DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Washington, D.C. 20201

September 14, 2010

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

/Joe J. Green/ for
FROM: George M. Reeb
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of New Jersey's Medicaid School-Based Health Claims Submitted by Public Consulting Group, Inc. (A-02-07-01052)

Attached, for your information, is an advance copy of our final report on New Jersey's Medicaid school-based health claims submitted by Public Consulting Group, Inc. We will issue this report to the New Jersey Department of Human Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Robert.Vito@oig.hhs.gov or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620 or through email at James.Edert@oig.hhs.gov. Please refer to report number A-02-07-01052.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services
Jacob Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

September 15, 2010

Report Number: A-02-07-01052

Ms. Jennifer Velez, Esq.
Commissioner
New Jersey Department of Human Services
222 South Warren Street
P.O. Box 700
Trenton, NJ 08625-0700

Dear Ms. Velez:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of New Jersey's Medicaid School-Based Health Claims Submitted by Public Consulting Group, Inc.* We will forward a copy of this report 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 this 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Richard Schlitt, Audit Manager, at (212) 264-4817 or through email at Richard.Schlitt@oig.hhs.gov. Please refer to report number A-02-07-01052 in all correspondence.

Sincerely,

/James P. Edert/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF NEW JERSEY'S MEDICAID SCHOOL-BASED HEALTH CLAIMS SUBMITTED BY PUBLIC CONSULTING GROUP, INC.

Daniel R. Levinson
Inspector General

September 2010
A-02-07-01052

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In New Jersey, the Department of Human Services is responsible for operating the Medicaid program.

Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P. L. No. 100-360) amended section 1903(c) of the Act to permit Medicaid payment for medical services provided to children under the Individuals with Disabilities Education Act through a child's individualized education plan. Pursuant to Federal and State requirements, such services require a referral or prescription from a properly credentialed physician or licensed practitioner. These services must be provided by an individual who meets Federal qualification requirements and be fully documented. In addition, pursuant to New Jersey's State Medicaid plan requirements, these services must be documented in a treatment plan.

For the period April 6, 2005, through June 27, 2007, New Jersey received more than $45.3 million in Federal Medicaid reimbursement for school-based health claims submitted by its billing agent, Public Consulting Group, Inc. (PCG).

OBJECTIVE

Our objective was to determine whether New Jersey's Medicaid school-based health claims submitted by its billing agent, PCG, complied with Federal and State requirements.

SUMMARY OF FINDINGS

New Jersey's claims for reimbursement of Medicaid school-based health services submitted by PCG did not fully comply with Federal and State requirements. Of the 100 school-based health claims in our sample, 64 claims complied with Federal and State requirements. However, the remaining 36 did not.

Of the 36 noncompliant claims, 11 claims contained more than 1 deficiency:

- Sixteen claims lacked a referral or prescription.
- Sixteen claims did not meet Federal provider qualification requirements.
- Fourteen claims contained services that were not provided or supported.
- One claim contained services not documented in the child's plan.

These deficiencies occurred because: (1) school-based health providers did not comply with guidance related to Federal requirements and (2) New Jersey did not adequately monitor school-based health claims for compliance with Federal and State requirements.

Based on our sample results, we estimate that New Jersey was improperly reimbursed $5,613,885 in Federal Medicaid funds during our April 6, 2005, through June 27, 2007, audit period.

RECOMMENDATIONS

We recommend that New Jersey:

- refund $5,613,885 to the Federal Government and

- consider the results of this review in its evaluation of our prior recommendations to ensure that its school-based health providers comply with Federal and State requirements.

NEW JERSEY COMMENTS

In its comments on our draft report, New Jersey disagreed with our recommended refund. In addition, New Jersey questioned our sampling methodology and disagreed with what we accepted as valid referrals. However, New Jersey described corrective actions that it has taken in response to our second recommendation. New Jersey also provided additional documentation for six claims we questioned in our draft report.

OFFICE OF INSPECTOR GENERAL RESPONSE

Our statistical sampling methodology used to determine the estimated overpayment was valid. After reviewing the additional documentation provided by New Jersey, we determined that some services for five claims complied with Federal and State requirements and revised our findings and recommended refund accordingly.

TABLE OF CONTENTS

Page

APPENDIXES

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Medicaid Coverage of School-Based Health Services

Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P.L. No. 100-360) amended section 1903(c) of the Act to permit Medicaid payment for medical services provided to children under the Individuals with Disabilities Education Act (IDEA) (originally enacted as P.L. No. 91-230 in 1970) through a child's individualized education plan.

Federal and State rules require that school-based health services be (1) referred or prescribed by a physician or another appropriate professional, (2) provided by an individual who meets Federal qualification requirements, (3) fully documented, (4) actually furnished in order to be billed, and (5) documented in the child's plan.

In August 1997, CMS issued a guide entitled *Medicaid and School Health: A Technical Assistance Guide* (technical guide). According to the technical guide, school-based health services included in a child's plan may be covered if all relevant statutory and regulatory requirements are met. In addition, the technical guide provides that a State may cover services included in a child's plan as long as: (1) the services are listed in section 1905(a) of the Act and are medically necessary; (2) all Federal and State regulations are followed, including those specifying provider qualifications; and (3) the services are included in the State plan or available under the Early and Periodic Screening, Diagnostic and Treatment Medicaid benefit. Covered services may include, but are not limited to, physical therapy, occupational therapy, speech pathology/therapy services, psychological counseling, nursing, and transportation services.

