid administrative reimbursement." "An MHAC administrative function would be outreach services for persons who may be eligible for Medicaid services."

Chapter 7 of the MHAC Handbook, "Monitoring and Quality Assurance," states: "Ongoing monitoring of the Mental Health Center Administrative Claiming (MHAC) program is a federal requirement. The Department of Social and Rehabilitation Services (SRS) will have lead responsibility for monitoring and quality control functions. SRS staff, or its authorized agent, will provide direct supervision and assistance for these functions."

According to chapter 4 of the MHAC Handbook, the MHC Coordinator is responsible for ensuring that a copy of the time study form and instructions are distributed to sampled staff just before the time at which observation data will be collected.

The U.S. Department of Health and Human Service's "A Guide for State and Local Government Public Assistance Agencies/Departments: Procedures for the Preparation and Submission of Cost Allocation Plans," states in "The Standards and Procedures for Random Moment Sampling," section II "General Concepts," that: "It is imperative that a sample design, once developed, be strictly adhered to. Violations in application of the sample design will introduce a bias that can invalidate the sample."

Condition: Time Study Was Statistically Invalid

The random moment time study used to allocate costs was statistically invalid: (1) limited work schedules did not allow for all possible sampled moments to have an equal chance of being selected, (2) participants coded activities in error, (3) the participants had knowledge in advance of when their moment in time was selected, and (4) the time study results were applied to costs outside the period of time covered by the time study.

Incorrect Work Schedules

All possible moments did not have an equal chance of being selected. The sampling universe did not account for the entire work time period used by employees. Of 828 random moment time study work schedules used by MAXIMUS, 731 (88 percent) did not represent the total work schedule submitted by the MHCs. In 645 instances, MAXIMUS selected a Monday through Friday, 9:00 a.m. to 3:00 p.m. (6-hour day), work schedule even though the MHCs had submitted a Monday through Friday, 8:00 a.m. to 5:00 p.m. (9-hour day), work schedule.

Because MAXIMUS used limited work schedules, the sampling universe decreased by nearly 8 million moments and accounted for only 68.57 percent of the total time worked by random moment time study pool employees during the audit period.

Additionally, because MAXIMUS selected a 6-hour day work schedule in most instances, the probability that lunch was a sampled activity increased. The MHC does not pay for lunch, however, participants were instructed to code lunch as administrative and general. Thus, a period of time that did not have associated cost was used to allocate cost.

Time Coding Errors

Of 379 random moment time study documents for which a reimbursable code was selected, 140 (36.93 percent) had 1 or more of 174 identified errors: (1) 105 errors in which the participants did not correctly code random moments based upon the activity description, (2) 69 documentation errors, and (3) 33 moments for which the MHC may not have incurred any costs.

The 33 additional moments all occurred during lunch. Participants did not correctly code such moments because most random moment time study participating staff were salaried employees for who lunch is not paid. The MHC did not incur any cost during lunch; therefore, lunch is unallowable for reimbursement under the MHAC program.

Advance Notice

Selected MHC staff stated that advance notice of their selected random moment was given to random moment time study participating staff. Staff were provided notice anywhere from the day of the random moment to three weeks before the random moment rather than just before the sampled moment as required by the MHAC Handbook.

Providing advance notice of the sampled random moment is a process vulnerability that may allow the results of the time studies to be altered in a way that would not reflect actual activities performed by the random moment time study pool participants and may result in an incorrect amount being claimed for reimbursement.

Costs Outside Sample Period

Contrary to Federal requirements, all but one of the MHCs that participated in the State agency's claim for the quarter that ended December 31, 2002, incorrectly included costs for the entire quarter instead of just the period covered by the time study (November 14, 2002, through December 31, 2002).

Cause: System Had Limited Capacity and the State Agency Lacked Oversight

The random moment time study was statistically invalid because of limited capacity and inadequate oversight. According to MAXIMUS, the random moment time study system did not have the capacity to account for the required number of work schedules necessary to represent the actual hours worked for all employees. In addition, the State agency did not have adequate policies and procedures in place to ensure sufficient oversight of the MHAC program. Specifically, the State agency did not adequately train random moment time study participating staff or complete quality assurance measures to prevent errors. The State agency did not ensure that the MHCs incurred costs for all activities coded with reimbursable codes.

STATE AGENCY INAPPROPRIATELY CLAIMED THE ENHANCED RATE

Criteria: Federal Reimbursement Rates

Federal regulations (42 CFR § 432.50(c)(2)) state that: "rates of [Federal reimbursement] in excess of 50 percent apply only to those portions of the individual's working time that are spent carrying out duties in the specified areas for which the higher rate is authorized."

