Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

PENNSYLVANIA IMPROPERLY CLAIMED $551 MILLION IN MEDICAID FUNDS FOR ITS SCHOOL-BASED PROGRAM

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Inspector General

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Office of Inspector General

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Report in Brief
Date: March 2024
Report No. A-02-21-01011

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

Pennsylvania Improperly Claimed $551 Million in Medicaid Funds for Its School-Based Program

Why OIG Did This Audit

As part of its oversight activities, HHS-OIG is conducting a series of audits of States that claim Medicaid school-based costs with the assistance of contractors. Prior OIG audits found that States claimed unallowable Federal funds because contractors improperly conducted random moment time studies (RMTSs). Pennsylvania is one of the States that receives the highest amount of reimbursement for Medicaid school-based services, and it has an agreement with a contractor to conduct its RMTSs.

The objective of our audit was to determine whether Pennsylvania properly claimed Federal funds through its Medicaid school-based program.

How OIG Did This Audit

Our audit covered approximately $590 million in Federal Medicaid payments for school-based services claimed from July 1, 2015, through June 30, 2019. This includes $498 million for Medicaid-eligible health services and $92 million for Medicaid administrative activities. We reviewed a stratified random sample of random moments, each coded as a "health service" or an "administrative activity." The stratified random sample comprised 310 random moments. We also reviewed the methods that Pennsylvania used to allocate health services costs to Medicaid.

What OIG Found

Pennsylvania improperly claimed Federal funds through its Medicaid school-based health services program. Specifically, Pennsylvania claimed estimated unallowable Federal funds totaling $182.5 million because it did not support that all moments used in RMTSs and coded as Medicaid-eligible were for Medicaid-eligible health services or Medicaid administrative activities. Also, Pennsylvania improperly claimed an additional $368.9 million when it used unsupported ratios to allocate costs to Medicaid. Finally, Pennsylvania's RMTSs did not include all days worked by school staff members because it did not include the first month of the school year. As a result of these deficiencies, Pennsylvania improperly claimed $551.4 million. These deficiencies occurred because Pennsylvania and its contractor developed complex cost allocation methods that were difficult or impractical to support with documentation or did not follow CMS guidance.

What OIG Recommends and Pennsylvania Comments

We made several recommendations to Pennsylvania, including that it refund $182.5 million in unallowable funds for unsupported Medicaid-eligible health services and Medicaid administrative activities, and support or refund $368.9 million claimed based on its unsupported cost allocation method. We also made procedural recommendations to assist Pennsylvania in preparing accurate and supportable claims.

Pennsylvania disagreed with our monetary and procedural recommendations related to our first two findings and agreed with our procedural recommendation related to our third finding (RMTSs did not include all days worked by school staff members). Specifically, Pennsylvania disagreed with our recommendations related to our finding that moments were not supported as Medicaid-eligible. According to Pennsylvania, it was not required to provide documentation other than what RMTS participants provided and is not responsible for ensuring that all service providers are appropriately licensed. Also, Pennsylvania indicated that its ratios for allocating costs to Medicaid are accurate. Pennsylvania also described actions that it has taken or plans to take to improve its calculation of accurate and supportable school-based claims for Medicaid reimbursement.

After reviewing Pennsylvania's comments, we revised our determinations for two moments. Accordingly, we revised our associated recommendations. We maintain that our findings and recommendations, as revised, are valid.

The full report can be found on the OIG website.

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INTRODUCTION

WHY WE DID THIS AUDIT

As part of its oversight activities, the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) is conducting a series of audits of States that claim Medicaid school-based costs with the assistance of contractors. Prior OIG audits found that States claimed unallowable Federal funds because contractors improperly conducted random moment time studies (RMTSs).[1] Pennsylvania is one of the States that receives the highest amount of reimbursement for Medicaid school-based services, and it has an agreement with a contractor to conduct its RMTSs.

OBJECTIVE

The objective of our audit was to determine whether the Pennsylvania Department of Human Services (State agency) properly claimed Federal funds through its Medicaid school-based program.

BACKGROUND

The Medicaid Program

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

The Individuals with Disabilities Education Act

States may claim Federal Medicaid funds for health services provided by schools under the Individuals with Disabilities Education Act (IDEA), which requires schools to provide special education and related services[2] for children with disabilities.

Among other requirements for Medicaid payment, health services must be necessary, as determined by a child's individualized education program (IEP). The IEP is a document describing a child's needs for special education and related services, and the educational and

[1] See Appendix B for related OIG reports.

[2] Related services are services required to assist a child with a disability to benefit from special education and may include health care services covered by Medicaid and non-health care services.

health services to be provided to the child. Health services must be provided by qualified practitioners that meet Federal and State license requirements.

The Pennsylvania School-Based ACCESS Program

The Pennsylvania School-Based ACCESS Program (SBAP) is jointly administered by the State agency and the Pennsylvania Department of Education. The SBAP allows school districts to receive reimbursement for health-related services provided to Medicaid-enrolled children whose services are documented in their IEP.[3] Before submitting claims, school districts must obtain parental consent to release protected information, including the associated child's IEP.[4] Under the SBAP, the State agency also claims Federal reimbursement for school-based Medicaid administrative activities, known as Medicaid administrative claiming (MAC).

Random Moment Time Studies

During our audit period, the State agency contracted with Public Consulting Group (PCG) to conduct quarterly statewide RMTSs to estimate the time spent on Medicaid-eligible health services and Medicaid-eligible administrative activities. At a randomly selected moment, a participant was required to identify the activity they were performing by answering five standard questions.[5] Based on the participant's answers, PCG assigned a Medicaid-eligible or non-Medicaid-eligible activity code to the moment. PCG may have also asked additional questions to determine how to code the moment. The coded results were aggregated and used to allocate personnel costs to the Medicaid program. Results of random moment sampling must be sufficiently detailed to determine whether the claimed services and activities are Medicaid-eligible. Appendix C contains details of selected Federal school-based documentation requirements.

Exhibit: Random Moment Time Study

An RMTS is a statistical method used to identify the percentage of time personnel spend on a particular activity, including a measurement known as the RMTS percentage. All activities performed—whether or not allowable under Medicaid—by school district staff participating in the Medicaid program should be included, and the entire time period involved must be covered by the sample.

[3] Payments made to the school districts are based on a fee schedule.

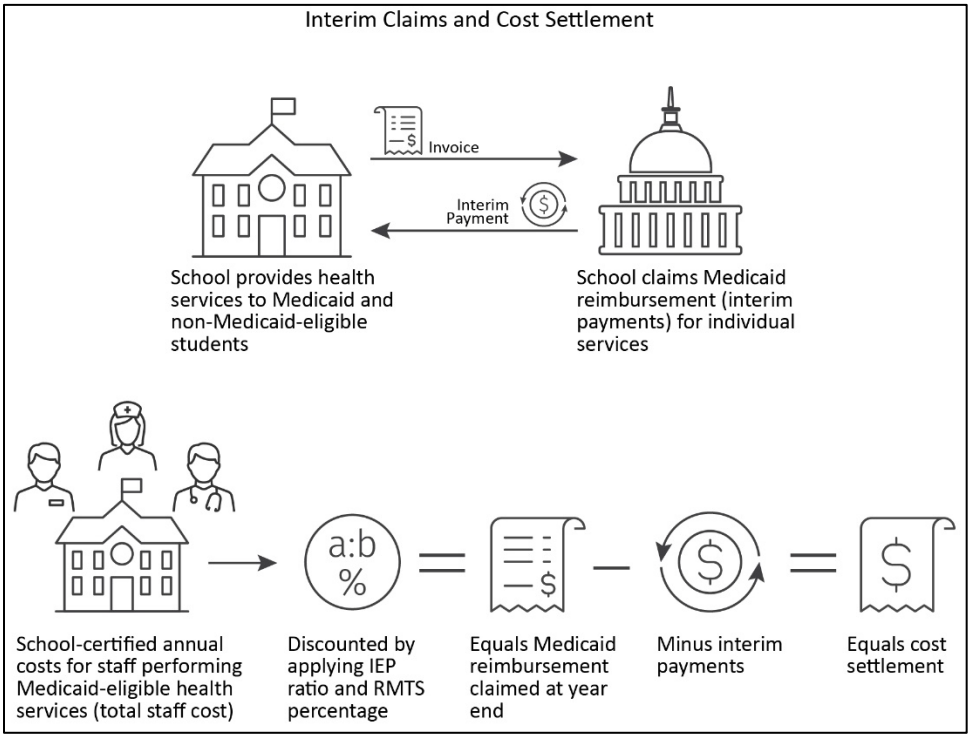
[4] See *Joint Guidance on the Application of the* Family Educational Rights and Privacy Act (FERPA) *and the* Health Insurance Portability and Accountability Act of 1996 (HIPAA) *To Student Health Records*, issued by HHS and the U.S. Department of Education, and Federal regulations cited therein. Available online at https://www.hhs.gov/sites/default/files/2019-hipaa-ferpa-joint-guidance-508.pdf. Accessed on Apr. 20, 2023.