New Jersey's Medicaid Program

In New Jersey, the Department of Human Services is responsible for operating the Medicaid program. Within the New Jersey Department of Human Services, the Division of Medical Assistance and Health Services administers the Medicaid program. The administrative responsibility for operating New Jersey's school-based health services program, known as the Special Education Medicaid Initiative (SEMI), is shared among three State departments: Human Services, Education, and Treasury. The State also contracted with a billing agent, Public

Consulting Group, Inc. (PCG), to help administer its Medicaid school-based health services program. The responsibilities of each are as follows:

1. The Department of Human Services oversees school-based health provider enrollment, provides technical assistance to school-based health providers, and processes providers' claims through New Jersey's Medicaid Management Information System fiscal intermediary.

2. The Department of Education certifies school-based health providers and provides policy guidance.

3. The Department of Treasury serves as the contract manager for the SEMI billing agent.

4. The billing agent is responsible for processing billing agreements and pupil registration information from school-based health providers providing technical assistance (including monitoring) on school-based health program issues, and conducting Medicaid eligibility verification for registered pupils. PCG was the contracted billing agent for New Jersey during our audit period.[1]

The primary State guidance for administering and operating the school-based health program is the *SEMI Provider Handbook* (State handbook). New Jersey and the billing agent developed the handbook using both education and Medicaid requirements. The State handbook is issued to all school-based health providers and contains detailed instructions on their responsibilities under the school-based health program. The State handbook developed with PCG incorporated recommendations and criteria from a prior Office of Inspector General audit report (A-02-03-01003) that were not included in the State handbook developed with the previous billing agent.

Pursuant to New Jersey's Medicaid State plan, the school-based health program comprises rehabilitative services,[2] evaluation services,[3] and transportation services.[4] School-based health

[1] PCG has overseen the SEMI program since January 2005 under a contingency-fee based arrangement. Although PCG is not paid directly with Federal Medicaid funds, it is paid a percentage of the Federal Medicaid reimbursements made for New Jersey's SEMI program. We selected this program for review as part of a nationwide contingency fee review.

[2] Often referred to as related school health services, rehabilitative services include occupational, physical, and speech-language therapies; audiology services; psychological counseling and psychotherapy; and nursing.

[3] Evaluation services identify the need for school-based health services and prescribe the range and frequency of services that the student requires. Evaluation services may include reevaluation or review of the current school-based health services specified in the child's plan.

[4] Transportation services are allowable when provided on the same day as a related service and when transportation is included in the child's plan. Pursuant to a May 21, 1999, letter from the Director of CMS's Center for Medicaid and State Operations to all State Medicaid directors, only specialized transportation can be billed to Medicaid. According to CMS, "specialized transportation" means that a child requires transportation in a vehicle adapted to serve the needs of the disabled, including a specially adapted school bus.

providers submit claims information to PCG through EasyTRAC, an online documentation system that provides access to student information. (EasyTRAC can store information, such as provider qualifications, child's plan dates, and parental consent dates, to support school-based health claims.) PCG then prepares claims based on the information received through EasyTRAC. A school-based claim consists of a bill for related school-based health services, evaluation services, or transportation services.

The Federal Government's share of costs for school-based health claims is known as the Federal medical assistance percentage (FMAP). From April 6, 2005, through June 27, 2007, the FMAP was 50 percent in New Jersey. For this period, New Jersey received more than $45.3 million of Federal Medicaid reimbursement for 157,114 claims.

Prior Office of Inspector General Audit Reports

On May 19, 2006, the Office of Inspector General issued a report (A-02-03-01003) on New Jersey's SEMI program for the period July 1, 1998, through June 30, 2001. The objective of the audit was to determine whether Federal Medicaid payments for school-based health services claimed by school-based health providers in New Jersey were in compliance with Federal and State requirements. Among other recommendations, the report recommended that New Jersey refund $51,262,909 to the Federal Government and work with CMS to resolve $1,046,786 in set aside claims.[5]

On February 8, 2008, the Office of Inspector General issued a report (A-02-04-01017) on the rates used by New Jersey for claiming Federal Medicaid reimbursement for the SEMI and Medicaid Administrative Claiming programs. The objective of the audit was to determine whether the rates used by New Jersey were reasonable and complied with Federal requirements and the Medicaid State plan. The report recommended that New Jersey work with CMS to determine overpayment amounts for the period July 1, 1998, through June 30, 2001, and ensure that rates used to claim Federal Medicaid reimbursement for school-based health services are properly developed and documented.

On April, 23, 2010, the Office of Inspector General issued a report (A-02-07-01051) to New Jersey regarding Medicaid school-based health claims submitted by its previous billing agent, Maximus, Inc., for the period July 27, 2003, through October 4, 2006. The report recommended that New Jersey provide proper and timely guidance on Federal Medicaid criteria to its school-based health providers and to improve its monitoring of school-based health providers' claims to ensure compliance with Federal and State requirements.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether New Jersey's Medicaid school-based health claims submitted by its billing agent, PCG, complied with Federal and State requirements.

[5] CMS sustained the recommendations with minor adjustments.

Scope

Our review covered 157,114 claims paid totaling $90,731,406 ($45,365,703 Federal share) for the period April 6, 2005, through June 27, 2007. During our audit, we did not review the overall internal control structure of PCG, New Jersey, or the Medicaid program. Rather, we limited our internal control review to those controls that were significant to the objective of our audit.

We conducted fieldwork at the Department of Human Service's offices in Mercerville and Trenton, New Jersey, as well as at 45 selected schools throughout the State.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidelines;
- held discussions with New Jersey and billing agent officials to gain an understanding of New Jersey's school-based health services program;
- obtained an understanding of computer edits and administrative controls regarding claiming Medicaid reimbursement for school-based health services;
- obtained a computer-generated file identifying all Medicaid school-based health claims submitted by New Jersey for the period July 27, 2003, through June 27, 2007;
- separated the file into two segments based on billing agent: claims submitted by Maximus Inc.,[6] and claims submitted by PCG, and the PCG sampling frame consisted of 157,114 student-months (all services provided to an individual student for a month during our audit period) with a total Medicaid paid amount of $90,731,406 ($45,365,703 Federal share);
- used stratified random sampling techniques to select a sample of 100 claims from the sampling frame of 157,114 claims;[7]
- visited the school associated with each sample claim to review documentation supporting the claim;[8]

[6] We are conducting a separate review (A-02-07-01051) of claims submitted by New Jersey for the period July 27, 2003, through October 4, 2006, when Maximus, Inc., was the State's school-based health services billing agent.

