

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW JERSEY CLAIMED HUNDREDS OF
MILLIONS IN UNALLOWABLE OR
UNSUPPORTED MEDICAID SCHOOL-
BASED REIMBURSEMENT**

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



**Daniel R. Levinson
Inspector General**

November 2017
A-02-15-01010

Office of Inspector General

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Report in Brief

Date: November 2017

Report No. A-02-15-01010

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



Why OIG Did This Review

A prior OIG review of New Jersey's payment rates for Medicaid school-based services found that the State calculated its rates using unallowable costs.

Federal law requires schools to provide special education and related services for children with disabilities. Schools are required to perform evaluations of children to determine whether they are entitled to services. Medicaid covers only those portions of evaluations that are medically necessary. New Jersey claims Medicaid reimbursement for school-based health services through its Special Education Medicaid Initiative (SEMI).

To develop its SEMI payment rates and submit Federal Medicaid claims on behalf of schools, New Jersey contracted with Public Consulting Group (PCG). Using a complex methodology, PCG developed rates for two types of Medicaid school-based services: one for rehabilitative services (e.g., speech therapy) and one for evaluation services.

Our objective was to determine whether New Jersey's payment rates for Medicaid school-based health services met Federal requirements.

How OIG Did This Review

We reviewed documents prepared by PCG to develop the State's SEMI payment rates.

New Jersey Claimed Hundreds of Millions in Unallowable or Unsupported Medicaid School-Based Reimbursement

What OIG Found

New Jersey did not follow Federal regulations and Centers for Medicare & Medicaid Services (CMS) guidance when it developed its payment rates for Medicaid school-based services and, as a result, claimed \$300.5 million in unallowable costs. New Jersey claimed an additional \$306.2 million in reimbursement using payment rates developed with unsupported costs.

Among our findings, we determined that (1) PCG improperly altered school employees' responses to timestudies to indicate that their activities were directly related to providing Medicaid services when the responses indicated the activities were unrelated; (2) New Jersey improperly incorporated into its payment rates more than \$400 million owed to the school employees' pension fund despite not having made scheduled payments to the fund in nearly 20 years; and (3) salaries of some employees who did not provide health-related services were incorporated into the payment rates. In addition, New Jersey did not maintain documentation related to the timestudies, which it used to identify the percentage of time personnel provided particular services.

What OIG Recommends and New Jersey Comments

We recommend that New Jersey refund \$300.5 million in Federal Medicaid reimbursement claimed based on payment rates that incorporated unallowable costs, work with CMS to determine the allowable amount of the remaining \$306.2 million claimed for Federal Medicaid reimbursement, and revise its payment rates so they comply with Federal requirements.

New Jersey disagreed with our findings and recommendations. New Jersey also submitted a memorandum from PCG asserting that its methodology for setting rates was reasonable, appropriate, and in compliance with the law.

After reviewing New Jersey's comments and the PCG memorandum, we maintain our findings and recommendations are valid. Neither New Jersey nor PCG provided additional support for how the payment rates were calculated.

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INTRODUCTION

WHY WE DID THIS REVIEW

A prior Office of Inspector General (OIG) review of New Jersey's payment rates for Medicaid school-based health services found that the State calculated its rates using unallowable costs.¹ As a result of the review, the State lowered its payment rates from \$1,120 to \$552 for evaluation services and from \$167 to \$21 for rehabilitation services retroactively to July 2003. Subsequently, the State, through a new contractor, increased the payment rates retroactively to July 2003 from \$552 to \$1,451 for evaluation services and from \$21 to \$50 for rehabilitation services.² This significant increase raised the question of whether the State was again using unallowable costs. We have performed numerous audits on Medicaid school-based services to ensure that proper payments were being made. Appendix A contains a list of recent OIG reports related to Medicaid school-based services.

OBJECTIVE

Our objective was to determine whether the New Jersey Department of Human Services' (State agency's) payment rates for Medicaid school-based health services met Federal requirements.

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 New Jersey, the State agency administers the Medicaid program.

The Individuals With Disabilities Education Act

The Individuals With Disabilities Education Act (IDEA) requires schools to provide special education and related services for children with disabilities. Related services are supportive

¹ *Review of New Jersey's Medicaid School-Based Rates (A-02-04-01017)*, issued February 8, 2008. The review found that New Jersey's rates, which were calculated in 1997, "improperly included 100 percent of the costs of certain personnel who spent only part of their time providing [Medicaid school-based] services."

² The dollar figures are retroactive to July 1, 2003. The current rates, effective July 1, 2014, are \$1,789 for evaluations and \$62 for rehabilitation services.

services required to assist a child with a disability to benefit from special education and include health care services covered by Medicaid and non-health-care services. The Social Security Act allows payment for Medicaid-covered services provided under IDEA. IDEA requires evaluations to determine whether a child is entitled to services.³ We refer to these evaluations throughout this report as “IDEA evaluations.” Medicaid covers only those portions of an IDEA evaluation that are related to determining a child’s health-related needs. Under IDEA, schools also prepare a statement of each child’s educational program, which is known as an individualized education plan (IEP).⁴

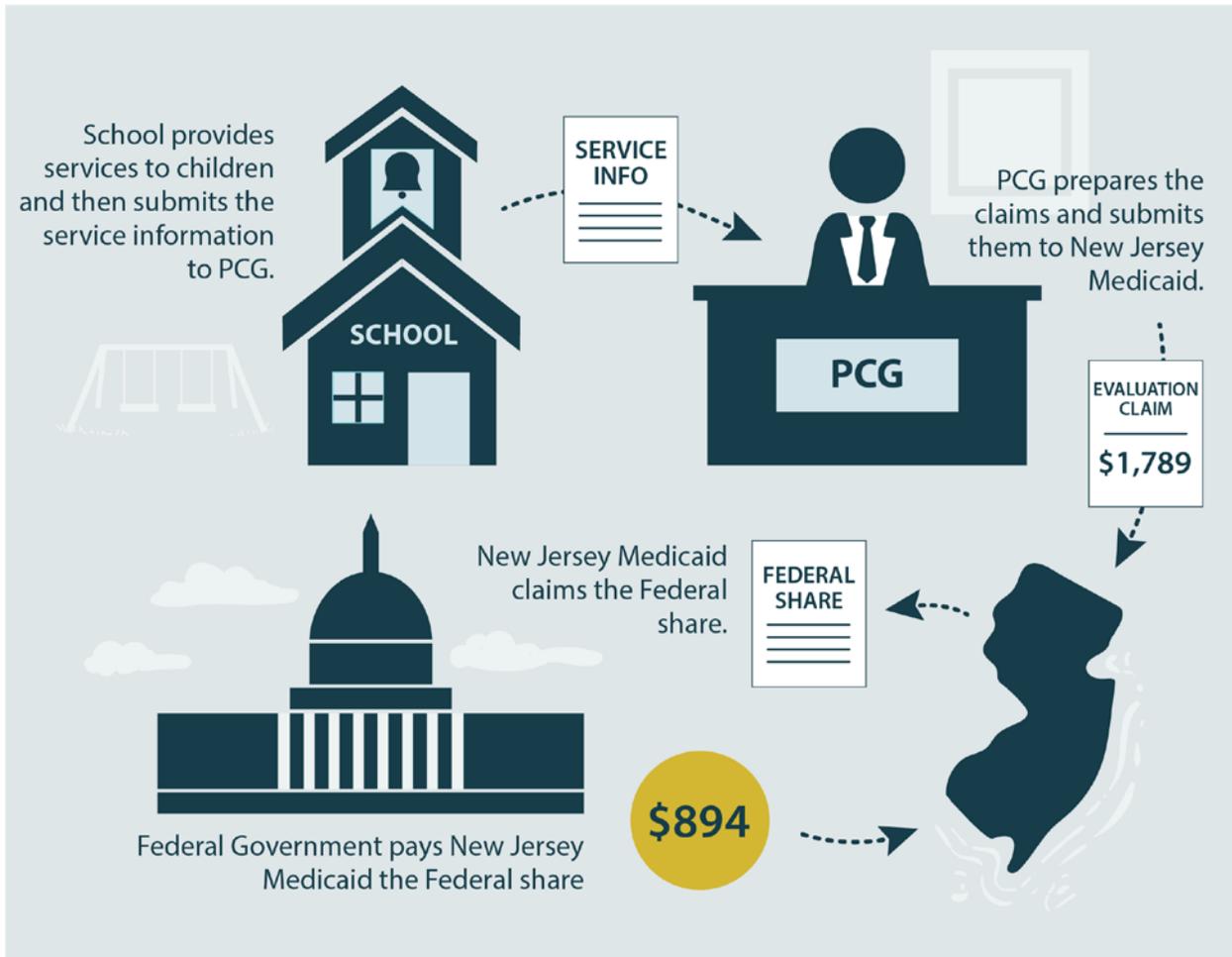
New Jersey’s Special Education Medicaid Initiative