[5] A participant was a school staff member randomly selected to participate in an RMTS. Participants were initially asked whether they were working during the sampled moment.

Pennsylvania's Medicaid Health Services Claims

The State agency obtains Federal reimbursement for school districts' actual costs.[6] For health services costs, the State agency uses a multistep process that includes interim payments, end-of-year cost totals, and a cost settlement. Throughout each school year, the State agency makes interim payments to school districts for Medicaid-eligible health services provided to Medicaid-eligible students. End-of-year costs are calculated through a complex process discussed below. The process includes conducting quarterly statewide RMTSs and the application of a percentage known as the IEP ratio. These final Medicaid-eligible costs are then compared to the interim payments to determine each school district's cost settlement. The figure that follows illustrates how the State agency determines each school district's cost settlement.

Figure: How the State Agency Calculates Cost Settlement



To calculate end-of-year costs, the Medicaid-eligible RMTS percentage is applied to total staff costs (i.e., Medicaid- and non-Medicaid-eligible costs) for school staff providing health services to determine the estimated total health services costs. To identify Medicaid-eligible costs, the IEP ratio is applied to the estimated total health services costs. This percentage is calculated by dividing the number of students enrolled in Medicaid that have IEPs containing health services by the total number of students (Medicaid- and non-Medicaid-eligible) that have IEPs

[6] Pennsylvania uses funds certified as actual expenditures by the school districts as the State share to receive matching Federal Medicaid funds.

containing health services. The cost settlement is then calculated as the difference between Medicaid-eligible costs and interim payments for each school district for each school year.[7]

Every school year since 2012—when the State agency began using this methodology—total school districts' Medicaid-eligible costs have exceeded their total interim payments, resulting in the State agency claiming additional Federal Medicaid funds. The additional Federal funds are paid directly to the school districts.

Medicaid School-Based Administrative Activities

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

Pennsylvania's Medicaid Administrative Claims

PCG also assists with quarterly MAC cost calculations. Each calculation is based on the same RMTSs used to calculate direct health service costs. However, the percentage used to allocate MAC costs is based on moments coded as administrative activities. The State agency keeps half of the Federal share and pays the other half to the school district. However, PCG is paid 50 percent of the school district's share—up to a maximum of $500 per school district per quarter.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $590,124,733 in Federal Medicaid payments for school-based services claimed for reimbursement in Pennsylvania from July 1, 2015, through June 30, 2019 (school years 2016 through 2019). This included $497,664,483 for Medicaid-eligible health services and $92,460,250 for Medicaid administrative activities. We reviewed a stratified random sample of 310 random moments,[8] each coded as a Medicaid-eligible "health service" or an "administrative activity."[9] We also reviewed the methods used to allocate health services costs to Medicaid.

[7] In Pennsylvania, the school year runs from July 1 through June 30.

[8] The sample unit is defined as an RMTS activity moment and a school district combination (moment-district combination).

[9] Specifically, we reviewed 205 activity moments coded as a Medicaid-eligible "health service" and 105 activity moments coded as a Medicaid "administrative activity." See Appendix D for our sample design and methodology.

We did not review the overall internal control structure of the State agency or PCG. Rather, we limited our review to those controls related to the State agency's Medicaid health services claiming methodology and the MAC claiming methodology.

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

Appendix A contains the details of our audit scope and methodology, Appendix D contains our sample design and methodology, and Appendix E contains our sample results and estimates.

FINDINGS

The State agency improperly claimed Federal funds through the SBAP for school-based services. Specifically, the State agency claimed estimated unallowable Federal funds totaling $182.5 million because it did not support that all moments used in RMTSs and coded as Medicaid-eligible were for Medicaid-eligible health care or Medicaid administrative activities. Also, the State agency improperly claimed an additional $368.9 million when it used unsupported ratios to allocate costs to Medicaid. Finally, the State agency's RMTSs did not include all days worked by school staff members because it did not include the first month of the school year. As a result of these deficiencies, the State agency improperly claimed $551.4 million.[10] These deficiencies occurred because the State agency and PCG used complex cost allocation methods that were difficult or impractical to support with documentation or did not follow CMS guidance.

THE STATE AGENCY DID NOT SUPPORT THAT ALL MOMENTS CODED AS MEDICAID-ELIGIBLE WERE FOR MEDICAID-ELIGIBLE HEALTH SERVICES OR MEDICAID ADMINISTRATIVE ACTIVITIES

Federal regulations require documentation to be maintained to assure that claims for Federal funds are in accordance with applicable Federal requirements and that documentation be made available for audits and examinations (42 CFR § 433.32, 45 CFR § 75.364). Federal regulations (42 CFR part 440) and the State Medicaid plan (Attachment 3.1-A) also require that certain services be provided by or under the direction of a licensed provider. The State agency's CMS-approved *Time Study Implementation Guide* (Implementation Guide) requires that only qualified providers be included in the RMTS.

Of the 310 items in our sample, 164 moments were supported but 146 were not. For 141 of the moments that were not supported, based on the State agency's documentation, we could

[10] The total recommended financial disallowance was $551,436,272, which included $182,565,445 in estimated unallowable Federal funds for moments not supported and $368,870,827 in improperly claimed funds because of unsupported ratios.

not determine whether the moment covered Medicaid-eligible health services listed in the associated student's IEP or Medicaid administrative activities. Also, for seven moments, the associated service provider was not licensed to provide the service that the participant described. Finally, for one moment, the associated service was provided by an assistant that required supervision; however, the credentials for the supervisor were not provided.[11]

- For the 141 moments that were not supported:

    - The State agency's contractor did not collect students' names or other identifying information. Therefore, neither the contractor nor the State agency could identify students to obtain student health records or IEPs to allow us to determine whether the associated services were Medicaid-eligible health services, Medicaid administrative activities, or educational services.

    - The State agency's contractor did not ask enough questions of the associated participant to ascertain whether the participant performed a Medicaid-eligible health service or a Medicaid administrative activity. For example, for one moment, a personal care assistant was assisting a student with reading. For another moment, a personal care assistant was monitoring a student's behavior while the student was listening to announcements. For these moments, the contractor did not ask the participant to describe the nature of the reading or behavioral monitoring so that the contractor could determine whether these activities were part of a health care therapy. The contractor also did not ask whether these activities were included as health care therapies in the IEPs. The activities instead could have had an educational goal of developing academic ability or maintaining school order and, accordingly, not be eligible for Medicaid payment. For another moment, an administrative employee was participating in an IEP meeting; however, the contractor did not ask the employee whether the employee attended because of educational objectives under IDEA, for other school concerns such as preventing litigation, or for activities such as assisting the student to receive access to Medicaid services.