[7] The 100 sample claims included 149 services: 47 for evaluation services, 43 for speech services, 19 for occupational therapy services, 14 for psychological counseling services, 12 for physical therapy services, 9 for nursing services, and 5 for transportation services.

[8] If documentation was not readily available, we accepted faxed copies at later dates.

- determined if the service provider or speech pathologist associated with the sample claim was certified by the American Speech-Language-Hearing Association (ASHA) and/or licensed by the New Jersey Division of Consumer Affairs, the State licensing agency; and

- estimated the dollar impact of the improper Federal reimbursement claimed in the total population of 157,114 school-based claims.

Appendix A contains the details of our sample design and methodology. Appendix B contains our sample results and estimates.

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

FINDINGS AND RECOMMENDATIONS

New Jersey's claims for reimbursement of Medicaid school-based health services submitted by PCG did not fully comply with Federal and State requirements. Of the 100 school-based health claims in our sample, 64 claims complied with Federal and State requirements. However, the remaining 36 did not. The table summarizes the deficiencies noted and the number of claims that contained each type of deficiency. Appendix C contains a summary of deficiencies, if any, identified for each sampled claim.

Summary of Deficiencies in Sampled Claims

Type of Deficiency	Number of Deficient Claims[9]
Referral or prescription requirements not met	16
Federal provider requirements not met	16
Services not provided or not supported	14
Services not documented in child's plan	1

These deficiencies occurred because: (1) school-based health providers did not comply with guidance related to Federal requirements and (2) New Jersey did not adequately monitor school-based health claims for compliance with Federal and State requirements.

Based on our sample results, we estimate that New Jersey was improperly reimbursed $5,613,885 in Federal Medicaid funds during our April 6, 2005, through June 27, 2007, audit period.

[9] The total exceeds 36 because 11 claims contained more than 1 deficiency.

REFERRAL OR PRESCRIPTION REQUIREMENTS NOT MET

Pursuant to 42 CFR § 440.110 (a)(b)(c), a referral or prescription from a physician or another licensed practitioner of the healing arts is required for physical therapy; occupational therapy; and services for individuals with speech, hearing, and language disorders provided by or under the direction of a qualified practitioner to be eligible for Medicaid reimbursement. For nursing services, the New Jersey Board of Nursing Statute 45:11-23 allows nurses to execute medical regimens as prescribed by a licensed (or otherwise legally authorized) physician or dentist.

For 16 of the 100 claims in our sample, the school-based health provider could not provide referrals or prescriptions to support the related service. Specifically, 15 speech therapy services did not meet Federal referral and prescription requirements, and 1 nursing service did not meet State prescription requirements.

FEDERAL PROVIDER REQUIREMENTS NOT MET

Federal regulations (42 CFR § 440.110) set forth provider credential requirements for physical, occupational, and speech therapy services. For 16 of the 100 claims in our sample, the speech therapy practitioner associated with the claim did not meet these regulations.

Speech Therapy Provider Requirements Not Met

Pursuant to 42 CFR § 440.110(c)(2), for a speech therapy claim to be eligible for Medicaid reimbursement, it must be provided by or under the direction of a speech pathologist who: (1) is certified by ASHA or (2) has completed the equivalent education requirements and work experience necessary to be eligible for ASHA's certificate of clinical competence or (3) has completed the academic program and is in the process of acquiring the necessary supervised work experience to qualify for the certificate.

In a December 28, 1993, letter, CMS asked New Jersey officials to provide assurance that speech therapy providers would meet the qualifications detailed in 42 CFR § 440.110(c)(2). In an August 1, 1995, letter, New Jersey assured CMS that it would bill Medicaid for only those services provided by or under the direction of qualified speech-language practitioners.

However, for 16 of the 100 claims in our sample, the practitioner who provided the speech therapy service was not ASHA-certified or did not have the equivalent educational requirements and work experience necessary to be eligible for ASHA certification.

ASHA requires all applicants for certification of clinical compliance to possess a master's or doctoral degree granted by a regionally accredited institution of higher education and have completed a minimum of 75 semester credit hours in a course of study addressing the knowledge and skills pertinent to the field of speech-language pathology. Additionally, applicants must complete a 350-hour minimum clinical practicum under the supervision of an individual who holds a certificate of clinical competence and a 36-week, full-time fellowship.

None of the practitioners associated with the 16 claims in our sample met these requirements. The practitioners who provided the services were authorized by the New Jersey Department of Education (DOE) to serve in public schools as either a speech correctionist or a speech language specialist. The DOE does not require specific coursework towards a master's degree, a 350-hour clinical practicum, or a clinical fellowship.

Finally, for the 16 sample claims in question, the school-based providers did not furnish any documentation showing that the services provided met the "under the direction of" requirements. Pursuant to 42 CFR § 440.110(c) and Medicaid State Operations Letter 95-12, issued on February 9, 1995, "under the direction of a speech pathologist" means that the speech pathologist is individually involved with the patient under his or her direction and accepts ultimate responsibility for the actions of the personnel that he or she agrees to direct.

SERVICES NOT PROVIDED OR NOT SUPPORTED

Pursuant to section 1902(a)(27) of the Act, States claiming Federal Medicaid funding must document services provided. This requirement is reiterated in CMS's technical guide and the State handbook, which both state that school-based health providers must maintain records documenting that a related service or evaluation service was provided. The technical guide states that relevant documentation includes the date and location of the service, the identity of the provider, and the length of time required for the service.