The State agency claims Federal Medicaid reimbursement for health services provided by schools under IDEA through its Special Education Medicaid Initiative (SEMI). The State Department of Treasury (Treasury), the administrative manager for SEMI, hired a contractor, Public Consulting Group (PCG), on a contingency fee basis to develop SEMI payment rates and submit claims on behalf of schools, which are overseen by the State Department of Education (DOE). Figure 1 (following page) illustrates how New Jersey processes and claims Medicaid school-based services.

³ The IDEA evaluation is broader in scope than a Medicaid evaluation. While a Medicaid evaluation determines whether Medicaid health-related services are needed, an IDEA evaluation determines whether a child has a disability that requires special education and related services, the child’s specific educational needs, and the special education and related services required to address those educational needs.

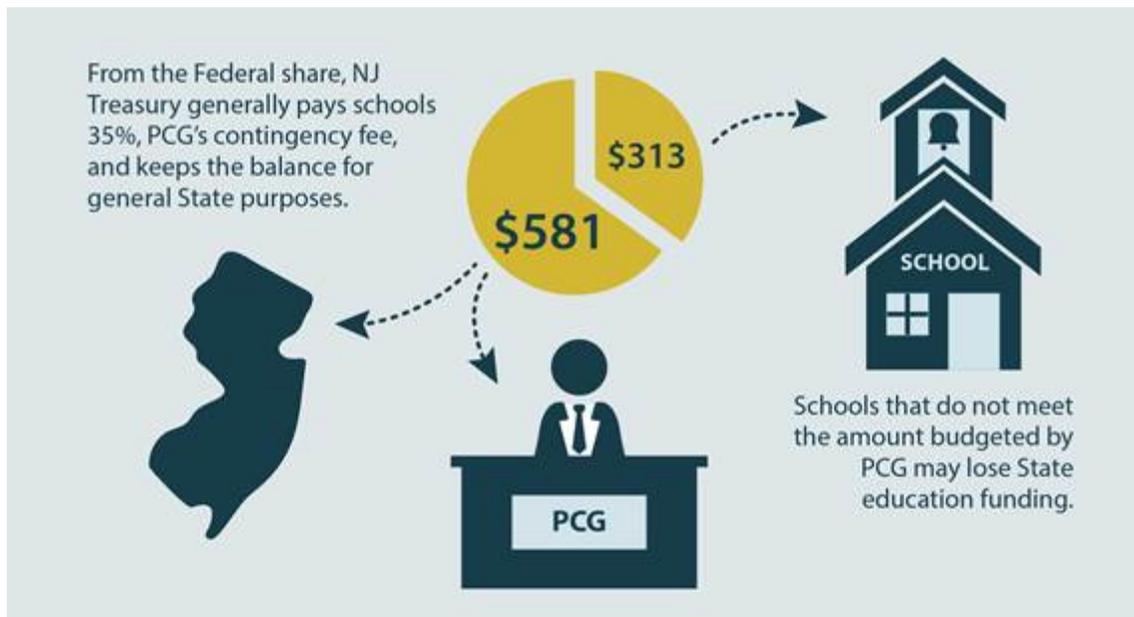
⁴ Schools prepare evaluation reports and IEPs to fulfill education-related mandates under IDEA. Medicaid funds may not be used to pay for the entire evaluation and IEP process. Medicaid covers only medical assessments conducted as part of an evaluation to determine a child’s health-related needs.

Figure 1: How New Jersey Processes and Claims Medicaid School-Based Services



The State agency pays schools only a percentage of Federal Medicaid funds obtained for SEMI services; the State keeps the remainder. Further, each school must reach 90 percent of the SEMI revenue budgeted by PCG each year or the school may lose State education aid. Figure 2 (following page) illustrates how New Jersey distributes the Federal share of Medicaid reimbursement for school-based services.

Figure 2: How New Jersey Distributes the Federal Share of Medicaid Reimbursement for School-Based Services



Federal Requirements Related to Developing Payment Rates

States must set payment rates consistent with efficiency, economy, and quality of care.⁵ New Jersey stated to CMS that its rates would be reasonably related to the cost of providing services.⁶

New Jersey decided to identify the costs used to set the rates by using random moment timestudies (RMTS).⁷ RMTS may be used to identify costs allocable to a Federal program when the methodology meets acceptable statistical sampling standards and the results are valid.

⁵ Social Security Act § 1902(a)(30)(A).

⁶ Supporting Documentation to State Plan Amendment 93-26.

⁷ An RMTS is a statistical method used to identify the percentage of time personnel spend on a particular cost objective.

CMS Guidance on Developing Payment Rates for School-Based Services

CMS has issued two guides on reimbursement for Medicaid school-based activities.⁸ The guidance states that payment rates must be supported by information on how the rates were determined, such as historical data and timestudies. Further, the State must maintain documentation of these payment rates to be made available to CMS upon request.⁹

CMS also issued a State Medicaid Director's Letter¹⁰ advising that school-based bundled rates presented a risk to the integrity of the Medicaid program. CMS stated that school-based bundled rates did not meet the statutory intent of section 1902(a)(30)(A) of the Social Security Act, which requires that States have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care. Specifically, CMS stated:

We believe that a bundled rate for school-based services is inconsistent with economy, since the rate is not designed to accurately reflect true costs or reasonable fee-for service rates, and with efficiency, since it requires substantially more Federal oversight resources to establish the accuracy and reasonableness of State expenditures.

CMS offered to help States develop new methods for developing rates for school-based services. New Jersey did not work with CMS to eliminate its bundled rates.

New Jersey's Payment Rates for Medicaid School-Based Services

Using a complex methodology based on the cost of providing services,¹¹ PCG developed payment rates for two types of Medicaid school-based services: one for rehabilitation services (e.g., physical therapy, speech therapy, and occupational therapy) and one for evaluation services (i.e., for determining the need for rehabilitation services). Each rate is bundled, meaning that separate service encounters, even when provided by different personnel, are combined into a single "unit." PCG stated that it identified the costs to set the rates in

⁸ *Medicaid and School Health: A Technical Assistance Guide* (issued August 1997 and available online at https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/school_based_user_guide.pdf) and *Medicaid School-Based Administrative Claiming Guide* (issued May 2003 and available online at <https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/medicaidbudgetexpendsystem/downloads/schoolhealthsvcs.pdf>).

⁹ 42 CFR § 447.203(a).

¹⁰ Issued May 21, 1999. Available online at <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD052199.pdf>. Last accessed November 18, 2016.

¹¹ Cost information was provided by DOE.

compliance with Office of Management and Budget (OMB) Circular A-87.¹² OMB Circular A-87 establishes the principles to determine whether costs of State and local governments are allowable under Federal awards.