- For the remaining eight moments, school districts did not follow the State Medicaid plan and State agency guidance that requires services to be provided by or under the supervision of a licensed therapist.[12] For example, for one sampled moment, an individual reported that they were providing speech therapy to a student; however, the State agency did not provide documentation that the individual was a licensed speech language pathologist. If a service provider is not adequately qualified to provide services, it could have a negative impact on the quality of care the student receives.

[11] The number of errors exceeds 146 because 3 moments had more than 1 deficiency.

[12] *Pennsylvania Department of Human Services School-Based ACCESS Program Handbook* (September 2019).

On the basis of our sample results, we estimated that the State agency claimed at least $182,565,445[13] in unallowable Federal Medicaid funds based on unsupported RMTS coding and services provided by unlicensed providers.

THE STATE AGENCY USED UNSUPPORTED RATIOS TO ALLOCATE COSTS

States must provide adequate support to show that their Medicaid funds have been used according to Federal requirements and must maintain adequate source documentation to support their expenditures (45 CFR § 75.302). In order to be allowable, costs must be allocable to Medicaid (i.e., chargeable or assignable to Medicaid in accordance with relative benefits received) (45 CFR §§ 75.403(a), 75.405). Also, State Medicaid agencies must assure appropriate audits of records if payment is based on costs of services (42 CFR § 447.202).

The State agency could not validate or provide support that the school districts' IEP ratios used to allocate Medicaid health services costs were correctly calculated. Federal privacy requirements[14] do not allow the State agency to review IEPs of students not enrolled in Medicaid,[15] which would be required to audit the school districts' IEP ratios.[16] Therefore, the State agency could not verify the *total* number of students (including those *not* enrolled in Medicaid) that had IEPs recommending health services (i.e., the denominator used in each school district's IEP ratio). The State agency's cost allocation method applied the IEP ratio to all health services costs claimed; therefore, $368,870,827[17] for health services costs is unsupported.

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[13] Specifically, the State agency claimed at least $128,793,656 in unallowable health services and at least $53,771,789 in unallowable Medicaid administrative activities. To be conservative, we recommend recovery at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

[14] See *Joint Guidance on the Application of the* Family Educational Rights and Privacy Act (FERPA) *and the* Health Insurance Portability and Accountability Act of 1996 (HIPAA) *To Student Health Records*, issued by HHS and the U.S. Department of Education, and the regulations cited therein. Available online at https://www.hhs.gov/sites/default/files/2019-hipaa-ferpa-joint-guidance-508.pdf. Accessed on Apr. 20, 2023.

[15] School districts obtain consent to disclose information to the State agency from a Medicaid-enrolled student's parent before they submit associated interim claims for Medicaid payment. However, some parents of Medicaid-enrolled students do not consent to disclose information to the State agency. Additionally, school districts do not request consent from parents of students not enrolled in Medicaid.

[16] As we later discuss in our response to the State agency's comments on our draft report, CMS informed us that it believes that IEPs with redacted personally identifiable information may be produced to comply with Federal privacy protections. The State agency has not offered to provide redacted IEPs to support school districts' IEP ratio calculations.

[17] This amount is the total health services Federal Medicaid funds of $497,664,483 less the dollar amount of unsupported health services moments (combined strata 1-3) estimated at the lower limit of the 90-percent confidence interval of $128,793,656.

THE STATE AGENCY DID NOT SAMPLE MOMENTS DURING THE FIRST MONTH THAT SCHOOLS WERE IN SESSION

Federal regulations state that RMTS results must be applied to the sample period, and the entire time period involved must be covered by the sample (45 CFR § 75.430(i)(5)(i)).

RMTSs performed by PCG, however, did not include days during the first full month that schools were in session. The State agency's Implementation Guide incorrectly states that CMS guidance does not require sampling during the first quarter of the school year.[18] The State agency used time studies conducted in the other three quarters to allocate costs for the first quarter. As a result, the State agency may have claimed incorrect Medicaid school-based costs.[19]

CONCLUSION

The State agency and its contractor used complex methods that were difficult or impractical to correctly implement and support with documentation. As a result, the State agency did not follow Federal RMTS requirements and claimed estimated unallowable Federal funds of at least $128,793,656 for unsupported moments for Medicaid-eligible health services and at least $53,771,789 for unsupported Medicaid administrative activities. The State agency claimed an additional $368,870,827 in unallowable Federal funds because it used ratios that were not supported.

RECOMMENDATIONS

We recommend that the Pennsylvania Department of Human Services:

- refund $182,565,445 to the Federal Government related to moments that could not be supported as Medicaid-eligible health services or Medicaid administrative activities;
- refund $368,870,827 to the Federal Government or provide documentation that can reasonably support its allocation of health services costs to Medicaid without using unverifiable IEP ratios;
- ensure that its contractor collects sufficient information so that the State agency can validate the contractor's coding of RMTS moments;
- ensure that school districts verify that providers are appropriately licensed before they provide health services to students;

[18] CMS officials confirmed to us that it would expect an RMTS to include all days worked in a school year.

[19] We are unable to quantify the effect of not including the first quarter in the RMTS.

- develop an accurate, supportable method to identify Medicaid costs that can be verified with source documents; and

- revise its RMTSs to include the first month of the school year.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with our first five recommendations (related to our first two findings) and agreed with our sixth recommendation (related to our third finding). Specifically, the State agency disagreed with our recommendations related to our finding that moments were not supported as Medicaid-eligible. According to the State agency, it was not required to provide documentation other than what RMTS participants provided. The State agency also stated that although it is responsible for ensuring that providers whose costs are being billed for Medicaid reimbursement are properly licensed and credentialed, it is not responsible for ensuring that all service providers are appropriately licensed before they provide health services to students, irrespective of Medicaid billing. In addition, the State agency disagreed with our recommendations related to our finding that the IEP ratio is unsupported because, according to the State agency, the IEP ratio is accurate. The State agency agreed with our recommendation related to our finding that RMTSs did not include days during the first full month that schools were in session. The State agency also described actions that it has taken or plans to take to improve its calculation of accurate and supportable school-based claims for Medicaid reimbursement.

After reviewing the State agency's comments, we revised our determinations for two moments for which we initially determined that the associated service provider was not licensed to provide the service described. Accordingly, we revised our associated recommendations. We made technical corrections to the report based on some of the State agency's comments and maintain that our findings and recommendations, as revised, are valid.

A summary of the State agency's comments and our responses follows. The State agency's comments, excluding attachments, are included as Appendix F.[20]

THE STATE AGENCY DID NOT SUPPORT THAT ALL MOMENTS CODED AS MEDICAID-ELIGIBLE WERE FOR MEDICAID-ELIGIBLE HEALTH SERVICES OR MEDICAID ADMINISTRATIVE ACTIVITIES

State Agency Comments

The State agency stated that it was not required to provide documentation other than what participants provided to support its coding of RMTS moments. The State agency indicated that the Implementation Guide states that RMTS contractors code participants' answers to a series of questions "according to the documentation submitted by the [participant]" and does not

[20] We are providing the State agency's comments, in their entirety, to CMS.

state that any additional supporting documentation is required. The State agency also stated that Federal laws limiting third-party access to student records and the lack of a workaround "demonstrates that student education records, such as IEPs or service logs, were never intended to be part of the documentation for [sampled moments], nor has CMS advised [the State agency] that additional documentation is required to support moments."

Although the State agency acknowledged that CMS guidance issued in May 2023 indicates that the State agency could produce supporting documentation that redacts or conceals personally identifiable information (PII) from student records, the State agency stated that this guidance cannot be applied retroactively. However, the State agency stated that this is an option that it can consider for future years. Nevertheless, the State agency also stated that it is unreasonable to request PII for each student that a participant works with.