In addition, pursuant to 42 CFR § 455.1(a)(2), States are required to have a method for verifying whether services reimbursed by Medicaid were actually furnished. Further, pursuant to 42 CFR § 455.18, New Jersey's Medicaid provider agreements require providers to certify that the information on their Medicaid claims is true, accurate, and complete.[10] Providers and billing agents also certify that they agree to keep records necessary to fully disclose the extent of services provided, as required by section 1902(a)(27) of the Act.

For 14 of the 100 claims in our sample, school-based health providers received Medicaid payments for services that were not provided or not supported. Specifically:

- For 10 claims, documentation indicated that the related service(s) billed were not provided.[11] Specifically:

    - For six claims, the school register indicated that the student was absent from school or school was not in session on at least 1 day that the school-based health provider claimed services.

[10] The regulation requires State Medicaid claim forms to include a certification by providers that the information on the claims is true, accurate, and complete or States may print similar wording above the claimant's endorsement on checks payable to providers. In New Jersey, both the *Provider Electronic Billing Agreement for Providers With Billing Agents* and the *Medicaid Health Insurance Portability and Accountability Act Electronic Data Interchange Agreement* include such certifications.

[11] The total exceeds 10 because 1 claim had multiple deficiencies.

- For four claims, documentation for the associated student did not support the number of services billed.

- For one claim, two separate school-based health providers submitted claims for the same evaluation service.

- For two claims containing specialized transportation services, school-based health providers did not have documentation to support the number of transportation services billed.

- For two claims, school-based health providers could not provide any documentation to support the related service.

CHILD'S PLAN NOT PROVIDED

Section 1903(c) of the Act permits Medicaid payment for medical services provided to children under IDEA if the services are included in a child's plan. Pursuant to Part B of IDEA, school districts must prepare a child's plan for each child that specifies all special education and related services that the child needs. New Jersey's State Medicaid plan provides that a child's plan must state which related services are to be provided. For 1 of the 100 claims in our sample, the associated school could not provide a child's plan.

CAUSES OF THE IMPROPER CLAIMS

Although PCG incorporated corrective actions recommended in one of our prior audit reports (A-02-03-01003) into their SEMI provider handbook, our review found deficiencies similar to those previously reported. We found two main causes of the improper claims.

Providers Did Not Comply With Federal Requirements

Some of the improper claims occurred because school-based health providers did not comply with Federal requirements. The State handbook specifies that per Federal requirements, speech therapy services must be provided by or under the direction of a ASHA-certified speech-language pathologist. In addition, the State handbook reiterates Federal requirements related to referrals for speech therapy, which must be referred by a licensed practitioner of the healing arts within the scope of his or her practice under State law. However, we found 24 claims for speech therapy services that did not meet these Federal requirements.

New Jersey Did Not Adequately Monitor School-Based Health Claims

Based on our review, we determined that monitoring of school-based health providers' claims for compliance with program requirements by New Jersey and PCG was not effective. From June 2007 through September 2007, PCG conducted 20 monitoring visits and found errors at 17 school districts. These visits identified deficiencies similar to those found in our audit. PCG submitted its findings to New Jersey, which made the necessary adjustments to the specific claims identified in PCG's reviews.

RECOMMENDATIONS

We recommend that New Jersey:

- refund $5,613,885 to the Federal Government and

- consider the results of this review in its evaluation of our prior recommendations to ensure that its school-based health providers comply with Federal and State requirements.

NEW JERSEY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, New Jersey disagreed with our recommended refund. In addition, New Jersey questioned our sampling methodology and disagreed with what we accepted as valid referrals. However, New Jersey also described corrective actions that it has taken in response to our second recommendation.

New Jersey provided additional documentation for six claims we questioned in our draft report. After reviewing this documentation, we determined that some services for five claims complied with Federal and State requirements and revised our findings and recommended refund accordingly. We have summarized New Jersey's comments, along with our response, below, and we have included those comments in their entirety as Appendix D.

Sampling Methodology

New Jersey Comments

New Jersey questioned our sampling methodology used to determine the estimate for the overpayment associated with unallowable claims for school-based health services and said that it resulted in inaccurate findings and recommendations. New Jersey stated that our sample size did not appear large enough for an accurate estimate of overpayments. New Jersey also said that our sample should have been stratified based on the type of service and the beneficiary's medical condition (i.e., type of disability).

Office of Inspector General Response

We followed our longstanding statistical sampling policies with regard to both sample size and stratification. The Departmental Appeals Board (Board) has supported the Office of Inspector General's (OIG) use of statistical sampling to calculate disallowances in accordance with these policies. Specifically, in one case involving the OIG's use of statistical sampling, the Board stated that "Since the individual case determinations were voluminous, the auditors used

statistical sampling techniques in lieu of examining all records to establish the amount of the disallowance, an approach upheld in principle by courts and this Board before."[12]

Additional Documentation

New Jersey Comments

New Jersey provided additional documentation for 6 of the 53 claims (S1-4, S1-7, S1-14, S1-46, S2-35, and S2-48) questioned in our draft report.[13]

Office of Inspector General Response

We reviewed the documentation that New Jersey provided for the six claims and accepted some services based on the documentation. Specifically, we accepted some services that we previously questioned because of referral or documentation issues; however, we continue to question services related to one claim (S1-7) that still did not meet documentation requirements. Additionally, we continue to question speech therapy services that did not meet referral and documentation requirements for a portion of another claim (S2-48). We have revised our findings, recommended refund, and Appendix C accordingly.