To identify the costs associated with school personnel who provide health-related services, PCG used the results from a prior contractor's RMTSs conducted in 2003 and 2004.¹³ The RMTS polls participants on an individual basis at random intervals over a given period and totals the results to determine work effort for the entire population of participating staff over that same period. The percentage of time school personnel spend providing health-related services is used in the calculation to determine the cost of providing health-related services. Personnel use an activity code to record the activity they are performing when their randomly selected moment occurs.

Proposed State Plan Amendment

In 2011, the State agency submitted to CMS a proposed State plan amendment that would allow the State to obtain Federal Medicaid funds for school-based services based on schools' costs through certified public expenditures.¹⁴ Under the proposed State plan amendment, a new "final" payment rate would be determined based on actual costs. The existing rates would be used to determine "interim" payment. At the end of each year, actual costs would be compared against interim payments to determine the amount over- or underpaid. However, CMS's determination regarding whether to approve the amendment was pending as of April 2017.

HOW WE CONDUCTED THIS REVIEW

Our review covered \$526,547,496 in Federal Medicaid reimbursement that the State agency claimed using its school-based evaluation and rehabilitation rates and \$80,138,811 that the State agency claimed under the unapproved State plan amendment. This amount, totaling \$606,686,307, was for services provided from July 2003 through June 2015.¹⁵ We reviewed State documents used to develop the rates to determine whether those rates met Federal requirements.

¹² The circular was relocated to 2 CFR part 225. After our audit period, OMB consolidated and streamlined its guidance, which is now located at 2 CFR part 200.

¹³ Specifically, PCG used results for three of the prior contractor's RMTSs. For these periods covered by the RMTSs, PCG included claims for 291,330 evaluations and re-evaluations and 154,557 rehabilitation service-days.

¹⁴ Public entities may certify that they have spent funds on Medicaid items or services that are eligible for Federal matching funds. These funds are referred to as certified public expenditures and may be claimed as the State's share of Medicaid expenditures.

¹⁵ Our prior review covered the period July 1998 through June 2001.

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 B contains the details of our audit scope and methodology.

FINDINGS

The State agency's payment rates for SEMI services did not meet Federal requirements. Specifically, the rates were based on unallowable costs and unsupported RMTSSs. Further, the State agency claimed unallowable costs related to an unapproved amendment to its Medicaid State plan. The State agency incorporated unallowable and unsupported costs in its SEMI rates primarily because it did not follow CMS guidance concerning bundled rates and RMTSSs.

We were able to quantify some, but not all, of the unallowable costs included in the SEMI rates. On the basis of the minimum amount of unallowable costs included in the rates, the State agency claimed at least \$220,314,119 in unallowable Federal Medicaid reimbursement. Further, the State agency claimed an additional \$80,138,811 in unallowable reimbursement on the basis of an unapproved State plan amendment. In total, \$300,452,930 in Federal Medicaid reimbursement was claimed based on payment rates that incorporated unallowable costs.

The State agency claimed an additional \$306,233,377 in reimbursement calculated with unallowable costs that we cannot quantify because the State agency based its rates on unsupported RMTSSs. Therefore, we are setting aside this amount for the State agency to work with CMS to determine the allowable amount.

THE RATES INCORPORATED SOME UNALLOWABLE COSTS THAT CAN BE QUANTIFIED

Payment Rates Incorporated Incorrect Random Moment Timestudy Activity Codes

Only costs related to providing Medicaid-covered services may be included in payment rates for Medicaid services. Therefore, only RMTS moments identified as occurring when individuals were providing Medicaid-covered services should be used to identify the percentage of those individuals' salaries incorporated into a Medicaid payment rate.¹⁶

The State agency incorporated unallowable costs in the evaluation and rehabilitation services rates because it incorrectly coded some of the responses used to determine the percentage of salaries expended to provide direct health services. PCG identified the costs of providing evaluation and rehabilitation services by using a prior contractor's RMTSSs, completed about

¹⁶ *Medicaid and School Health: A Technical Assistance Guide*. The section entitled "Establishing Payment Rates" (page 29) describes methods for identifying Medicaid-related costs to be included in payment rates.

2 years earlier. The RMTSs used to develop the payment rates included 1,575 responses from school employees. Employees responded to the RMTSs by providing an activity code related to what they were doing at a random moment in time as well as a description of their activities. PCG used the percentage of “activity code 1” (direct health services) responses to the RMTSs to determine the percentage of salaries to use in the rates. Thus, the number of activity code 1 responses directly affected the associated rate amount.

PCG recoded 235 of the employees’ responses, many of which also contained a narrative description of what the employee was doing, to indicate that the employee was providing a Medicaid-eligible direct health service.¹⁷ On the basis of the participants’ narrative descriptions of what they were doing, we determined that only 32 of the 235 responses were correctly recoded as direct health services, and the remaining 203 were not. (See Figure 3 for examples.)

Figure 3: Examples of Improper Activity Code Alterations

The following responses to the RMTSs were recoded as being directly related to providing health services:

- A social worker indicated that they were “scheduling students to see me” and coded this as “general administration.”
- A social worker indicated that they were “contacting a parent on the phone” and coded this as “development and monitoring of educational and social services.”

Although neither response indicated that the employee was providing health services, PCG recoded the responses to indicate that they were.

Payment Rates Incorporated Unpaid Pension Costs

States must set payment rates consistent with efficiency, economy, and quality of care. PCG stated that it identified the costs to set the rates in compliance with OMB Circular A-87. OMB Circular A-87 states that accrued pension costs are allowable for a given fiscal year if they are funded for that year within 6 months after the end of the year. Costs funded after the 6-month period are allowable in the year funded.

The State agency’s payment rates incorporated the cost of payments to the school employees’ pension fund¹⁸ totaling \$435,287,077; however, the State has not made regular payments or a full annual payment to the fund in nearly 20 years.

¹⁷ Conversely, PCG changed responses from 46 employees to indicate that they were not providing Medicaid-eligible health services. We determined that all of these changes were made correctly. We also determined that 35 additional responses that PCG had not recoded should not have initially been recorded as direct health services.

¹⁸ DOE provided PCG with information about payments to the Teachers’ Pension and Annuity Fund, which is managed by Treasury.

The base year used to set the State agency's payment rates was State fiscal year (SFY) 2004. During this year, the State made zero payments to the pension fund. The State has not provided us with evidence that it ever paid the \$435,287,077 that PCG claims is a 2004 pension cost. Therefore, the State agency should not have included these costs as a SEMI expense in its payment rate calculations.

Evaluation Rate Incorporated Learning Disabilities Teacher-Consultant Salaries

PCG incorporated learning disabilities teacher-consultant salaries in the evaluation rate. These salaries are unallowable because teacher-consultants provide special education services, not health-related services.

In a description of its rate-setting methodology, PCG stated that it excluded costs associated with learning disabilities teacher-consultants because they do not perform any medical services and are not medical providers as customarily recognized in the State's Medicaid program. However, we found that PCG did not remove all learning disabilities teacher-consultant salaries when calculating payment rates.

We calculated the amount of learning disabilities teacher-consultant salaries incorrectly incorporated into the evaluation rate as more than \$61 million. Our calculations are shown in Appendix C.

Rehabilitation Rate Incorporated Costs for Support Services

Under IDEA, services are generally defined as either "special education" or "related services." Medicaid does not cover special education services or non-health-related services.¹⁹

PCG incorporated special education support services of \$75,379,253 in the rehabilitation rate. Specifically, PCG incorporated the DOE account "Other Support Services – Students – Extraordinary Services." DOE defines this account as "the costs of services other than related services provided to students as a result of an IEP that are unique to individual students, such as one-to-one aides." In a description of its accounts, DOE indicated that this account only includes costs for special education services.