The State agency also reviewed the sample moments that we determined to be unsupported and indicated the following:

- Of the 69 moments coded as health services, 24 were supported by coding descriptions found in the Implementation Guide.

- Of the 72 moments[21] coded as administrative activities, 20 were supported by coding descriptions found in the Implementation Guide and 49 were for direct health service participants that were coded as unallowable.

Additionally, the State agency stated that it does not concur that it is responsible for ensuring that providers are appropriately licensed before they provide health services to students. Rather, the State agency stated that it is responsible for ensuring that providers on a statewide health services staff list who bill the Medicaid program are properly licensed and credentialed. The State agency reviewed the 10 moments identified in our draft report as not being provided by or under the supervision of a licensed therapist and determined that 7 of these moments were associated with providers for whom it could not produce a license to show that the services were provided by or under the direction of a licensed provider.

The State agency also questioned the validity of our sampling methodology because 11 administrative activity moments included in our sample were for dates prior to the beginning of our audit period.[22]

Although the State agency disagreed with our recommendations, it described actions it has taken or plans to take to improve contractor coding of moments and ensure that health

[21] OIG provided a total of 72 moments to the State agency as MAC errors; the State agency only indicates 70 in its response.

[22] Eight of these administrative activity moments were for direct health service participants that the State agency stated were coded as unallowable and three were for participants who did not provide direct health services.

services providers are licensed. Further, the State agency stated that it selected a new RMTS contractor, assigned it additional training responsibilities regarding time study participants and provider licensing, and increased State agency oversight of the contractor's coding.

Office of Inspector General Response

We do not agree with the State agency's assertion that 24 moments coded as health services and 20 moments coded as administrative activities were supported. We acknowledge that the Implementation Guide states that coding is based on time study participants' answers to initial and followup questions necessary to determine whether moments are Medicaid-eligible. As we explained in our finding, however, the State agency's prior contractor did not ask enough questions of RMTS participants to ascertain whether participants performed a Medicaid-eligible health service or a Medicaid administrative activity. Thus, according to the Implementation Guide, the State agency did not always support that moments were Medicaid-eligible. Moreover, States must make source documents available for audit to support claims for Federal Medicaid reimbursement. CMS officials have informed us that they believe that service documentation with redacted PII may be produced to comply with Medicaid requirements and Family Educational Rights and Privacy Act (FERPA) privacy protections.[23]

We disagree with the State agency's assertion that it cannot produce supporting documentation because, according to the State agency, CMS's guidance cannot be applied retroactively. CMS's guidance provides instructions on how a State agency could support its claims for Federal Medicaid funds under existing law. We also disagree with the State agency's contention that, in the future, it would be unreasonable for RMTS participants to identify the students they are working with. This practice would make it less burdensome for school districts to locate and provide redacted service documentation for audit and oversight purposes.

Regarding the 49 moments that were coded as unallowable, we note that the State agency included these moments in its calculation of the percentages used to allocate administrative costs for MAC reimbursement.

We agree that it is the State agency's responsibility to ensure that providers on the statewide health services staff list who bill the Medicaid program are properly qualified. The list is used as the source for selecting RMTS participants; therefore, all RMTS participants should be appropriately licensed or credentialed and/or supervised. We also agree with the State agency that seven moments were associated with providers for whom it could not produce a license to show that the associated services were provided by or under the direction of a licensed provider. However, in addition to the seven providers for whom the State agency agreed that it did not provide a license, the State agency did not provide a license for one other provider.

[23] We note that a trusted third party (e.g., a certified public accounting firm) may be required to attest that redacted service documentation correspond with sampled items selected from redacted student lists.

Based on the State agency's comments, we revised our determinations for two health service moments and our related recommendation (financial disallowance).[24, 25]

Regarding the State agency's comments on the validity of our sampling methodology, our audit period was based on claims for reimbursement by Pennsylvania from July 1, 2015, through June 30, 2019, as stated in Appendix A. For the State agency's administrative claim for the quarter beginning July 1, 2015, in accordance with its Implementation Guide, the State agency used moments from the three preceding quarterly RMTSs to calculate Medicaid reimbursement. Thus, we correctly joined the moments in these three preceding RMTSs to school district costs for the quarter beginning July 1, 2015, and included these combinations in our sampling frame because they were used to calculate a claim for Medicaid reimbursement within our audit period. Refer to Appendix D for our sample design and methodology.

We commend the State agency for assigning its new RMTS contractor additional training responsibilities regarding time study participants and provider licensing and for its increased oversight of the contractor's coding.

THE STATE AGENCY USED UNSUPPORTED RATIOS TO ALLOCATE COSTS

State Agency Comments

The State agency indicated that the IEP ratio is accurate because school districts have access to students' IEPs and use that access in the development of the IEP ratio used in the cost reconciliation and settlement process. According to the State agency, its cost allocation methodology, including the use of the IEP ratio, was approved by CMS and was based on CMS guidance, including sample State plan materials. Also, FERPA's privacy restrictions were in place when the State agency obtained CMS approval to use an IEP ratio to allocate costs. Further, the State agency stated that it did not develop the IEP ratio with its contractor. According to the State agency, its cost allocation plan, which includes the IEP ratio, was adopted by the State agency "in close coordination" with CMS.

Additionally, the State agency indicated that, as recently as May 2023, the cost-based reimbursement methodology is, according to CMS, "the most commonly used payment methodology" for Medicaid school-based services. It also stated that Pennsylvania is 1 of approximately 26 States that use a cost-based methodology that incorporates an IEP ratio.

[24] Of the 47 providers we identified to the State agency as potentially unqualified, the State agency provided documentation showing that 39 were qualified. The State agency agreed that 7 were unqualified. For the remaining provider, the State agency said that the date of the associated sampled moment was outside of record retention guidelines. Because the State agency provided documentation showing that all but 8 providers were qualified, we reduced the recommended disallowance of $183,205,803 in the draft report.

[25] As a result, we also revised our finding and recommendation related to the State agency's use of unsupported ratios because, as described in footnote 17, the dollars associated with this finding are tied to the estimated dollar amount of unsupported health services moments.

Office of Inspector General Response

We revised our report to acknowledge that the State agency did not develop the IEP ratio with its prior contractor. CMS officials, however, informed us that the State agency's prior contractor and another State's Medicaid agency proposed the IEP ratio to CMS before CMS worked with Pennsylvania's State agency. Thus, the State agency's prior contractor developed or adopted the IEP ratio—not CMS.

CMS officials also informed us that State Medicaid agencies must be able to produce source documents to verify their IEP ratio. As we explained in our finding, this obligation is part of the requirements of the Medicaid program, and without verification, the accuracy of the IEP ratio cannot be ascertained. Further, in its May 2023 guidance, CMS reinforced the importance of having documentation available to support the IEP ratio.[26] The guidance also stated that documentation with redacted PII potentially may be produced to comply with Medicaid requirements and Federal privacy protections.[27] In response to the State agency's comments, we modified our fifth recommendation to reflect CMS's guidance. Accordingly, we recommend that the State agency develop an accurate, supportable method to identify Medicaid costs that can be verified with source documents.

We believe that the State agency should have another opportunity to support its allocation of prior costs to Medicaid. The State agency may provide redacted IEPs or any other reasonable method to support its cost allocation. The State agency should work with CMS, and if CMS requests, we may provide technical assistance to help CMS assist the State agency.

THE STATE AGENCY DID NOT SAMPLE MOMENTS DURING THE FIRST MONTH THAT SCHOOLS WERE IN SESSION

The State agency agreed with our recommendation to revise its RMTSs to include all dates that school is in session and stated that it included a requirement to conduct an RMTS for the July through September quarter in the contract for its new RMTS contractor. We commend the State agency for requiring its new RMTS contractor to sample all dates worked by school personnel.

[26] See *Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming*. Available online at: https://www.medicaid.gov/sites/default/files/2023-07/sbs-guide-medicaid-services-administrative-claiming-ud.pdf. Accessed on Oct. 11, 2023.