Federal regulations (42 CFR § 432.50(a)(b)) state that reimbursement at the enhanced 75-percent rate is available for skilled professional medical personnel and directly supporting staff for salary or other compensation, fringe benefits, travel, per diem, and training. However, pursuant to 42 CFR § 432.50(d)(1), the following criteria must be met:

(i) The expenditures are for activities that are directly related to the administration of the Medicaid program, and as such do not include expenditures for medical assistance;

(ii) The skilled professional medical personnel have professional education and training in the field of medical care or appropriate medical practice. 'Professional education and training' means the completion of a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is demonstrated by possession of a medical license or certificate. . . .

(iii) The skilled professional medical personnel are in positions that have duties and responsibilities that require those professional medical knowledge and skills. . . .

In addition, the State agency's MHAC Handbook, chapter 3, "Time Study Participants," states that only those administrative activities that require the use of medical expertise are reimbursable at the enhanced rate of 75 percent.

OMB Circular A-87, Attachment B, item 27 "Lobbying," states that: "the cost of certain influencing activities associated with obtaining grants, contracts, cooperative agreements, or loans is an unallowable cost." However, item 30, "Memberships, subscriptions, and professional activities," states that: "costs of the governmental unit's memberships in business, technical, and professional organizations are allowable."

Condition: Inappropriate Rate of Reimbursement

The State agency inappropriately claimed 75-percent Federal reimbursement instead of 50 percent for activities that did not require skilled professional medical personnel expertise. The random moment time study is designed based on a percent-to-total allocation methodology allowing costs that do not meet Federal requirements to be allocated to the enhanced codes for skilled professional medical personnel.

In addition, the State agency claimed MHC dues and fees at the enhanced rate; however, they are only reimbursable at the 50-percent rate. A portion of the costs for membership dues may be unallowable because they may contain a component that would be for costs related to lobbying efforts on the MHC's behalf.

Cause: Claim Calculator Weakness

The State agency inappropriately claimed the enhanced rate because of a weakness in the claim calculator[4], an Excel spreadsheet template, MAXIMUS utilized to calculate each MHC's claim.

Generally, the MHAC program methodology is composed of the following processes: (1) MHCs report costs to MAXIMUS, (2) MAXIMUS utilizes the statewide time study results and allocates the cost to the proper codes, (3) those services that benefit Medicaid and non-Medicaid beneficiaries are adjusted by the specific MHC Medicaid eligibility rate, and (4) MAXIMUS reports the results to the State agency and the State agency submits the amount on the CMS-64 report.

Some activities were improperly reimbursed at the enhanced rate. The claim calculator allowed for reimbursement at the enhanced rate for expenses other than Skilled Professional Medical Personnel salary, other compensation, fringe benefits, travel, per diem, and training.

The time study results percentage for Code 12 - General Administration (lunch, vacation, breaks, supervision, etc.), was applied to the other activity codes and increased each of them proportionately, including the skilled professional medical personnel codes that are reimbursed at

[4]See Appendix A for a step-by-step discussion of the claim calculator.

the 75-percent rate instead of the 50-percent rate. In addition, while the calculator removes expenses for materials, supplies, other costs, contracted services, and indirect expenses from the enhanced rate, it still allowed for the reimbursement of membership dues (a portion of which may be unallowable) and fees at the enhanced rate.

TIME STUDY PERCENTAGES TRANSPOSED IN CLAIM CALCULATION

Criteria: Accurate Information Needed for Claim Calculator

OMB Circular A-87, Attachment C (A), states that: "There needs to be a process whereby these central service costs can be identified and assigned to benefited activities on a reasonable and consistent basis. All costs and other data used to distribute the costs included in the plan should be supported by formal accounting and other records that will support the propriety of the costs assigned to Federal awards."

Condition: Claim Calculated Incorrectly

The State agency's claim for the quarter that ended March 31, 2003, was calculated by MAXIMUS with transposed time study percentages. The claim calculator calculated the reimbursable amount based on information obtained from the individual MHCs. In calculating the State agency's claim for the quarter that ended March 31, 2003, MAXIMUS transposed the results of the time study for that quarter when applying those percentages to the activity codes in the claim calculator worksheets for each of the participating MHCs.

Cause: State Agency Lacked Adequate Oversight

The State agency lacked adequate oversight to ensure the submitted claim numbers were accurate. The original claim calculated for the quarter that ended March 31, 2003, had the correct time study percentages, but according to MAXIMUS, the percentages were applied to the wrong activity codes because of inaccurate data entry and an inadequate quality control.