Referrals

New Jersey Comments

New Jersey stated that for two sample claims (S1-5, S1-41) the individual who referred the speech therapy services was certified by ASHA but was not licensed by the State's licensing body. For a third sample claim (S2-41), New Jersey stated that the referral was signed by a non-licensed speech therapist who had taken a State exam, "proving educational equivalency needed for ASHA certification." New Jersey stated that, because ASHA-certified individuals can provide speech therapy services, referrals for speech therapy services by ASHA-certified individuals should be allowed.

Office of Inspector General Response

We disagree with New Jersey's statement that an unlicensed individual can refer services. Pursuant to 42 CFR § 440.110 (a)(b)(c), referral or prescription from a physician or another licensed practitioner of the healing arts is required for physical therapy; occupational therapy; and services for individuals with speech, hearing, and language disorders.

[12] California Department of Social Services, DAB No. 816 (1986); see also Maine Dept. of Health and Human Services, DAB No. 2292 (2009); New York State Office of Children and Family Services, DAB No. 1984(2005); California Department of Social Services, DAB No. 524 (1984); Ohio Department of Public Welfare, DAB No. 226 (1981); and precedents cited therein.

[13] In its comments, New Jersey stated that it also provided additional documentation for a seventh claim (S1-3). New Jersey officials subsequently stated that they did not have any additional information to support this claim.

Attendance

New Jersey Comments

New Jersey stated that five sample claims (S1-6, S1-17, S2-29, S2-39, S2-40) had service documentation to support the claims although attendance data for the corresponding student indicated an absence. New Jersey indicated that there are multiple reasons that an error could have occurred in documenting attendance and that "valid service documentation data" should be accepted as proof of service delivery.

Office of Inspector General Response

Students must be in attendance on a given day to receive school-based health services on that day. To determine if a student was in attendance on the date of a sampled service, we reviewed the school register to determine if school was in session and the student was marked present. We then compared the school's attendance record to the SEMI service record. For the five sample claims, the school register indicated that the student was absent from school. Further, for one of the sample claims (S1-6), the service record indicated that the student received services on two Federal holidays, when the school was closed. Therefore, we did not accept the billed SEMI services for these claims.

Transportation

New Jersey Comments

New Jersey stated that one sample claim (S2-36) should be allowed because all students in day training centers receive specialized transportation because of the severity and uniqueness of their disabilities. Specifically, New Jersey stated that wheelchair lifts, nurses, and aides are examples of essential resources used when transporting these students to and from day training centers.

Office of Inspector General Response

The bus log that supported the transportation services for sample claim S2-36 did not identify the individual students that were provided transportation. Rather, the log contained the number of students present on the bus—a number that varied throughout the month. Without some way to identify the students present (e.g., initials or names), we were unable to determine whether the student associated with the sample claim used the specialized transportation for the dates he received related services.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was Medicaid claims for school-based services provided by school-based health providers in New Jersey that were submitted for Federal Medicaid reimbursement by Public Consulting Group, Inc. The claims were for service dates from September 1, 2003, through June 5, 2007, with payment dates from April 6, 2005, through June 27, 2007 (our audit period).

SAMPLING FRAME

The sampling frame was a computer file containing 157,114 student-months representing all claims for school-based services provided by school-based health providers in New Jersey with payment dates from April 6, 2005, through June 27, 2007. The total Medicaid paid amount for the 157,114 student-months was $90,731,406 ($45,365,703 Federal share). State officials extracted the database from the paid claims' files maintained at the Medicaid Management Information System fiscal agent.

SAMPLE UNIT

The sample unit was an individual student-month. Each sample unit represents all services provided to an individual student for a month during our audit period that were billed for Federal Medicaid reimbursement by Public Consulting Group, Inc.

SAMPLE DESIGN

We used stratified random sampling to evaluate the population of Medicaid school-based claims. To accomplish this, we separated the sampling frame into two strata:

- Stratum 1—less than $1,500: 130,854 student-months
- Stratum 2—equal to or greater than $1,500: 26,260 student-months

SAMPLE SIZE

We selected a sample of 100 student-month claims with 50 items from each stratum.

SOURCE OF THE RANDOM NUMBERS

We used the Office of Inspector General, Office of Audit Services' statistical software, RAT-STATS, to generate the random numbers.

METHOD OF SELECTING SAMPLE ITEMS

We sequentially numbered the student-months in each stratum. After generating 50 random numbers for each stratum, we selected the corresponding frame items. We then created a list of the 100 sample items.

ESTIMATION METHODOLOGY

We used RAT-STATS to calculate our estimates. We used the lower limit of the 90-percent confidence interval to estimate the overpayment associated with the unallowable claims.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Stratum Number	Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Unallowable Claims	Value of Unallowable Claims (Federal Share)
1	130,854	$20,479,208	50	$7,839	21	$2,077
2	26,260	24,886,495	50	51,402	15	5,008
Total	**157,114**	**$45,365,703**	**100**	**$59,241**	**36**	**$7,085**

Estimated Overpayment Associated with the Improper Claims
(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	$8,066,382
Lower Limit	$5,613,885
Upper Limit	$10,518,880

APPENDIX C: SUMMARY OF DEFICIENCIES FOR EACH SAMPLED CLAIM

Legend

1	Referral or prescription requirements not met
2	Federal provider requirements not met
3	Services not provided or not supported
4	Services not documented in child's plan

Office of Inspector General Review Determinations on the 100 Sampled Claims

Claim No.	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
S1-1					0
S1-2					0
S1-3	X				1
S1-4					0
S1-5	X				1
S1-6			X		1
S1-7			X		1
S1-8					0
S1-9					0
S1-10					0
S1-11					0
S1-12		X	X		2
S1-13					0
S1-14					0
S1-15		X			1
S1-16					0
S1-17			X		1
S1-18	X	X			2
S1-19	X	X			2
S1-20					0
S1-21		X			1
S1-22					0
S1-23	X			X	2
S1-24					0
S1-25					0
S1-26					0
S1-27			X		1
S1-28					0
S1-29		X			1
S1-30	X	X			2
S1-31	X	X			2
S1-32	X				1
S1-33					0