[27] We note that a trusted third party, such as a certified public accounting firm, may be required to attest that redacted IEPs correspond with sampled items selected from redacted student lists.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed $590,124,733 in Federal Medicaid payments for school-based services claimed for reimbursement by Pennsylvania from July 1, 2015, through June 30, 2019 (school years 2016 through 2019). This included $497,664,483 for Medicaid-eligible health services and $92,460,250 for Medicaid administrative activities. We reviewed a stratified random sample of 310 random moments, each coded as a Medicaid-eligible "health service" or an "administrative activity."[28] We also reviewed the methods used to allocate health services costs to Medicaid.

We assessed the reliability of the State agency's claims data by reconciling it to the school-based services that it claimed for Federal Medicaid reimbursement on its CMS-64 forms (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) and to cost reports school districts submitted to PCG. We determined the data to be sufficiently reliable for the purposes of this report.

During our audit, we did not review the overall internal control structure of the State agency, its contractor, or the Medicaid program. Rather, we limited our review to those controls related to the State agency's Medicaid health services claiming methodology and the MAC claiming methodology.

We conducted our audit from March 2021 through June 2023. We performed audit work by reviewing the documentation provided to us electronically by the State agency.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with State agency officials to gain an understanding of the SBAP and school district cost reports;
- obtained and reviewed documents from the State agency that were used to calculate SBAP costs, including RMTS results and summarized school district cost reports;
- reviewed final net settlements from the State agency that were used to claim costs for services provided from July 1, 2015, through June 30, 2019;
- reconciled Medicaid interim claims reported on the cost settlement summaries from the

[28] Specifically, we reviewed 205 activity moments coded as a Medicaid-eligible "health service" and 105 activity moments coded as a Medicaid "administrative activity."

State agency to the interim claims in the Federal Medicaid claims database;

- reconciled interim claims reported on CMS-64 forms to interim claims from the State agency;

- reconciled the final net settlement reported on the State agency's cost settlement report to the amount reported as school-based health services on CMS-64 forms;

- assessed the completeness and reasonableness of the random moment data;

- joined the Medicaid-eligible coded activity moments to corresponding school districts in such a manner that each moment was listed once for each school district, resulting in a listing of 6,838,987 unique combinations of RMTS activity moments to school districts;

- selected a stratified random sample that included 310 moment-district combinations that were coded as Medicaid-eligible;[29]

- reviewed the stratified random sample and, for each sample item:

    - determined if coding was supported by documentation provided,

    - determined the cost effect of any unsupported code on its corresponding school district for the sample item, and

    - calculated the related unallowable claim amount for Federal reimbursement;

- estimated the total amount of overpayment for Medicaid school-based health services and administrative activities related to unsupported RMTS activity moment coding;[30] and

- discussed our results with State agency officials.

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

[29] Each item in our sampling frame corresponded to a unique combination of an RMTS activity moment and a school district. See Appendix D for details on our sample design.

[30] See Appendix E for our sample results and estimates.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
New Jersey's Medicaid School-Based Cost Settlement Process Could Result in Claims That Do Not Meet Federal Requirements	A-02-20-01012	03/08/2022
New York Improperly Claimed $439 Million In Medicaid Funds for Its School-Based Health Services Based on Certified Public Expenditures	A-02-18-01019	07/20/2021
Florida Received Unallowable Medicaid Reimbursement for School-Based Services	A-04-18-07075	11/24/2020
Nebraska Claimed Unallowable School-Based Administrative Costs Because of Improper Coding of Random Moment Timestudy Responses	A-07-19-03234	08/14/2020
New Jersey Improperly Claimed Tens of Millions for Medicaid School-Based Administrative Costs Based on Random Moment Sampling That Did Not Meet Federal Requirements	A-02-17-01006	11/08/2019
Vulnerabilities Exist in State Agencies' Use of Random Moment Sampling To Allocate Costs for Medicaid School-Based Administrative and Health Services Expenditures	A-07-18-04107	12/06/2018
New Jersey Claimed Hundreds of Millions in Unallowable or Unsupported Medicaid School-Based Reimbursement	A-02-15-01010	11/27/2017
Texas Improperly Received Medicaid Reimbursement for School-Based Health Services	A-06-14-00002	08/14/2017

APPENDIX C: SELECTED SCHOOL-BASED DOCUMENTATION REQUIREMENTS

To claim Federal reimbursement, the allocation of costs for Medicaid-eligible and non-eligible activities requires careful documentation of all work performed by certain school staff over a set period of time that is used to identify, measure, and allocate the school staff time that is devoted to services and activities reimbursable by Medicaid.[31]

Federal reimbursement may be available for Medicaid-eligible health services included in a child's IEP. CMS's *Medicaid and School Health: A Technical Assistance Guide* states that a school must keep records that details student-specific information regarding all specific services provided. Relevant documentation includes who provided the service and any required medical documentation related to the student's diagnosis or medical condition. This information is necessary in the event of an audit.[32]

CMS's *Medicaid School-Based Administrative Claiming Guide* states that documentation of results must be sufficiently detailed to determine whether the claimed activities are necessary for the proper and efficient administration of the State plan. The burden of proof and validation of sample results remains the responsibility of the State agency. To meet this requirement, the time study documentation can include a narrative description of the Medicaid activity being performed, including student names or case information where applicable. Regardless of how the State validates sample results, the State must maintain appropriate documentation for audit purposes.[33]

[31] State Plan Amendment Att. 3.1A and 4.19B; the *Medicaid School-Based Administrative Claiming Guide*, May 2003; and the *Pennsylvania School-Based ACCESS Program Implementation Guide* contain details of these requirements.

[32] CMS, *Medicaid and School Health: A Technical Assistance Guide*, August 1997. Available online at https://www.hhs.gov/guidance/document/medicaid-and-school-health-technical-assistance-guide. Accessed on June 21, 2023.

[33] CMS, *Medicaid School-Based Administrative Claiming Guide*, May 2003. Available online at https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/medicaidbudgetexpendsystem/downloads/schoolhealthsvcs.pdf. Accessed on June 21, 2023.

APPENDIX D: SAMPLE DESIGN AND METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 6,838,987 unique combinations of RMTS activity moments joined to the school districts to which PCG's RMTS results were applied to allocate costs from July 1, 2015, through June 30, 2019. Each RMTS activity moment coded as Medicaid-eligible was joined to every school district participating in the corresponding quarter to create a unique RMTS activity moment to school district combination (moment-district combination).[34]

SAMPLE UNIT

The sample unit was defined as a moment-district combination.

SAMPLE DESIGN AND SAMPLE SIZE

We randomly selected 310 sample items according to the following stratified design:

Stratum	Range of Potential Financial Impact Amounts for Moment-District Combinations[35]	Frame Count	Sample Size
1	Combinations with potential health service impact amounts ≤$151.14	3,468,085	75
2	Combinations with potential health service impact amounts >$151.14 and ≤$442.06	638,915	55
3	Combinations with potential health service impact amounts >$442.06	175,427	75
4	Combinations with potential administrative activity impact amounts ≤$61.93	2,234,942	40
5	Combinations with potential administrative activity impact amounts >$61.93 and ≤$248.78	268,042	30
6	Combinations with potential administrative activity impact amounts >$248.78	53,576	35
Total		**6,838,987**	**310**

[34] The RMTS activity moments were coded as Medicaid-allowable for either direct health services or administrative activities. The 6,838,987 moment-district combinations in the sampling frame included 4,282,427 direct health service moment-district combinations and 2,556,560 administrative activity moment-district combinations.

[35] Potential impact amounts were calculated by using the RMTS results and other applicable ratios to determine the potential impact each Medicaid allowable moment had on the total calculated Medicaid costs.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OIG/OAS) statistical software.