Office of Inspector General Calculation of Unallowable Costs

PCG's inclusion of costs based on the use of incorrect activity codes, unpaid pension costs, and unallowable special education costs inflated the payment rates used to claim Federal Medicaid reimbursement. We recalculated the rates by removing these unallowable costs and applied corrected rates to the State's claims for school-based health services to determine the unallowable Federal Medicaid funds claimed. We calculated that the State agency claimed

¹⁹ *Medicaid and School Health: A Technical Assistance Guide*, pages 9 and 12.

unallowable Federal Medicaid funds of \$220,314,119 for the period July 2003 through June 2015. Our calculation of this amount is shown in Appendix D.

Costs Claimed Based on Proposed State Plan Amendment

CMS guidance states that a State may not claim Federal Medicaid reimbursement based on a pending amendment to its Medicaid State plan.²⁰ In 2011, the State agency submitted to CMS a proposed State plan amendment that would allow the State to obtain Federal Medicaid funds for school-based services based on schools' costs through certified public expenditures.²¹ As of April 2017, CMS's decision to approve or deny the proposed State plan amendment was still pending; however, the State agency had claimed \$80,138,811 in Federal Medicaid reimbursement for SFYs 2012 through 2015 based on the proposed State plan amendment.

THE RATES INCORPORATED SOME UNALLOWABLE COSTS THAT CANNOT BE QUANTIFIED

Payment Rates Incorporated Non-Medicaid-Related Costs

PCG used sampled moments from RMTSs from previous years by a prior contractor to determine SEMI costs. However, these previous RMTSs were designed to determine Medicaid administrative costs and therefore included only one activity code for all direct health services (both Medicaid- and non-Medicaid-eligible services). Because PCG included all moments under this single activity code in its payment rate calculation, the rate included non-Medicaid-eligible costs.

In addition, RMTS participants were instructed to code IDEA evaluations as direct health services. Therefore, IDEA evaluation activities that were only educational in nature may have been coded as direct health services, resulting in educational costs being incorporated into the payment rates.

We cannot determine the percentage of time that personnel spent providing direct health services not covered by Medicaid, or whether unallowable educational costs were incorporated into the Medicaid evaluation payment rates. Accordingly, we cannot determine the amount by which the rates are overstated and the resulting unallowable Federal Medicaid funds claimed.

²⁰ State Medicaid Director Letter, "Policy for the Review of State Plan Amendments," Jan. 2, 2001. Available online at <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd010201.pdf>.

²¹ The State agency's proposed amendment was submitted subsequent to a CMS review to determine whether the State could claim Federal Medicaid funds for school-based services if it did not pay schools any State funds toward the provision of Medicaid-eligible services. CMS did not issue a final report related to its review.

Unsupported Random Moment Timestudies

CMS guidance (*Medicaid and School Health: A Technical Assistance Guide* (1997) and *Medicaid School-Based Administrative Claiming Guide* (2003)) require RMTSs to be statistically valid. In addition, rates must be supported by information on how they were derived, such as historical data and RMTSs. Further, State Medicaid agencies must maintain documentation of these payment rates to be made available to CMS on request.

Most Sample Moments Not Considered

PCG discarded most of the sample moments in the RMTSs it used to develop the payment rates. In 2006, PCG used RMTSs conducted by a prior contractor over the last three quarters of SFY 2004 to develop rates that were applied retroactively to 2003. Of the original 7,294 responses, PCG used only 1,575 to develop the rates.²²

When PCG removed sample moments from the original sample, it could have created an invalid and biased sample that produced inaccurate results. PCG's changes to the number of sample moments greatly changed the results of the RMTSs. Whereas the prior contractor's results indicated that personnel spent 16 percent of their time performing direct health services, the results of the RMTSs after PCG discarded most sampled moments indicated that personnel spent 51 percent of their time on direct health services.²³

Sample Moment Documentation Not Maintained

While Federal regulations generally require States to maintain documentation to support claims for 3 years (42 CFR § 433.32(b)), there is no similar requirement for the maintenance of documentation for payment rates. Regulations (42 CFR § 447.203(a)) require States to "maintain documentation of payment rates and make it available to HHS upon request."

However, PCG and the State did not maintain all RMTS documentation—a major component of payment rates. PCG provided RMTS participant response forms related to two of the three quarters of SFY 2004 that it incorporated into the payment rates. Further, the documentation for the two quarters was not complete.

²² For the first of the 3 quarters, PCG used only 182 of the 1,058 responses received from the previous contractor. For the second quarter, PCG used 717 of the 2,315 responses received, and for the third quarter, PCG used 676 of the 2,487 responses received.

²³ PCG's improper alterations to RMTS responses discussed earlier further increased the percentage of time personnel appeared to have spent on direct health services to 62 percent.

Financial Impact of Unsupported Costs on Payment Rates Cannot Be Calculated

To determine whether PCG correctly used the RMTSs and whether its modification of the sample was valid, we would have to review complete RMTS documentation for all 3 quarters of SFY 2004, which the State agency and PCG did not provide. Because the State agency did not provide complete RMTS documentation, we cannot determine whether PCG correctly used the RMTSs or whether its modified sample is valid and unbiased. Therefore, we cannot quantify the impact of the unsupported RMTSs on the payment rates.

CONCLUSION

The State hired PCG, a contingency fee contractor, which developed rates that were based on unallowable and unsupported costs. These rates were significantly higher than those developed by a prior contractor (the rates were increased from \$552 to \$1,451 for evaluation services and from \$21 to \$50 for related services). The State agency then used these rates to claim unallowable and unsupported Federal Medicaid funds.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$300,452,930 in Federal Medicaid reimbursement claimed based on payment rates that incorporated unallowable costs,
- work with CMS to determine the allowable amount of the remaining \$306,233,377 that we have set aside because the rates included unallowable costs that we cannot quantify, and
- revise its payment rates so they comply with Federal requirements.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with our findings and recommendations. The State agency also submitted a memorandum from PCG responding to our draft report findings related to PCG's payment rate calculations. In the memorandum, PCG asserted that its methodology for setting SEMI rates was reasonable, appropriate, and in compliance with the law.

After reviewing the State agency's comments and the PCG memorandum, we maintain that our findings and recommendations are valid. Neither the State agency nor PCG provided additional support for how payment rates for SEMI services were calculated.

The State agency's comments, including PCG's memorandum, are included as Appendix E. We did not include attachments to these documents because of their length.

THE RATES INCORPORATED SOME UNALLOWABLE COSTS THAT CAN BE QUANTIFIED

Payment Rates Incorporated Incorrect Random Moment Timestudy Activity Codes

State Agency Comments

In its memorandum, PCG disagreed with our finding that it incorrectly coded some RMTS responses used to calculate payment rates. PCG asserted that CMS's *Medicaid School-Based Administrative Claiming Guide*²⁴ states that a direct health service code should be used "when providing care, treatment, and/or counseling to an individual," including related administrative activities. Therefore, according to PCG, it properly coded activities provided by Medicaid-allowable practitioners as direct health services, including the examples described in Figure 3 in this report.

PCG also stated that, subsequent to our exit conference with the State agency, it located and provided us with most of the RMTS response forms that substantiate the activity codes that PCG assigned to them.

Office of Inspector General Response

While we agree with PCG's summary of CMS's description of what constitutes direct health services, we disagree with PCG's assumption that every Medicaid-qualified professional who responded to the RMTS was providing direct health services. RMTS participants originally coded their activities as educational, social services, or general administrative, and PCG reclassified a number of these codes to reflect they were providing direct health services. Further, this process resulted in the RMTS responses being counted in the calculation of both the Medicaid administrative costs (as originally coded) and the direct health services costs (as reclassified by PCG).

Our review of the random moments indicated that the participants' original coding was supported by their narrative descriptions. For example, a social worker contacting a parent could be related to a social service—a non-Medicaid-eligible activity that PCG coded as a direct health service. PCG did not provide further documentation to support its assertion that the social worker described in Figure 3 was actually providing a direct health service.