Claim No.	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
S1-34		X			1
S1-35					0
S1-36		X			1
S1-37					0
S1-38					0
S1-39					0
S1-40	X				1
S1-41	X				1
S1-42					0
S1-43					0
S1-44					0
S1-45					0
S1-46					0
S1-47		X			1
S1-48					0
S1-49					0
S1-50					0
S2-1					0
S2-2					0
S2-3					0
S2-4					0
S2-5					0
S2-6					0
S2-7					0
S2-8					0
S2-9					0
S2-10			X		1
S2-11					0
S2-12					0
S2-13					0
S2-14					0
S2-15					0
S2-16	X				1
S2-17					0
S2-18					0
S2-19			X		1
S2-20					0
S2-21					0
S2-22					0
S2-23					0
S2-24					0
S2-25					0
S2-26	X	X			2

Claim No.	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
S2-27					0
S2-28		X			1
S2-29			X		1
S2-30					0
S2-31					0
S2-32					0
S2-33	X	X			2
S2-34					0
S2-35					0
S2-36			X		1
S2-37					0
S2-38					0
S2-39			X		1
S2-40			X		1
S2-41	X	X			2
S2-42					0
S2-43			X		1
S2-44		X			1
S2-45					0
S2-46					0
S2-47					0
S2-48	X		X		2
S2-49	X		X		2
S2-50					0
Category Totals	16	16	14	1	47

36 claims in error

APPENDIX D: NEW JERSEY COMMENTS

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

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DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
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August 2, 2010

James P. Edert
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Department of Health and Human Services
Office of Inspector General
Office of Audit Services Region II
Jacob K. Javits Federal Building
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Report Number: A-02-07-01052

Dear Mr. Edert:

This is in response to your letter dated May 6, 2010 concerning the Department of Health and Human Services, Office of the Inspector General's (OIG) draft report entitled "Review of New Jersey's Medicaid School-Based Health Claims Submitted by Public Consulting Group, Inc." Your letter provides the opportunity to comment on this draft report.

The objective of this review was to determine whether New Jersey's Medicaid school-based health claims submitted by its billing agent, Public Consulting Group, Inc. (PCG), complied with Federal and State requirements. The review period was April 6, 2005 through June 27, 2007.

The draft audit report concluded that New Jersey's claims for reimbursement of Medicaid school-based health services submitted by PCG did not fully comply with Federal and State requirements. While 60 of the 100 school-based health claims in the sample fully complied with all Federal and State requirements, the remaining 40 did not meet one or more of the applicable requirements. The report states that the deficiencies occurred because: (1) school-based health providers did not comply with guidance related to Federal requirements; and (2) New Jersey did not adequately monitor school-based health claims for compliance with Federal and State requirements. Based upon the sample results, the auditor estimated that New Jersey was improperly reimbursed $6,369,708 in Federal Medicaid funds during the April 6, 2005 through June 27, 2007 audit period.

We appreciate the opportunity to provide this response to the draft OIG audit report. Following are the auditors' recommendations and the Division of Medical Assistance and Health Services (DMAHS) responses:

1. The OIG recommends that New Jersey should refund $6,369,708 to the Federal Government

The State does not concur with this recommendation. Based on the analysis outlined below, which was performed with the assistance of a statistician, we believe that the sampling methodology used by the auditor resulted in inaccurate findings and recommendations.

Analysis of OIG Sampling Methodology

To select a probability sample of a population in order to accurately estimate some characteristic of the total population, it is necessary to define the population.[1] This definition of a population for a particular study is called the *sampling frame*. Individual elements and units within the sampling frame are selected for a study using various kinds of sampling procedures.

The selection of *random samples* is the preferred method for studies in which population characteristics are estimated based on a sample because random sampling leads to extremely accurate estimates when the sampling procedures are appropriate for what we know (or can assume) about the characteristics of the total population. Random samples can be selected by *simple random sampling* or by *stratified random sampling*. Simple random sampling leads to accurate results if we know or can assume that the population is relatively *homogenous* with respect to the questions of interest. For instance, a sample of student-months representing the rate of non-compliance of all Medicaid school-based health claims submitted for *one type of service* for individuals within *one type of disability category* selected by *simple random sampling* may be extremely accurate for estimating the overall rate of non-compliance.

If known or assumed, however, that the population is *heterogeneous* with respect to the questions of interest so that the findings are likely to differ substantially within subgroups of the population, the validity of the estimates of population characteristics is greatly improved by *stratified random sampling*. Stratified random sampling ensures that the proportion of individual units within each subgroup of the sample matches the proportion of individual units within each subgroup of the total population and thus the combined estimates derived from subgroups within the sample represent the characteristics of the total population accurately.

Medicaid claims for school-based services in New Jersey include a broad array of different types of services. The services for which school-based health claims are submitted include:

1. Rehabilitative services--occupational, physical, and speech-language therapies; psychological counseling and psychotherapy; and nursing;

[1] McBurney, D. H., & White, T. L. (2007). *Research Methods.* Thomson Wadsworth, Belmont, CA.

2. Evaluation services identifying the need for specific services and prescribing the range and frequency of services that the student requires which may include reevaluation or review of the current services specified in the child's plan; and
3. Specialized transportation services in a vehicle adapted to serve the needs of the disabled, including specially adapted school buses, when provided on the same day as a related service and when transportation is included in the child's plan.