METHOD OF SELECTING SAMPLE ITEMS

Within each stratum, we sorted the units by moment date, school district to which the moment was assigned, last name of participant, first name of participant, and school district to which the moment was joined, and then consecutively numbered the sample units in each of the strata. After generating the random numbers for each stratum, we selected the corresponding frame units for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of Medicaid cost overpayments for the direct health services portion of the sampling frame (strata 1 through 3). We also used OIG/OAS statistical software to estimate the total amount of Medicaid cost overpayments for the administrative activity portion of the sampling frame (strata 4 through 6). To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Table 1: Medicaid Health Services Moment-District Combinations

Stratum	Frame Count	Sample Size	Unsupported Moment-District Combinations
1	3,468,085	75	29
2	638,915	55	16
3	175,427	75	29
Total	**4,282,427**	**205**	**74**

Table 2: Medicaid Administrative Activity Moment-District Combinations

Stratum	Frame Count	Sample Size	Unsupported Moment-District Combinations
4	2,234,942	40	31
5	268,042	30	22
6	53,576	35	19
Total	**2,556,560**	**105**	**72**

Estimated Unallowable Federal Medicaid Costs Claimed in the Sampling Frame[36]
(Limits Calculated at the 90-Percent Confidence Level)

Table 3: Medicaid Health Services Estimates

Point Estimate	$162,980,727
Lower Limit	$128,793,656
Upper Limit	$197,167,799

Table 4: Medicaid Administrative Activities Estimates

Point Estimate	$65,869,338
Lower Limit	$53,771,789
Upper Limit	$77,966,886

[36] We estimated that the State agency claimed unallowable Federal funds of at least $182,565,445 ($128,793,656 for unallowable health services and $53,771,789 for unallowable Medicaid administrative activities).

APPENDIX F: STATE AGENCY COMMENTS

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

NOV - 8 2023

Ms. Brenda M. Tierney
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, New York 10278

Dear Ms. Tierney:

This is in response to your letter dated July 12, 2023, which transmitted the U.S. Health and Human Services, Office of Inspector General (OIG) draft report number A-02-21-01011 titled *Pennsylvania Improperly Claimed $551 Million in Medicaid Funds for Its School-Based Program*. The objective of this audit was to determine whether the Pennsylvania Department of Human Services properly claimed Federal funds through its Medicaid school-based program.

The cost-based reimbursement methodology currently in use by the Pennsylvania Department of Human Services (DHS) in the School Based Access Program (SBAP) was implemented following a financial management review conducted by the Centers for Medicare & Medicaid Services (CMS). The methodology as described in Attachment 4.19B of Pennsylvania's Medicaid State Plan was based on guidance, including sample State Plan pages, provided by CMS (see Exhibit 1, highlighting added). The cost allocation plan described in the *Pennsylvania School-Based ACCESS Program Time Study Implementation Guide for Direct Services and Administrative Claiming* (Implementation Guide) was developed in close coordination with CMS. Since CMS' approval of Pennsylvania's State Plan Amendment (SPA) for providing school-based services and the Implementation Guide, both in 2014, Pennsylvania has utilized these documents to implement and administer the SBAP.

DHS contracted with Public Consulting Group (PCG) to support its SBAP program beginning in 2012, and PCG was involved in the initial rollout of the new cost-based methodology to the Local Education Agencies (LEAs). Training for the LEAs was provided by DHS in conjunction with the Pennsylvania Department of Education (PDE) and PCG to ensure LEAs had detailed information about the time study and the cost reporting process.

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The draft report states that "deficiencies occurred because Pennsylvania and its contractor developed complex cost allocation methods that were difficult or impractical to support with documentation or did not follow CMS guidance." In fact, Pennsylvania implemented the cost-based reimbursement methodology and cost allocation plan that were approved by CMS. The approved SPA established the process to determine the Individualized Education Program (IEP) ratio that is applied at cost settlement, and the Implementation Guide laid out the parameters for conducting the Random Moment Time Study (RMTS) and using its results to calculate the administrative claim and direct medical percentage, processes that the OIG finds fault with. Based on its inaccurate assessment of Pennsylvania's SBAP as noted here and below, the OIG is recommending that Pennsylvania refund approximately 93 percent of all federal financial participation (FFP) received during the audit period.

The draft report contains six recommendations. Below is each recommendation, followed by DHS' response.

OIG Recommendation 1: We recommend that the Pennsylvania Department of Human Services refund $183,205,803 to the Federal Government related to moments that could not be supported as Medicaid-eligible health services or Medicaid administrative activities.

DHS Response: We do not concur with the OIG's finding related to unsupported RMTS nor this recommendation. DHS has operated its SBAP time studies according to the guidelines established in the Implementation Guide, as approved by CMS, with an effective date of October 1, 2012. Page 5 of the Implementation Guide states that: "Each moment selected from the pool is included in the time study and coded according to the documentation submitted by the employee." In other words, the information provided by the respondent in the initial response and any follow-up responses is the documentation for the activity described in the moment. Page 11 explains that: ""Coders" are employed by the RMTS contractor to review the documentation of participant activities performed during the selected moments and to determine the appropriate activity code." The documentation to be reviewed is the information that the respondent provided in response to the questions below (from Page 12 of the Implementation Guide).

"Documentation of sampled moments must be sufficient to provide answers to six questions needed for accurate coding:

1. Were you working during your sampled moment?
2. Who was with you?
3. What were you doing? Please be as specific as possible.
4. Why were you doing this activity?
5. Is this activity regarding a Special Education student?
6. Is the service you provided part of the child's IEP?"

The Implementation Guide (Page 12) also notes that the LEA is required to maintain the following documents in support of the RMTS results:

- A Direct Service Cost Pool list of eligible individuals, including job categories; and
- An Administrative Service Provider Only Cost Pool of eligible individuals, including job categories.

Despite the terms of the Implementation Guide, during its audit, the OIG requested that DHS contact LEAs to gain access to student data such as IEPs and direct service logs. While LEAs do seek to obtain parental consent for students receiving health-related services, this consent provides access to student records for purposes of billing Medicaid and, contrary to what is on page two of the draft report, it does not cover release of such records to a third party. The OIG acknowledged in its draft report to DHS that both the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA) restrict access to student-related materials that may provide additional support for the activity described in the moment response. The OIG also acknowledged that it is unaware of a solution or workaround that would allow us to gain access to student-related materials to provide additional support for responses. Therefore, the OIG is aware of the limitations and restrictions associated with accessing these documents and sharing them with a third party. This demonstrates that student education records, such as IEPs or service logs, were never intended to be part of the documentation for the moment, nor has CMS advised us that additional documentation is required to support moments.

In its May 2023 guidance, CMS addressed the effects of HIPPA and FERPA that limit the sharing of a student's education record within the school-based services arena and provided information regarding how States can update their programs to work within the privacy requirements applicable for students while also meeting the documentation needs of the Medicaid program. On page 95 of the guidance, CMS states that "In order to meet the documentation requirements applicable to Medicaid and to be prepared for audit, school-based providers can furnish de-identified or masked data, which has been redacted or conceals PII." While this is an option that DHS can consider for future years of the SBAP, such guidance cannot be applied retroactively.

Further, the Implementation Guide describes the RMTS as intended to capture the time that eligible staff spend performing "Medicaid related activities." Moments are coded as Medicaid eligible if the respondent is providing a service covered under Pennsylvania's state plan or described in the Implementation Guide, without regard for the student's Medicaid eligibility status at the time of the moment.

In reviewing the moments that the OIG provided to DHS as being unsupported, we noted errors and inconsistencies with the data provided. Specifically, the stratified random sample of 310 random moments noted on page 4 of the draft report contains moments that occurred prior to the OIG's stated audit period of July 1, 2015 through June 30, 2019. These errors and inconsistencies affect the validity of the sample selected by the OIG and, as a result, bear directly upon the calculation of the amount of

FFP the OIG recommends DHS repay.