SOME MHCs INCLUDED UNALLOWABLE COSTS, UNSUPPORTED ADMINISTRATIVE CHARGES, AND ENCUMBRANCES

Criteria: Expenditures Must Be Adequately Documented

OMB Circular A-87, Attachment A(C)(1)(j), states that costs must be adequately documented to be allowable.

An encumbrance is commonly defined as an obligation that is chargeable to an appropriation and for which a part of the appropriation is reserved. Encumbrances are not considered elements of expenditures.

Condition: State Agency Included Improper Amounts

The State agency included in its claim improper amounts reported by one MHC. The MHC could not provide any documentation to support the amounts. The MHC could not explain why five transactions were no longer in the MHC's accounting system. The five transactions totaled $35,462 and were included in the State agency's claim for the quarter that ended December 31, 2002. In addition, the MHC inappropriately included encumbrances totaling $750,915 in its reported expenditures for the quarter that ended March 31, 2003.

Causes: Inadequate Oversight and Lack of Training

The State agency did not provide adequate oversight and training to ensure that the costs claimed by the MHC were allowable or that documentation existed to support the costs. According to the MHC, the report that was used to determine its costs included encumbrances and was not limited to actual expenditures during the quarter. This is because of the number of reports available from their system and staff not being familiar with their new system.

SUMMARY

The State agency did not claim MHC Medicaid administrative costs for the quarters that ended December 31, 2002, and March 31, 2003, in accordance with applicable Federal requirements and guidelines. Because we found the random moment time study to be invalid we did not itemize the effect of the other findings. We were unable to determine what portion (if any) of the State agency's claim for Medicaid reimbursement was allowable. Therefore, we set aside the $3,060,098 of Federal reimbursement the State agency received for the quarters ended December 31, 2002, and March 31, 2003, for CMS adjudication.

RECOMMENDATION

We recommend that the State agency work with CMS to resolve the $3,060,098 Federal reimbursement that we set aside.

AUDITEE'S COMMENTS

The State agency concurred with the findings and the recommendation. The State Agency agreed to work with CMS to resolve the $3,060,098 that we set aside, and stated that it would continue efforts to ensure that its MHC Medicaid administrative costs comply with all Federal requirements.

The State agency's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We commend the State agency for working with CMS to resolve the $3,060,098 in Federal reimbursement that we set aside. We also commend the State agency for taking corrective action to insure that its MHC Medicaid administrative costs comply with all Federal requirements.

OTHER MATTER

The State agency did not adhere to all of the conditions (see Appendix B) imposed by CMS when CMS granted conditional approval to the State agency to claim Federal reimbursement for the costs of administrative activities performed by MHCs.

Specifically, the State agency did not adhere to CMS's fifth condition that it review and approve any forms, documents, and/or other related materials that are developed for use by this program, before implementation. The State agency failed to allow CMS the opportunity to review and approve the final Administrative Claiming Agreement (Agreement) before implementation. CMS had only conditionally approved the Agreement contained in the MHAC Handbook. The final Agreement, used by the State agency and MHCs, contained significantly different language, which the State agency did not submit or get approved by CMS.

In addition, the State agency did not adhere to CMS's sixth condition that it review and approve any changes to the approved Kansas MHAC program before implementation. The draft MHAC Handbook submitted for CMS's approval did not contain language specifying how the Federal reimbursement received would be allocated between MAXIMUS, the participating MHCs, and the State agency. The State agency did not submit for CMS's review and approval information related to the change in the MHAC program that resulted in the State agency retaining 33.38 percent of the claimed Federal reimbursement rather than the five percent CMS had understood the State agency would retain.

Based on the State agency's methodology, it retained a total of $392,038 of the $1,174,428 Federal reimbursement claimed for the quarter that ended December 31, 2002. If it had only retained five percent, the State agency would have retained only $58,721 of the $1,174,428 – a difference of $333,317. In addition, it retained a total of $629,460 of the $1,885,670 Federal reimbursement claimed for the quarter that ended March 31, 2003. If the State agency had only retained five percent, it would have retained only $94,284 of the $1,885,670 – a difference of $535,176.