Each subgroup of services is quite likely to differ substantially in ways that may impact overall estimates of noncompliant claims for the entire population of school-based health claims. In addition to the cost of services, the proportion of claims submitted varies by type of service. The proportion of claims submitted as well as the extent to which multiple claims are submitted for services provided across all three major types of services differs substantially by disability group as well with some lower-incidence disability groups accounting for a relatively high proportion of claims. Since it is likely that types of noncompliance-- services not provided or supported, services lacking a referral or prescription, services meeting Federal provider qualification requirements, and services not documented in the child's plan-- are also correlated with the type of services provided, any estimation procedure based on a sampling frame that does not take these factors into account in estimating the incidence of noncompliant claims overall will not be accurate.

The sampling frame for the estimates of noncompliance reported in the draft report entitled *Review of New Jersey's Medicaid School-Based Health Claims Submitted by Public Consulting Group, Inc.*, is described as "a computer file containing 157,114 student-months representing all claims provided by school-based health providers in New Jersey with payment dates from April 6, 2005 through June 27, 2007." The sample unit was an individual student-month representing all services provided to an individual student for a month during the audit period.

Despite the heterogeneity of types of claims filed and likely correlations among types of claims and types of claim deficiencies and disability groups, the only variable used to define the sampling frame for the OIG study was the level of reimbursement. The population of student-months identified for the audit was stratified in this way:

Table 1. OIG sample results and estimates

Stratum Number	Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Unallowable Claims	Value of Unallowable Claims (Federal Share)
1 (<$1500)	130,854	$20,479,208	50	$7,839	24	$2,210
2 (≥$1500)	26,260	$24,886,495	50	$51,402	16	$5,936
Total	157,114	$45,365,703	100	$59,241	40	$8,146

This sampling frame does not accurately estimate noncompliant claims because key factors likely to be highly correlated with noncompliance estimates such as type of service--rehabilitation, evaluation, and transportation--and disability groups are not taken into account along with the dollar amount of the claims.

It is important to note, however, that even this analysis does not accurately reflect the characteristics of the defined strata as shown by the table below. The purpose of defining a sampling frame is to take the proportionality of the subgroups in the sample and population into account in deriving the population estimates. As shown in Table 2, this was not done for this analysis. The total value of claims in Stratum 1 was 45% of the total. In the sample, however, the value of claims for Stratum 1 was only 13% *of the total value. The sample that was drawn does not accurately reflect the relative value of claims in each stratum.*

Table 2. OIG sample results and estimates with population and sample percentages

Stratum Number	*Claims in Frame*	*Value of Frame (Federal Share)*	*%*	*Sample Size*	*Value of Sample (Federal Share)*	*%*	*Unallowable Claims*	*Value of Unallowable Claims (Federal Share)*
1	*130,854*	*$20,479,208*	*45%*	*50*	*$7,839*	*13%*	*24*	*$2,210*
2	*26,260*	*$24,886,495*	*55%*	*50*	*$51,402*	*87%*	*16*	*$5,936*
Total	*157,114*	*$45,365,703*	*100%*	*100*	*$59,241*	*100%*	*40*	*$8,146*

The May 6, 2010 draft report is silent as to the justification for selecting a sample size of only 50 student-month claims from a stratum with a total of 130,854 student-months and a sample size of only 50 student-month claims from a stratum with a total of 26,260 student-months for a total of only 100 student-month claims from a total of 157,114 student-month claims. We do not believe these samples are large enough for an accurate estimate of overpayment for unallowable school-based Medicaid claims in New Jersey. As we discussed in our analysis of the sampling methodology, there is a great deal of variance in types of claims filed and the amount of those claims. When it is known that population characteristics vary greatly, it is usual for researchers studying that characteristic to select fairly large samples in order to obtain valid estimates of the population characteristic. Given the broad range of types of and amounts of claims, it does not appear that results found for this very small sample of claims generalize across the entire population of school-based Medicaid claims in New Jersey during the period under investigation.

The sampling frame chosen for this investigation was simply not adequate to provide a valid estimate of the amount of overpayment associated with unallowable claims for school-based Medicaid services in New Jersey. The sampling frame chosen fails to account for many key variables such as type of service and type of disability served likely to be correlated with both the value of claims and types of deficiencies in claims. In addition, given the known variance

across types of claims and the amount of claims across the state, the sample sizes chosen were too small to justify generalization of the results to the entire population of claims in the state.

Additional Documentation Provided to the OIG

Additional documentation to support citations 1-3, 1-4, 1-7, 1-14, 1-46, 2-35 and 2-48 was located and forwarded to the auditor.

- Two (2) ST services for citation 1-3 - total FFP is $53.23
- Three (3) ST services for citation 1-4 – total FFP is $79.85
- One (1) Counseling service for citation 1-7 - total FFP is $51.24
- One (1) Counseling service for citation 1-14 - total FFP is $26.62
- One (1) Counseling service for citation 1-46 - total FFP is $26.62
- Three (3) PT services for citation 2-35 - total FFP is $79.85
- One (1) Evaluation service and three (3) PT services for citation 2-48 – total FFP is $856.82

These claims represent $1,174.23 in FFP, which we believe are fully supported. We have been advised by the OIG that they will review the additional documentation and include the results of their review along with any appropriate adjustments in their final report.

Analysis of Speech Qualifications

Some of the citations, specifically 1-5 and 1-41, are related to speech services provided by individuals having the ASHA certification and not a NJ state license. While we agree that the provider of the referral did not have the NJ license, they ***were*** ASHA-certified as required by Federal Medicaid regulations. We believe that meeting the federal standard is acceptable for the speech therapy services in question. Therefore those claims should be acceptable. For citation 1-5 there are five (5) ST services with a total FFP of $133.08 that we believe should be allowed; for citation 1-41 there are four (4) ST services with a total FFP of $106.46 that we believe should be allowed.

For citation 2-41, the referral was signed by a non-licensed speech therapist. The therapist in question had taken the Praxis in August 2006, proving educational equivalency needed for ASHA certification. We believe this is a valid claim with an FFP of $53.23.