*
- The OIG identified 70 moments as MAC Errors, but 11 of those moments were for dates prior to the stated start date of the audit period; nevertheless, DHS reviewed those moments and found 4 of them to be supported by the coding descriptions in the Implementation Guide.
- We determined that 20 of the moments from the stated review period were supported by the coding descriptions in the Implementation Guide.
- Of the moments the OIG identified as MAC Errors, 49 responses were associated with direct service cost pool respondents and were coded as unallowable and treated in accordance with pages 13, 14, and 16 of the Implementation Guide. (This figure includes eight moments that were outside of the review period.)
- Of the 69 moments the OIG identified as Direct Service Errors, we found 24 of them to be supported by the coding descriptions found in the Implementation Guide.

The response to moments questioned on the basis of credentialing is addressed under Recommendation 4.

Although we disagree with this recommendation, we have already done the following:
- Additional training and verification review were instituted with the primary coding vendor and the oversight vendor to ensure consistent interpretation of Pennsylvania's CMS-approved Implementation Guide.
- In the past four years, DHS increased its own review of coded moments to ensure that coding results reflect the additional training provided and align with the CMS-approved Implementation Guide.

In addition:
- With support from the vendor responsible for operating the RMTS beginning in October 2023, additional training for time study participants and RMTS coordinators at the LEAs was developed and is being provided in advance of the October-December 2023 time study and will be provided on an ongoing basis moving forward. For reference, from 2015 to 2023, the SBAP was supported by two vendors. PCG was responsible for the RMTS and submission of direct service and special transportation claims. A second vendor was responsible for cost reconciliation and settlement, as well as a variety of oversight activities. In 2022, we issued a request for proposals to engage one vendor to support the SBAP. The new single-vendor contract is effective October 1, 2023.
- We have developed a strong internal process to carry out the blind review of moments for purposes of validation, as set forth in the Implementation Guide, as it transitions to a single vendor in support of the SBAP.

***OIG Note:** OIG provided a total of 72 moments to Pennsylvania as MAC errors.

OIG Recommendation 2: We recommend that the Pennsylvania Department of Human Services refund $368,230,469 to the Federal Government or provide documentation that can reasonably support its allocation of health services costs to Medicaid without using unverifiable IEP ratios.

DHS Response: We do not concur with the OIG's finding that IEP ratios used to calculate the Medicaid allowable portion of LEA costs to provide health-related services are unverifiable. Therefore, we do not agree with repaying any of this amount. The CMS-approved methodology under which DHS operates the SBAP requires the use of an IEP ratio to determine Medicaid eligible costs. While the OIG states that the ratios cannot be supported due to an inability to view supporting documentation, there were no new restrictions on access to student documentation that arose after the time that the methodology and the IEP ratio were approved by CMS.

The OIG incorrectly states that the IEP ratio is part of a methodology developed by DHS and its contractor. The cost-based reimbursement methodology was adopted by DHS after working closely with CMS, reviewing sample state plan materials provided by CMS, and ultimately implementing the methodology as approved by CMS (see Exhibit 1). The cost-based reimbursement model was being adopted by a number of states at the time that we submitted our SPA for approval. This model involves reimbursement through interim payments using LEA specific rates for direct services paid throughout the year that, after the conclusion of the fiscal year, are reconciled and settled against the actual costs of providing the services (On pages 2 and 3 of the draft report, the OIG incorrectly states that payments are made to LEAs based on a fee schedule. In addition, page 3 of the draft report incorrectly indicates that PCG applies the Medicaid-eligible RMTS percentage (what we refer to as the direct medical percentage) and the IEP ratio to calculate end of year costs. PCG calculates the direct medical percentage which is applied by the vendor responsible for the cost reconciliation and settlement process, during which the LEA-specific IEP ratios are also applied.). This methodology is used to more accurately calculate the true cost for schools to provide Medicaid-eligible services to students. As recently as the May 2023 guidance issued by CMS, the cost-based reimbursement methodology is noted as "the most commonly used payment methodology for Medicaid SBS" (p. 47 of CMS SBS Guidance). Pennsylvania is one of approximately 26 states that utilize a cost-based methodology that incorporates an IEP ratio.

In its June 2012 letter to Pennsylvania (see Exhibit 1), CMS notes that if non-IDEA (Individuals with Disabilities Education Act) services would be covered, changes to the cost identification process would be necessary: "In particular, the Medicaid allocation statistic will not be the IEP ratio but may be the Medicaid eligibility ratio." This guidance is the basis for DHS' use of the IEP Ratio, which requires that the numerator and denominator take into account those students receiving health-related services documented in an IEP. Additionally, the May 2023 guidance from CMS notes that a ratio of Medicaid students to total students would apply only in a Free Care situation where an IEP is not required (p. 64 of CMS guidance). It goes on to suggest ways that states could make changes to their program to have a general Medicaid eligibility rate that

could be applied for all services as a way to further reduce the administrative burden on LEAs (pp. 96-97 of CMS guidance).

The IEP ratios reported by Pennsylvania's LEAs are developed using the December 1 Count Report of special education students, which is data gathered by the PDE and is used for reporting on the federal level for this and other programs. The LEAs use this data to then determine which of those students who have a health-related IEP service are also Medicaid eligible by directly accessing DHS' Medicaid Management Information System (MMIS). As noted in the response to Recommendation 1, HIPAA and FERPA restrict access to student-related materials that may provide additional support for verification of the IEP ratio. However, Pennsylvania's participating LEAs do have access to those IEPs and use that access in the development of their LEA-specific IEP ratio used in the cost reconciliation and settlement process. Privacy requirements of FERPA and HIPAA that limit direct access to student IEPs by the state Medicaid agency are not new and existed at the time the methodology was recommended and approved by CMS in the 2012-2013 timeframe. Recent CMS guidance from May 2023 recognizes restrictions to accessing IEP records and provides alternatives for states.

Although we disagree with this recommendation, we have already done the following:

- LEAs are required to maintain a record of eligibility verification as part of the documentation of their IEP ratio. This documentation must contain the eligible "as of" date and the initials of the individual completing the verification process.
- During the cost reporting process, any ratio that is a significant change from the prior year sets a flag for review and requires confirmation by the LEA that the ratio is accurate.
- During the cost reporting process, any ratio reported at 100% results in direct outreach from DHS' vendor and requires either documentation to support the ratio as stated or a corrected ratio to be entered.
- When improperly reported ratios are discovered, action is taken to recoup payments from affected LEAs.
- The Oversight & Monitoring (O&M) process was instituted after the completion of the CMS Financial Management Review as a mechanism for DHS to review LEA documentation for program compliance, including the IEP ratio.

In addition:

- We are working with the SBAP vendor to add an attestation by the LEA that the IEP ratio entered into the cost report is accurate and supported by the LEA's documentation.
- We are currently reviewing the updated SBS guidance from CMS for other potential necessary changes.

OIG Recommendation 3: We recommend that the Pennsylvania Department of Human Services ensure that its contractor collects sufficient information so that the State agency can validate the contractor's coding of RMTS moments.

DHS Response: We believe that the CMS-approved Implementation Guide provides the parameters for what information is required to be collected as part of the moment response process. The OIG has not demonstrated how this approach to documentation is not appropriate, given that CMS approved the Implementation Guide.

Our response to Recommendation 1 provides a detailed explanation of the documentation that is required to be maintained in accordance with the Implementation Guide.

The RMTS captures random moments where respondents are working with students who may or may not be Medicaid-eligible, as well as those who may or may not have a signed parental consent on file. Because FERPA and HIPAA require the school district to obtain the consent of the parent before disclosing a student's PII to the State Medicaid/Children's Health Insurance Program agencies, it is unreasonable to request PII for each student that a respondent works with through the RMTS. The Implementation Guide establishes that moment responses must be sufficient to provide answers to six questions, which are then used to allow coding of that moment to align with the descriptions and examples provided in the guide for each code, thereby satisfying the requirement for documentation. The CMS-approved Implementation Guide does not indicate a requirement for student health records or IEPs to determine whether activities at the time of the moment were attributable to Medicaid-eligible health services, Medicaid administrative activities, or educational activities.