We reviewed the additional information provided after our exit conference and found the documentation to be incomplete or inaccurate. Specifically, thousands of RMTS response forms were not included, the forms provided were disorganized, and the forms were not referenced on the summary worksheets. As a result, tracing original activity codes to those that PCG revised was problematic.

²⁴ See footnote 8.

Payment Rates Incorporated Unpaid Pension Costs

State Agency Comments

In its memorandum, PCG disagreed that the State agency incorporated unpaid pension costs into the payment rates. PCG stated that it reasonably relied on Medicare regulations on cost data (42 CFR § 413.24) when it included accrued pension costs in its computation of the rates. Further, PCG stated that State officials informed PCG that 96 percent of the pension liability was paid prior to PCG's rate-setting activities.

Office of Inspector General Response

Medicare regulations on cost data do not apply to Medicaid rate-setting methodologies. We note that PCG stated in its rate analysis that it followed OMB Circular A-87, not Medicare regulations. As described in our findings, OMB Circular A-87 states that accrued pension costs are allowable if they are funded within 6 months after the end of the fiscal year. Further, per Medicare regulations, accrued pension costs would be unallowable unless they were paid within 1 year.²⁵ Finally, neither the State agency nor PCG provided evidence that any of the accrued pension costs detailed in our findings have been paid.

Evaluation Rate Incorporated Learning Disabilities Teacher-Consultant Salaries

State Agency Comments

In its memorandum, PCG disagreed with our finding that it incorporated learning disabilities teacher-consultant salaries in the evaluation rate. Although PCG agreed that these salaries should be excluded from the rate, it asserted that its method for extracting the salaries was reasonable. Specifically, PCG stated that it calculated an allocation rate based on the total amount of school-based salaries in the evaluation account compared to the total amount of salaries in both the evaluation and instructional accounts. According to PCG, it then applied the allocation to a salary cost pool.

Office of Inspector General Response

According to our analysis, PCG's description does not accurately reflect how it extracted the salaries. As we describe in detail in Appendix C, PCG's method included at least \$61 million of unallowable teacher-consultant costs in the rates. Therefore, we do not agree with PCG's assertion that its method for extracting learning disabilities teacher-consultant salaries was reasonable.

²⁵ 42 CFR § 413.100(c)(2) (2005). (This edition of the CFR was in effect when PCG calculated the rates.)

Rehabilitation Rate Incorporated Costs for Support Services

State Agency Comments

In its memorandum, PCG disagreed with our finding that it incorporated costs for personnel who do not perform Medicaid-covered health services in the rehabilitation rate. PCG stated that it included costs charged to the DOE account detailed in our finding because it is consistent with the methodology used by the previous vendor and approved by CMS. PCG stated that DOE includes the costs of additional rehabilitation services in this account that are unique to individual students, such as audiology, psychological counseling, and psychotherapy. As these are health-related services, PCG asserted that it was proper for them to be included in the rehabilitation rate.

Office of Inspector General Response

Neither the State agency nor PCG provided documentation to support the assertions that PCG made in its memorandum. The State only provided PCG's unsupported statement to refute DOE's descriptions of its accounting classifications. Further, PCG provided no support for its assertion that the audiology, psychological counseling, and psychotherapy services that it cited as examples would be included in the account in question rather than in DOE's related services account.²⁶ In addition, PCG and the State agency have provided no evidence that CMS approved a prior contractor's rate-setting method. Therefore, we maintain that these costs should not be included in the rate.

Costs Claimed Based on Proposed State Plan Amendment

State Agency Comments

In its comments, the State agency asserted that a disallowance of Federal Medicaid reimbursement based on the unapproved State plan amendment is not warranted. According to the State agency, it will be entitled to claim Federal Medicaid funds retroactive to July 1, 2011, once CMS approves the proposed State plan amendment.

Office of Inspector General Response

As described in the report, CMS guidance states that Federal reimbursement is not allowable for costs claimed on the basis of a pending State plan amendment. (See page 10.) In a State Medicaid Director Letter dated January 2, 2001, CMS stated that it will not provide Federal Financial Participation for any State plan amendment until the amendment is approved. CMS

²⁶ According to DOE, related services "such as speech therapy, occupational therapy, physical therapy, and additional counseling" would be recorded in the DOE account "Other Support Services – Students – Related Services." Counseling of students and parents provided by guidance counselors would be recorded in a separate DOE account ("Other Support Services – Students – Regular").

explained that this would prevent it from advancing funds on pending amendments that may be subsequently disapproved. Therefore, Federal reimbursement claimed on the basis of a pending State plan amendment is unallowable.

PAYMENT RATES INCORPORATED SOME UNALLOWABLE COSTS THAT CANNOT BE QUANTIFIED

Payment Rates Incorporated Non-Medicaid-Related Costs

State Agency Comments

In its memorandum, PCG disagreed with our finding that it incorporated non-Medicaid-related costs in its payment rate calculation. PCG stated that it was reasonable for it to use an RMTS designed to identify Medicaid administrative costs because (1) it was the most accurate and current data available at the time, (2) it met CMS's statistical validity requirements, and (3) utilizing an existing RMTS was more efficient and less disruptive for school staff and providers than developing a new RMTS.

PCG asserted that, per CMS's *Medicaid School-Based Administrative Claiming Guide*, it used a single code for all direct health services. PCG contended that differentiating between Medicaid- and non-Medicaid-reimbursable services is irrelevant to the determination of rates. In addition, PCG stated that medical professionals correctly coded their evaluations as Medicaid evaluations.

Office of Inspector General Response

The State agency was not required to use an RMTS to set the SEMI rates. Because it opted to use this method, however, it was required to use a valid RMTS. PCG used an RMTS that was designed to calculate an allocation of costs among categories included in its design. SEMI costs were not among those categories. Nevertheless, PCG used the RMTS to allocate costs among the SEMI and other programs despite the inability to properly account for non-Medicaid-reimbursable activities.

We disagree with PCG's assertion that including non-Medicaid-reimbursable activities in the direct health services activity code is irrelevant to the determination of rates. PCG's rate was calculated by dividing the total cost by PCG's estimate of the number of evaluations and rehabilitation services provided to special education students. Including non-Medicaid-reimbursable health services in the total cost allocated to those services increases these rates.

Finally, PCG's assertion that medical professionals correctly coded their evaluations as Medicaid evaluations is not supported. The basis of PCG's evaluation rate calculation was the child-study-team account. Some of the professionals on the child-study team perform both Medicaid and IDEA (non-Medicaid-reimbursable) evaluations. The RMTS was not designed to allocate costs to the SEMI program and consequently did not distinguish between these two types of

evaluations. Therefore, educational IDEA evaluations may have been coded as direct health services, resulting in non-Medicaid-reimbursable education costs being incorporated into the payment rates.

Unsupported Random Moment Timestudies

State Agency Comments

In its memorandum, PCG asserted that it was unfair to state that it had discarded most sample moments in the RMTS or to suggest that doing so could have created an invalid and biased sample. PCG stated that it deliberately excluded RMTS responses for participants who did not provide direct health services. PCG argued that the number of responses it used was sufficiently large for the modified sample to be statistically valid. PCG also contended that we could have checked whether PCG removed responses in an unbiased manner because it provided us with all of the timestudy data for two of the three RMTS quarters. PCG stated that it has no reason to believe that data for the third quarter would be different from the two quarters that it provided.

Office of Inspector General Response

We agree that the costs of personnel who did not provide direct health services should not have been included in the payment rates. However, it was potentially unreasonable for PCG to use the RMTS to identify SEMI costs when it had to remove most random moments to focus on direct health services. Moreover, PCG did not provide support for the removals despite the substantial impact on the determination of rates. The documents that PCG provided for the two RMTS quarters were incomplete and inadequate and raise concerns about whether PCG correctly summarized and used the prior contractor's sample documents. We determined that thousands of documents were missing from the two quarters and that some participants' job titles were not sufficiently detailed to correctly identify them as someone who did or did not provide direct health services. We also found many anomalies in the documents, such as signatures dated prior to the sampled moment. Finally, PCG's activity code worksheet totals did not agree with the activity code schedules that it used in the rate-setting document.