We believe the items 1-5, 1-41 and 2-41 are valid claims, with a total of $292.77 in FFP.

Attendance

There are several citations where documentation is in place to support the claim, but the auditor's review of attendance data from the school's Student Information System, indicates an absence. We strongly believe that the service documentation data supports the claims, and that there are multiple reasons an error could have occurred in documenting attendance. There are policy and logistical issues that make attendance data less reliable than service documentation data. For example, if a student is late, he may be marked absent but still

receive a service later in the school day. Similarly, if a student leaves early he could be marked absent but still have received a service prior to departure.

We believe that items 1-6, 1-17, 2-29, 2-39 and 2-40 are valid claims, with a total of $342.03 in FFP

Transportation
In one case the auditor disallowed 13 units of transportation for a student that attended a New Jersey Day Training Center, specifically Passaic County. The auditor cited the direct services as valid claims but the corresponding transportation services were disallowed because the bus log did not identify the specific student names. As was mentioned to the auditor on numerous occasions, all students that are placed in the Day Training Centers receive specialized transportation due to the severity and uniqueness of their disabilities. Wheelchair lifts, nurses, aides, etc. are all essential resources when transporting these students to and from the centers. We believe that item 2-36 is a valid claim in the amount of $563.65.

With the analysis performed and additional documentation presented, we believe the total unallowed FFP should be adjusted downwards, at a minimum, to $5,773.32. This is a reduction from the $8,146 cited in the report that was used to calculate the disallowance.

2. New Jersey should consider the results of this review in its evaluation of prior recommendations to ensure that its school-based health providers comply with Federal and State requirements.

Guidance to School Districts
We would like to stress that the State of New Jersey has taken a number of steps to provide guidance to the school districts. We have several staff devoted to administering the project, including coordination of relevant state agency efforts and communication to school districts. Communications include an updated provider manual, a SEMI reference website, and training sessions. Since the time period for which this audit covers, we have taken additional steps to inform Local Education Agencies (LEA) of their responsibilities in meeting both Federal and State requirements.

- Training sessions are done both regionally and on a one-on-one basis with district administrators.
- Regional meetings are held twice a year and are well attended by districts. The vendor is required to cover the regulations of the SEMI program at these meetings.
- Each district submitting claims has participated in an administrator training with the vendor, where the SEMI regulations are covered directly with district.
- We have updated our SEMI reference website and now include the SEMI Provider Handbook, as well as other policy documents that explicitly state how to correctly implement the program.
- The vendor has provided a toll free number and an online message board for districts to access.

Current Pre-Payment Audit Process

We have implemented an electronic tool for school districts to use to document health related services and implemented mandatory compliance checks where districts provide additional data (IEP dates, provider qualifications, and referral data) before claims are processed. This policy now requires all LEAs to upload compliance data prior to claiming, so that our vendor can match the data to claims submission. If required data is not provided, a claim is not processed.

The State has improved its monitoring of the school-based health providers. The current vendor has implemented stronger post claiming quality assurance procedures, which includes a yearly on-site monitoring of a sample set of districts provided by the State. Any lapses in compliance are explicitly stated to the district with suggestions on how to align their internal processes to match Federal and State regulations. Claims that do not comply with Federal and State requirements are appropriately adjusted.

District Training

Training is an imperative component of a quality program. Therefore, our vendor has implemented a multi-tiered approach to training. Districts receive concentrated training during the start-up and implementation of the program, with follow up training provided in subsequent years. A typical district will receive the following initial trainings:

- ***Start-Up Meeting*** – review of program rules and regulations with district administrators
- ***Administrator Training*** – district administrators learn to utilize software provided by vendor and how to maintain compliance with program requirements
- ***Staff Training*** – other district staff learn how to appropriately utilize software by vendor and learn Medicaid rules

The number of training sessions can vary based on districts requests and district need.
To supplement initial training, PCG provides follow up sessions to reinforce program requirements. All districts have the opportunity to attend the following trainings:

- ***Regional Training*** – district administrators attend training held twice a year to review program regulations, as well as discuss any updates or changes to the program
- ***Online Trainings*** – provided on a weekly basis, available to all districts statewide. Topics can include: administrator role and responsibility, other district staff training, and program regulations.

In total, PCG has conducted nine Regional Trainings, the most recent being April 2010. Prior to June 30, 2007 (the end date of the report) PCG had conducted three Regional Trainings. This ensures that districts that do not actively reach out to PCG have an opportunity to review program regulations, ask questions and receive any clarification needed.

All districts have the opportunity to attend the online trainings provided by the vendor. These trainings cover aspects of Medicaid claiming, including program start-up, the role and responsibilities of the district coordinator, and specific topic-based trainings aimed at program compliance. In total, the vendor has provided 363 online trainings that are open to all districts. Training schedules are sent out monthly, and provide both conference call and web login information. Trainings aimed at program regulations and the district's responsibility to maintain compliance with the regulations account for 235 out of the 363 online trainings. The vendor continues to hold online sessions every week.

In addition to direct training, the vendor provides helpdesk support for district administrators and staff regarding program regulations. Each district is assigned a client representative from the vendor. This facilitates a working relationship between the district and the vendor and ensures district staff members have a resource available to answer any questions.

Overall, the State has taken previous results and enhanced its training, resources, pre-payment audit processes and post-payment processes to ensure compliance with Federal and State requirements by all participating LEAs and health providers.

If you have any questions or require additional information, please contact me or Richard Hurd at (609) 588-2550. We would like to thank the OIG audit team for their professionalism throughout our review of their findings and recommendations. In addition, we also appreciate their courtesy in providing to us the documentation that they were able to obtain from the school districts

Sincerely,

John R. Guhl, VGH

John R. Guhl
Director

JRG:H
c: Jennifer Velez
Richard Hurd