School-based Services Guidance issued by CMS in May 2023 does not recommend any increased requirements for documentation of random moment activities, but rather repeatedly calls for steps that would reduce the administrative burden placed on LEAs.

Although we disagree with this recommendation, we have already done the following:

- Additional training and verification review were instituted with the primary coding vendor and the secondary review vendor to ensure consistent interpretation of Pennsylvania's CMS-approved Implementation Guide.
- Training activities with the primary coding vendor also addressed consistent and effective follow-up questions when initial responses were insufficient to identify the correct code for the moment.
- In the past four years, we increased our own review of coded moments to ensure that coding results reflect the additional training provided and align with the CMS-approved Implementation Guide.

In addition:

- With support from the new RMTS vendor, additional training for time study participants and RMTS coordinators at the LEAs was developed and is being provided in advance of the October-December 2023 time study and will be provided on an ongoing basis moving forward.
- Training is offered live on multiple dates prior to the start of the quarterly time study and recorded trainings are also made available. Additionally, the vendor provides separate Q&A sessions to foster communication with the LEAs and

ensure they understand the importance of their responses in documenting Medicaid-eligible activities.
- At the time a participant receives a moment, they are presented with several training slides to ensure they understand the process.

OIG Recommendation 4: We recommend that the Pennsylvania Department of Human Services ensure that school districts verify that providers are appropriately licensed before they provide health services to students.

DHS Response: DHS' responsibility is to ensure that LEAs verify that providers on the direct service staff pool list whose costs are being reported for Medicaid reimbursement are properly licensed and credentialed in accordance with the State Plan. Therefore, we do not concur that the State is responsible to ensure that providers are appropriately licensed before they provide health services to students, irrespective of Medicaid billing. A school guidance counselor may meet the needs of the student, the requirements of the IEP, and the school's responsibility under IDEA to provide counseling services, even if that individual is not eligible to bill in the Medicaid program.

The OIG reached out to DHS in late September 2022 with a request for information related to provider credentials. The email communication noted that while the reviewer was able to verify the majority of licenses, the email included a spreadsheet of instances where they could not be verified. In its review of the providers for whom the OIG indicated that no credentials could be identified, we again noted some errors and inconsistencies in the data that was provided. The OIG requested documentation of credentials for 47 providers. The results of our review of those moments are as follows:

- Four of the requests were for moments that occurred prior to the identified audit period; nevertheless, we provided credentials for two of those moments.
- In three instances, no credentialing information could be found.
- In one instance the individual was not a qualified provider as described in the State Plan.
- For the remaining 39 providers in question, appropriate credentials were provided for the individual to the OIG. In all but one instance of a provider that required supervision, credentials for the supervisor were provided as well.

Although we disagree with this recommendation, we have already done the following:
- O&M reviews, including verification of credentials, began with completion of the State fiscal year 2014-2015 cost settlement. These reviews require LEAs to provide documentation demonstrating compliance with program requirements, including the qualifications of providers.
- Beginning with the September 2019 update to the SBAP Handbook, specific credentialing requirements are outlined by provider type to ensure LEAs understand what documentation must be maintained. Samples of appropriate credentials are shared and discussed in training sessions provided to LEAs.

In addition:

- O&M reviews will continue as a means to provide an in-depth review of documentation maintained by LEAs for purposes of program compliance.
- The new vendor contract effective October 1, 2023, requires the vendor to provide LEA Support Liaisons who will work directly with LEAs on key areas of compliance, including maintaining proper credentials for direct service providers.

OIG Recommendation 5: We recommend that the Pennsylvania Department of Human Services develop an accurate, supportable method to identify Medicaid costs that does not rely on unverifiable IEP ratios.

DHS Response: We do not concur that the IEP ratio is not an accurate method to identify costs. The cost allocation methodology currently in use by DHS, including the use of an IEP ratio, was approved by CMS. Additionally, the guidance issued by CMS in May 2023 continues to reference the use of an IEP ratio to determine Medicaid allowable costs.

As has been previously noted in this response, the Department has followed the methodology, to include the use of an IEP ratio, as recommended and approved by CMS in both Pennsylvania's Implementation Guide and State Plan.

Although we disagree with this recommendation, we have already done the following:

- O&M reviews, including verification of IEP ratios, began in 2016 following settlement of the State fiscal year 2014-2015. (We randomly selected 10% of participating LEAs per fiscal year). Documentation submitted by the LEA in support of its IEP ratio must demonstrate that the LEA verified Medicaid eligibility as of December 1 of the fiscal year in review.
- O&M reviews may identify that an LEA successfully documented and reported the correct IEP ratio, under-reported its IEP ratio, over-reported its IEP ratio, or failed to document any IEP ratio. If the IEP ratio is over-reported, the LEA's settlement is adjusted and improperly claimed reimbursement is recouped. If no documentation can be provided, the IEP ratio is adjusted to 0% and all reimbursement for that year is recouped.
- The cost settlement vendor created additional edit checks within the desk review process for cost reporting to identify potential errors in the IEP ratio and initiated direct outreach to any LEA reporting a 100% IEP ratio.

In addition:

- As with many other states, we will be considering adoption of one of the alternative cost reporting methods described in the May 2023 School Based Service Guidance from CMS.

OIG Recommendation 6: We recommend that the Pennsylvania Department of Human Services revise its RMTSs to include the first month of the school year.

DHS Response: We concur with the recommendation to revise our RMTS to include the time period that has been referred to as the summer quarter or inactive quarter, based on the guidance within Pennsylvania's approved Implementation Guide.

DHS has been operating its RMTS based on its CMS-approved Implementation Guide, which includes the following language regarding the July to September quarter on page 4:

> Because activities and services are not provided in the LEA when school is not in session, a time study will not be conducted from July to September. An average of the prior three quarters' time study results will be used to calculate a claim for the summer months. This is consistent with the May 2003 Medicaid School-Based Administrative Claiming Guide which states:
>
> > *"...the results of the time studies performed during the regular school year would be applied to allocate the associated salary costs paid during the summer. In general, this is acceptable if administrative activities are not actually performed during the summer break, but salaries (reflecting activities performed during the regular school year) are prorated over the year and paid during the summer break." (p. 42)*

Corrective Action already taken:

- We are aware of similar findings in reviews of other states' school-based claiming programs and are working towards implementing a time study during the July to September quarter.

Corrective Actions moving forward:

- In anticipation of operating a July-September time study beginning in 2024, we included that task in the SBAP vendor contract that is effective October 1, 2023.

SBAP staff are currently reviewing the updated School-Based Services guidance issued by CMS in May 2023 to identify additional opportunities to enhance and promote the operation of the SBAP while alleviating the administrative burden for the LEAs. Even as we look forward to the opportunity to reshape our school-based Medicaid program using CMS' updated guidance, we believe it is unreasonable to hold DHS accountable to guidance issued by CMS in 2023 for activities that occurred between 2015 and 2019. CMS' updated guidance illustrates that States can modify their CMS-approved SBAP processes to better capture approved services but does not suggest deficiencies or lapses in the operation of school-based programs in prior years.

Thank you for the opportunity to respond to this report. If you have any questions, please contact Mr. David Bryan, Bureau of Financial Operations, Audit Resolution Section, at (717) 783-7217 or davbryan@pa.gov.

Sincerely,

Stephanie Shell
Deputy Secretary for Administration

Enclosure

c: Mr. Calvin Jones, Office of Inspector General
Mr. David Bryan, Bureau of Financial Operations, Audit Resolution Section