In reference to the impact on the sample size, PCG claims that the remaining number of moments for the three RMTS quarters more than satisfied the required level of statistical validity. However, after PCG modified the RMTS, one RMTS quarter was left with 182 (8 percent) of the original 2,492 moments sampled, well below the minimum 385 moments that, in its memorandum, PCG stated is required for a sample to be statistically valid.

COMPLIANCE WITH FEDERAL REQUIREMENTS

Federal Requirements for Calculating the Payment Rates

State Agency Comments

The State agency disagreed with our finding that it was not in compliance with Federal requirements for calculating the payment rates. Specifically, the State agency stated that Federal regulations provide broad flexibility to establish payment rates and that States must assure that payments for Medicaid services are consistent with efficiency, economy, and quality-of-care. The State agency contended that its rates did not have to be cost-based. Rather, according to the State agency, it could be reimbursed on a fee-for-service basis. The State agency stated that, prior to late 2011, its Medicaid State plan did not address how fee-for-service rates would be calculated. Therefore, the State agency asserts, our argument that PCG's rate-setting did not accurately capture costs in 2004 is irrelevant. Finally, the State agency argued that the rates based on current costs under the proposed State plan amendment are higher than the amount claimed based on the fee-for-service rates.

Office of Inspector General Response

We agree that the Federal requirement governing payment rates is broad. The State agency is required to support that its payment rates are consistent with efficiency, economy, and quality-of-care. However, contrary to this requirement, the State agency included unallowable Medicaid costs in the rate-setting methodology. We also agree that the Medicaid State plan provision regarding payment rates for school-based services generally refers only to "fees" and does not explicitly state that these services would be based on costs. However, the Medicaid State plan should include the method used to set payment rates.²⁷ Also, supporting documentation submitted by the State agency to CMS for its review of the proposed State plan provision provides evidence that CMS and the State agency understood that payments would be based on costs.²⁸

In our calculation of the disallowance, we used the same methodology that the State agency used in setting the rates by removing the elements that were not related to providing school-based services.

²⁷ 42 CFR § 447.201(b).

²⁸ According to the supporting documentation, the State agency stated that the rates are "reasonably related to the cost of providing the covered services." Further, the documentation states that each fee for rehabilitative services "represents a daily bundled rate, including both direct and indirect costs." Regarding the evaluation rate, the documentation states that "a single, separate fee for evaluation has been established based on the reasonable cost of providing the services." In addition, the State agency identified several categories of costs included in the rates, such as salaries and benefits.

We note that the State agency's position regarding its rate-setting methodology is contrary to the recommendation of its own Medicaid recovery audit contractor (RAC). In 2013, the RAC recommended that the State agency reduce its rates based on a prior OIG audit finding that unallowable costs were included in the rate calculation. However, the State agency did not implement the RAC's recommendation and continued to use the increased rates developed by PCG.

Finally, we maintain that the calculation of costs under the proposed State plan amendment is not relevant because CMS has not approved the State agency's proposal, and PCG's cost calculation under the proposed methodology has not been audited.

Federal Requirements for Retaining Documentation for Payment Rates

State Agency Comments

The State agency disagreed with our determination that it did not comply with Federal requirements for retaining documentation for payment rates. The State agency acknowledges that its failure to maintain documentation was not the basis of our recommended disallowance. Nevertheless, the State agency disagreed with our interpretation of Federal law and our finding that the rates were not supported.

According to the State agency, 42 CFR § 447.203(a) does not require it to "maintain all documentation relating to its rate-setting methodology indefinitely, even after the State ceases to use the rate set by that methodology." Rather, the State agency asserts that the regulation requires only that a State maintain documentation of what rates were actually paid to providers—not how it developed the rates. The State agency also asserted that its obligations to comply with the regulation expired in 2012, when it ceased using rates developed based on an RMTS from 2003–2004. Finally, the State agency contends that it failed to provide the documents for only one RMTS quarter.

Office of Inspector General Response

The State agency did not adequately support its payment rates and the allowability of Federal Medicaid funds claimed based on those rates. In its comments, the State agency incorrectly stated that it ceased to use the rates based on an older RMTS and, thus, was not required to maintain any documentation to support these rates. Although the State agency submitted a proposed State plan amendment to revise its methodology, the amendment, as discussed throughout the report, has not been approved by CMS, and the State agency continues to claim Federal reimbursement based on the rates reviewed in this audit.²⁹

²⁹ The State agency also was required to maintain the documentation supporting its rates because it has not resolved our prior audit's recommendations with CMS. See 42 CFR § 433.32.

The State agency's argument that 42 CFR § 447.203(a) only requires a State to maintain documentation of what rates were actually paid to providers—not how the rates were developed—is not consistent with the purpose of the regulation. The section setting forth the basis and purpose of 42 CFR part 447, subpart B, states, “[t]his subpart prescribes State plan requirements for setting payment rates to implement, in part, section 1902(a)(30) of the [Social Security] Act” (emphasis added).³⁰ Further, the Departmental Appeals Board (DAB) has indicated that 42 CFR § 447.203(a) requires a State to demonstrate that payment rates supporting claims are consistent with its Medicaid State plan.³¹ During our audit period, on an annual basis, the State agency inflated rates developed for 2004. Therefore, it should maintain documentation to support the original payment rates.

³⁰ 42 CFR § 447.200.

³¹ See Maine Dept. of Health & Human Services, DAB No. 2292 (Dec. 24, 2009).

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>North Carolina Claimed Millions in Unallowable School-Based Medicaid Administrative Costs</i>	<u>A-04-15-00101</u>	10/6/2016
<i>Michigan Improperly Received Medicaid Reimbursement for School-Based Health Services</i>	<u>A-05-13-00056</u>	9/30/2016
<i>Alabama Claimed Millions in Unallowable School-Based Medicaid Administrative Costs</i>	<u>A-04-13-00094</u>	7/13/2016
<i>Massachusetts Generally Complied With Medicaid Requirements When Claiming Reimbursement for School-Based Health Services</i>	<u>A-01-14-00003</u>	9/30/2015
<i>Kansas Improperly Received Medicaid Reimbursement for Medicaid School-Based Health Services</i>	<u>A-07-13-04207</u>	8/6/2014
<i>Maine Improperly Claimed Medicaid Payments for School-Based Health Services Submitted by Portland School Department</i>	<u>A-01-11-00011</u>	4/29/2013
<i>Arizona Improperly Claimed Federal Reimbursement for Medicaid School-Based Administrative Costs</i>	<u>A-09-11-02020</u>	1/22/2013
<i>New Hampshire Did Not Always Correctly Claim Medicaid Payments for School-Based Transportation Services</i>	<u>A-01-11-00008</u>	10/10/2012
<i>Review of Kansas Medicaid Payments for the School District Administrative Claiming Program during the Period April 1, 2006, Through March 31, 2009</i>	<u>A-07-10-04168</u>	10/6/2012
<i>Review of Colorado Direct Medical Service and Specialized Transportation Costs for the Medicaid School Health Services Program for State Fiscal Year 2008</i>	<u>A-07-11-04185</u>	4/3/2012
<i>Review of Medicaid Reimbursement Rates for School-Based Services in West Virginia</i>	<u>A-03-05-00203</u>	4/21/2011

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered \$526,547,496 in Federal Medicaid reimbursement that the State agency claimed using its school-based evaluation and rehabilitation rates and \$80,138,811 that the State agency claimed under an unapproved State plan amendment. This amount, totaling \$606,686,307, was for services provided from July 2003 through June 2015.

Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Medicaid Management Information System (MMIS) file for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the MMIS data to the State's claim for reimbursement on the Quarterly Medicaid Statement of Expenditures (Form CMS-64).

During our audit, we did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective.

We performed fieldwork at the State agency's and DOE's offices in Trenton, New Jersey, and at CMS's office in Ewing, New Jersey, from June 2015 through June 2016.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with officials from the State agency, DOE, Treasury, and PCG to gain an understanding of the rate-setting methodology and support;
- obtained electronic files from the State agency's MMIS listing the claims for evaluation and rehabilitation services from July 1, 2003, through June 30, 2015;
- reconciled the school-based services claimed for Federal reimbursement by the State agency on Form CMS-64 for our audit period with the data obtained from the MMIS files to establish reasonable assurance of authenticity and accuracy;
- obtained and reviewed documents from the State agency and PCG that PCG used to develop the rates;
- reviewed OIG and CMS documents related to the following OIG audits:

- *Review of New Jersey’s Medicaid School-Based Rates (A-02-04-01017)*, issued February 8, 2008;
- *Review of New Jersey’s Medicaid School-Based Claims Submitted by Maximus, Inc. (A-02-07-01051)*, issued April 23, 2010; and
- *Review of New Jersey’s Medicaid School-Based Claims Submitted by Public Consulting Group, Inc. (A-02-07-01052)*, issued September 15, 2010;³²
- discussed with CMS officials and reviewed CMS files related to:
 - the CMS Financial Management review of New Jersey school-based services, dated April 5, 2010, and
 - the State agency’s proposed State plan amendment (No. 11-13) for SEMI services, dated September 30, 2011;
- discussed with CMS officials the State agency’s methodology and support for its rates;
- calculated the minimum unallowable costs included in the State agency’s school-based rates and the amount claimed under the proposed State plan amendment, and calculated the minimum effect on the evaluation and rehabilitation rates and Federal Medicaid reimbursement paid to the State agency; 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.

³² We reduced our recommended disallowance in this report to account for the disallowances taken in our audits issued in 2010 (A-02-07-01051 and A-02-07-01052).

**APPENDIX C: OFFICE OF INSPECTOR GENERAL ANALYSIS OF LEARNING DISABILITIES
TEACHER-CONSULTANT SALARIES INCORPORATED INTO EVALUATION RATE**

To determine whether learning disabilities teacher-consultant salaries were completely removed from the child-study-team account, we first calculated the total paid salaries of child-study-team members: psychologists, social workers, and learning disabilities teacher-consultants. As described by DOE, the total salaries (\$315,311,601) were allocated to child-study-team and non-child-study-team accounts. On the basis of DOE’s calculations, we determined that the maximum amount of learning disabilities teacher-consultant salaries allocated to non-child-study-team activities was \$14,570,627,³³ meaning that there was at least \$84,258,969 in learning disabilities teacher-consultant salaries remaining in the child-study-team account. However, PCG removed only \$22,730,807 of this amount from the account when it determined the evaluation rate. Therefore, at least \$61,528,162 in learning disabilities teacher-consultant salaries were improperly incorporated into the evaluation rate. (See calculation below.)

Child-study-team salaries calculated by DOE before allocation:

Psychologists	\$93,787,045
Social workers	122,694,960
Learning disabilities teacher-consultants	<u>98,829,596</u>
Total child-study-team salaries before allocation	\$315,311,601
Less: child-study-team account ³⁴ balance	<u>300,740,974</u>
Salaries allocated to non-child-study-team accounts ³⁵	<u>\$14,570,627</u>

Learning disabilities teacher-consultants salaries	\$98,829,596
Less: Salaries allocated to non-child-study-team accounts	<u>14,570,627</u>
Minimum teacher-consultants salaries in child-study-team account	\$84,258,969
Less: Amount removed by PCG	<u>22,730,807</u>
Minimum teacher-consultants salaries used in evaluation rate	<u>\$61,528,162</u>

³³ This calculation made the conservative assumption that no psychologists’ or social workers’ salaries were allocated to non-child-study-team activities.

³⁴ The DOE account named “Other Support Services – Students – Special” is used to record the costs associated with the services provided by child-study-team members.

³⁵ Child-study-team members may also provide the services resulting from an IEP, which would be recorded in the account “Other Support Services – Students – Related Services.” Also, child-study-team members may provide services to nonclassified pupils and regular instruction staff to prevent or remediate learning problems, which would be recorded in the account “Other Support Services – Students – Regular.”

APPENDIX D: CALCULATION OF UNALLOWABLE AMOUNT

The following calculations demonstrate the impact of the incorrect (1) allocation of unpaid pension costs, (2) reassignment of RMTS activity codes when calculating the percentage of time performing SEMI services, (3) incorporation of teacher-consultant salaries in the evaluation rate, and (4) incorporation of extraordinary services in the rehabilitation rate. Unpaid pension costs are captured in the fringe benefits and support and general indirect costs accounts.

Evaluation Rate	PCG	OIG
Other support services – students – special	\$300,740,974	\$300,740,974
Less: minimum teacher-consultant salaries in account	<u>(22,730,807)</u>	<u>(84,258,969)</u>
Total psychologist and social worker salaries in account	\$278,010,167	\$ 216,482,005
Purchased SEMI evaluation services	\$15,053,298	\$15,053,298
Support and general indirect costs	173,867,655	149,591,375
Fringe benefits	<u>106,036,831</u>	<u>74,175,501</u>
Total costs	\$572,967,951	\$455,302,179
Percentage of time performing SEMI services ³⁶	73.78	56.66
Total claimable costs	\$422,735,754	\$257,989,240
Divided by number of evaluations and re-evaluations	<u>÷ 291,330</u>	<u>÷ 291,330</u>
Base Rate per Evaluation	<u>\$1,451.05</u>	<u>\$885.56</u>
Rehabilitation Rate	PCG	OIG
Other support services – students – related services	\$161,415,987	\$161,415,987
Other support services – students – extraordinary services	<u>75,379,253</u>	<u>–</u>
Total rehabilitation salaries	\$236,795,240	\$161,415,987
Support and general indirect costs – related services	\$48,217,252	\$48,217,252
Support and general indirect costs – extraordinary services	20,923,203	–
Fringe benefits – related services	40,854,963	35,446,789
Fringe benefits – extraordinary services	<u>17,725,355</u>	<u>–</u>
Total costs	\$364,516,012	\$245,080,028
Percentage of time performing SEMI services ³⁷	73.78	56.66
Total claimable costs	\$268,939,914	\$138,870,431
Divided by number of service-days	<u>÷ 154,557</u>	<u>÷ 154,557</u>
Base Rate per Rehabilitation	<u>\$ 50.28</u>	<u>\$ 25.96</u>

³⁶ Total of the direct health and pro rata share of the general administration activity codes.

³⁷ See footnote 36.

Base Rates Comparison	PCG	OIG	OIG as % of PCG Rate
Evaluation rate	\$1,451.05	\$885.56	61.03%
Rehabilitation rate	\$50.28	\$25.96	51.63%

Calculation of Unallowable Federal Share	PCG Rates Federal Share	OIG Rates Federal Share	Unallowable Federal Share
Evaluation	\$309,447,897		
Less: Disallowance from prior audit #1	2,986,169		
Disallowance from prior audit #2	<u>3,079,719</u>		
Total after prior audit Disallowances	\$303,382,009	\$185,150,734 ³⁸	\$118,231,275
Rehabilitation	\$217,099,599		
Less: Disallowance from prior audit #1	3,788,734		
Disallowance from prior audit #2	<u>2,261,301</u>		
Total after prior audit disallowances	\$211,049,564	\$108,966,720 ³⁹	<u>\$102,082,844</u>
Rates unallowable Federal share			<u>\$220,314,119</u>
Unapproved State plan amendment Federal share			\$80,138,811 ⁴⁰
Total Unallowable Federal Share			<u>\$300,452,930</u>

³⁸ \$303,382,009 times 61.03 percent. Figures are not an exact match because of rounding.