APPENDIXES

STEPS TO DETERMINE AMOUNT OF ALLOCATED COST

CLAIM CALCULATOR

We reviewed the claim calculator, which is an Excel spreadsheet MAXIMUS used to determine the amount of cost to be allocated to each mental health center (MHC) for Federal reimbursement. MAXIMUS prepared a claim calculator for each quarter. The calculator works as follows:

PRELIMINARY STEPS

- MHCs allocate expenses into "Random Moment Sampling Pool, Unallowable, Indirect and Other" costs and determine the amount of Federal revenue.
- MHCs complete random moment time studies.
- MHCs determine their individual Medicaid Eligibility Rate (MER).
- MAXIMUS compiles the time studies, verifies the selected codes, and determines the percent to total for each code.
- MAXIMUS applies the results for "Code 12 - General Administration" to each of the other codes, causing each percentage to increase proportionately.

TABLE 1 OF CLAIM CALCULATOR

- Random moment sampling pool expenses are brought into the calculator in four categories: (1) "Travel, Training, Dues, and Fees," (2) "Salary and Fringe Benefits," (3) Contractors/Purchased Services, and (4) "Materials, Supplies, and Other Expenses."
- Indirect costs are brought into the calculation and allocated by "Full Time Equivalent." They are added with the four categories in bullet 1 of Table 1 of the Claim Calculator to determine "Gross Expense."
- Federal revenues are subtracted from "Gross Expense" to get "Net Claim Cost."
- Net Claim Cost is broken into two categories: (A) "Salary, Benefits, Travel, Training and Dues less Revenue" and (B) "Materials, Supplies, Other, Contractors/Purchased Services plus Indirect."

TABLE 2 OF CLAIM CALCULATOR

- Each time study percentage is applied to category (A) Salary, Benefits, Travel, Training and Dues less Revenue. The person entering the data must specify whether that code is reimbursable or non-reimbursable and whether a MER is applicable.

TABLE 3 OF CLAIM CALCULATOR

- Each time study percentage is applied to category (B) Materials, Supplies, Other, Contractors/Purchased Services plus Indirect. The person entering the data must specify whether that code is reimbursable or non-reimbursable and indicate a MER, if applicable.

TABLE 4 OF CLAIM CALCULATOR

- The results of Table 2 and Table 3 are added together. However, for skilled professional medical personnel codes, the category B expenses (Materials, Supplies, Other, Contractors/Purchased Services plus Indirect) are added in with the non-skilled professional medical personnel code counterpart because these expenses do not qualify for the enhanced reimbursement. For example, the Materials, Supplies, Other, Contractors/Purchased Services plus Indirect expenses for Code 10B (skilled professional medical personnel) are added in with the category A and B expenses for Code 10A (non-skilled professional medical personnel). Only the Category A expenses (Salary, Benefits, Travel, Training and Dues less Revenue) remain under Code 10B and are applied to the enhanced rate.

TABLE 5 OF CLAIM CALCULATOR

- The applicable MER is applied to the results of Table 4. From here the applicable 50-percent rate for non-skilled professional medical personnel codes and 75-percent rate for skilled professional medical personnel codes is applied to determine the amount of the non-skilled professional medical personnel and skilled professional medical personnel claims.

APPENDIX B

Excerpt from CMS letter dated March 30, 2005, to the State agency granting approval of the MHC claiming program subject to the six conditions below:

1. The State agrees that any regulations or national guidelines issued by CMS relating to the use of time study codes or methodologies for conducting time studies or other elements of claims for the administrative activities will be incorporated into the program on a prospective basis.

2. Any costs claimed under the approved plan are subject to Federal financial management review or audit.

3. Under Federal regulations at 45 CFR 95.509, a state must submit an amendment to its cost allocation plan (CAP) with respect to significant changes affecting the methodology used to allocate costs under the CAP. In accordance with this regulation, Kansas must update its CAP to reference the MAC program claiming methodology approved by this letter. Furthermore, under 45 CFR 95.517, with respect to costs claimed by the State based on a proposed CAP amendment that had not been approved by the Division of Cost Allocation, the State must retroactively adjust its claim in accordance with the approved CAP.

4. The State must create separate sub-program codes under the CAP for 50% and 75% FFP [Federal financial reimbursement] claims.

5. The CMS will be given the opportunity to review and approve any forms, documents, and/or other related materials that are developed for use by this program, prior to implementation. These would include, but are not limited to time study training materials, time study logs and instructions, time study survey instruments, validation results, quarterly financial expenditure forms and instructions, and statistical methodologies for the CMHCs.

6. Any changes to the approved Kansas CMHC Administrative Claiming must be submitted to CMS for review and approval prior to implementation. The State is at risk for any claims for FFP submitted prior to final CMS approval of the changes, and CMS may initiate necessary corrective actions pursuant to its final review.

KANSAS
SOCIAL AND REHABILITATION SERVICES
GARY J. DANIELS, SECRETARY
KATHLEEN SEBELIUS, GOVERNOR

July 27, 2006

Patrick J. Cogley
Regional Inspector General for Audit Services
Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

Re: Report Number A-07-05-03063

Dear Mr. Cogley,

Thank you for the opportunity to respond to the Office of Inspector General (OIG) draft report entitled "Review of Kansas's Mental Health Center Medicaid Administrative Costs for Quarters Ending December 31, 2002 and March 31, 2003."

Kansas agrees with the recommendation made in the report that, "We (OIG) recommend that the State agency work with CMS to resolve the $3,060,098 in Federal reimbursement that we (OIG) set aside." Kansas has already met with the CMS Regional Office to discuss what steps need to be taken to resolve this set aside. In brief, Kansas has made adjustments to its Mental Health Center Administrative Claiming (MHCAC) procedures that address many of OIG's findings and will be making more adjustments to address the remaining findings. Kansas will implement these procedural changes itself without the assistance of a private contractor and file claims for future quarters using the new procedures. The new claims for future quarters will help substantiate the amount of funding which should be provided for Kansas' previous and yet to be filed claims. The following provides specific responses to OIG's findings and what Kansas has done and is doing to respond.

OIG Finding - The State agency used a statistically invalid random moment time study because:

- Work schedules were incomplete,
- Errors were made in selecting reimbursement codes,
- Advance Notice was provided to persons participating in the random moment study, and
- Costs were claimed outside the sample period.

Kansas Response - Kansas has made the following adjustments to its procedures to address these findings:

- In recent quarters the time study has included complete and correct work schedules for all sampled persons. Kansas will continue this practice as it directly administers the program.
- Staff selected through the random moment study will not be identifying the reimbursement code that best fits the activity in which they are engaged. Instead, Kansas will employ telephone pollers who will call staff selected for the random moment time study. The telephone poller will ask the staff being polled to fully and completely describe the task in which they were engaged at the time period selected which will be just prior to the call. The telephone poller will obtain sufficient information to correctly classify the activity into the

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correct reimbursement code. The telephone poller will also take steps to document and confirm the accuracy of the staff's description of their work activity. A quarterly review will be done of 25% of all staff activity responses and resulting reimbursement coding done by the telephone poller.

- Using telephone pollers to call staff just after the time that was selected for the random moment study ensures they do not receive advance notice of their participation in the sample.
- Kansas will gather data for the random moment study for the entire quarter to ensure validity.

OIG Finding – The State agency inappropriately claimed 75 percent Federal reimbursement instead of 50 percent for activities that did not require skilled professional medical personnel (SPMP) expertise. Lobbying costs may also have been inappropriately claimed.

Kansas Response – At CMS' recommendation, Kansas will discontinue claiming any enhanced match whether or not the activity requires and is provided by SPMP. Kansas understands this will reduce the amount of its Federal claim. In addition, from the beginning of the program Kansas has made it clear to all reporting agencies that the cost of "lobbying" is unallowable. Finally, the new Kansas procedures will require that lunch time be coded as not scheduled at work. These policies will be re-iterated to participating mental health centers as Kansas implements its adjusted procedures and compliance will be monitored by completing a 25% field review of all CMHC cost reports.

OIG Finding – Time study percentages were transposed in the claim calculator for the quarter ending March 31, 2003.

Kansas Response – Kansas will diligently review all entries in the claims calculator to ensure transposition and other errors do not occur. Kansas will also do a field review 25% of all claims each quarter to check for the existence of these and other errors in submission and report them immediately to CMS.

OIG Finding – The State agency included in its claim improper amounts reported by one MHC.

Kansas Response – Kansas will ensure that all accounting transactions are kept for seven years. Kansas will also ensure that encumbrances are not be reported as expenses. Compliance with these policies will be achieved by doing a field review of 25% of all cost reports for each quarter.

Kansas believes the steps that it has taken and will take to address all of OIG's findings will result in valid Federal claims in the future. These valid claims will demonstrate the extent to which past and yet to be filed claims should be recognized allowing Kansas and CMS to resolve the amounts OIG has set aside.

Thank you again for this opportunity to respond to the report.

Sincerely,

Ray Dalton,
Acting Deputy Secretary of Health Care Policy
Social and Rehabilitation Services

cc. Gary J. Daniels, Ph.D., Secretary of Social and Rehabilitation Services
Marcia J. Nielsen, Ph.D., Executive Director of the Kansas Health Authority