³⁹ \$211,049,564 times 51.63 percent. Figures are not an exact match because of rounding.

⁴⁰ See discussion on page 10 regarding the State agency's claims under the unapproved State plan amendment.

APPENDIX E: STATE AGENCY COMMENTS



CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
PO Box 700
TRENTON NJ 08625-0700

July 14, 2017

ELIZABETH CONNOLLY
Acting Commissioner

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

RE: *OIG Draft Report No. A-02-15-01010*

Dear Ms. Tierney:

We write in response to the draft audit report, *New Jersey Claimed Hundreds of Millions in Unallowable or Unsupported Medicaid School-Based Reimbursement, A-02-15-01010* ("Draft Report"), which reviews New Jersey's Special Education Medicaid Initiative ("SEMI") program, through which the State claims federal financial participation ("FFP") in rehabilitation and evaluation services delivered in schools.

The state contests the Draft Report's findings and recommendations for the following reasons: The SEMI rates before 2012 were fully consistent with the state plan, which did not require cost-based reimbursement for evaluation and rehabilitation. In fact, before 2012, the State claimed FFP based on rates that were below the school districts' costs. Starting in 2012, the State claimed FFP based on a state plan amendment ("SPA") that the Centers for Medicare & Medicaid Services ("CMS") has yet to approve, despite its submission six years ago. Disallowing these costs before CMS has made a final decision on the SPA is premature.

1. From 2005 to 2012, New Jersey's SEMI Rates Were Fully Compliant with the State Plan and Applicable Federal Law.

The Medicaid statute and CMS regulations make clear that States are responsible for setting payment rates for Medicaid providers. 42 C.F.R. § 447.200. "States have broad flexibility under the [Medicaid] Act . . . to set the methods for establishing provider payment rates." 76 Fed. Reg. 26,342, 26,343 (May 6, 2011). The only substantive limitation in federal law on a State's ability to set payments rates is found in Section 1902(a)(30)(A) of the Social Security Act ("SSA"), which provides that States must "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

Ms. Brenda M. Tierney
 July 14, 2017
 Page 2

The New Jersey state plan authorizes the State to provide school-based rehabilitative services and evaluation through the SEMI program. Add. to Att. 3.1-A, p. 13(d).1. During the audit period, the state plan provision governing reimbursement for school-based rehabilitation and evaluation services provided for reimbursement on a “fee-for-service” basis:

Reimbursement for School-Based Rehabilitative Services will be fee-for-service. The evaluation services will be reimbursed by means of one fee, and the rehabilitative services will be reimbursed through a separate fee. . . .

Att. 4.19B, p. 22a (attached as Exh. 1). The state plan did not provide that SEMI program reimbursement would be equal to the school districts' costs.

The Draft Report does not even mention the state plan provision. To the contrary, it appears that the auditors may have been unaware of it, as the Draft Report suggests that the rates were required to be cost-based. For example, the Draft Report criticizes features of the random moment sampling and alleges that inappropriate costs were included in the pool that the Public Consulting Group (“PCG”) used to create the rates. But the state plan, prior to late 2011, did not require that the rates reimburse costs; rather, it simply called for “fee-for-service” reimbursement, without addressing how those fee-for-service rates would be calculated. While PCG came up with reasonable fee-for-service rates in part by reviewing costs in state fiscal year 2004, and thus the rates had some relation to costs in 2004, the rates were not cost-based rates subject to the requirements governing cost-based reimbursement.

Given that the rates were not required to be cost-based, the OIG's argument that PCG's rate-setting did not accurately capture costs in 2004 is irrelevant. In addition, the attached memorandum from PCG explains why its cost calculations were reasonable and appropriate.

We acknowledge that the State's fee-for-service SEMI rates had to comply with Section 1902(a)(30)(A), *i.e.*, among other things, they had to be “consistent with efficiency, economy, and quality of care.” The Draft Report does not assert that the rates paid before 2012 violate Section 1902(a)(30)(A). Indeed, the cost reconciliation process that the State has used pursuant to the September 2011 SPA has confirmed that PCG's methodology yielded rates that were “consistent with efficiency, economy, and quality of care.” Specifically, this cost reconciliation has confirmed that PCG's rates did not result in reimbursement in excess of costs: rather, reimbursing the school districts for costs pursuant to the September 2011 SPA results in payments to school districts that are greater than the state plan rates developed by PCG:

FY12 - FY15 Cost Settlement Comparison			
Year	School Districts' Medicaid Allowable Costs for SEMI program	Medicaid SEMI Claims Paid at Interim Rate (i.e., paid at pre-2012 methodology rates)	Cost Settlement (FFP)
FY12	\$154,670,309.53	\$109,620,649.73	\$21,563,353.26
FY13	\$184,216,232.58	\$128,233,483.72	\$26,971,302.24
FY14	\$184,492,499.70	\$129,388,335.80	\$27,049,770.74
FY15	\$163,170,106.07	\$154,061,338.42	\$4,554,383.83

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The Draft Report fails to address the fact that the pre-2012 rates were actually below costs.

In sum, while the auditors criticized the methodology by which the rates were calculated, that criticism incorrectly assumes the rates were required to be based on costs, and the Draft Report does not allege that the rates violate any other provision of state or federal law or policy. Furthermore, the Draft Report ignores the evidence showing that the pre-2012 rates resulted in reimbursement below cost.

2. The State's Document Retention Was Consistent with Federal Law and Policy.

The Draft Report asserts that the State failed to comply with federal law and/or policy by failing to maintain the random moment sample forms associated with one of the sampled quarters.

The State disagrees with the OIG's interpretation of federal law.¹ The State was not required to retain and produce documentation supporting its rate-setting a full decade after the rates were developed.

The Draft Report acknowledges that, "[w]hile Federal regulations generally require States to maintain documentation to support claims for 3 years (42 C.F.R. § 433.32(b)), there is no similar time requirement for the maintenance of documentation for payment rates." However, the Draft Report seems to suggest that 42 C.F.R. § 447.203(a) requires the State to maintain all documentation relating to its rate-setting methodology indefinitely, even after the State ceases to use the rate set by that methodology. That suggestion reflects a misreading of Section 447.203(a), which provides in full "[t]he agency must maintain documentation of payment rates and make it available to HHS upon request." "Documentation of payment rates" in this provision does not mean "documentation establishing that the rates were determined in a statistically valid manner," but rather means documentation of what rates were actually paid to providers. Furthermore, Section 447.203(a) cannot reasonably be read to require States to indefinitely maintain such documentation. At the very latest, the State's Section 447.203(a) obligations expired in 2012, when the State stopped using the rates developed based on the 2003-04 random moment sampling.

3. A Disallowance of Claims Submitted Pursuant to SPA 11-13 Is Not Warranted.

In September 2011, the State submitted a SPA to CMS to transition from a fee-for-service system to a cost-based methodology for the SEMI program, with an effective date of July 1, 2011. Under the new SPA: the State pays the school districts an interim rate equal to the pre-existing rates developed by PCG; after the year has concluded, the school district certifies its costs for Medicaid rehabilitation and evaluation; and, once the State has the school district's certified costs, the State reconciles those costs to the amount paid pursuant to the interim rates, and pays the school district the difference. See SPA TN No. 11-13 (Exh. 2) (redlines reflect changes made to original submission at CMS's request).

The State submitted the SPA over six years ago and has diligently pursued approval ever since. Between December 2011 and May 2016, the State responded to no fewer than *seven* sets of

¹ Although the Draft Report does not use this alleged noncompliance as a basis for the disallowance, the State nevertheless would like to register its disagreement with these findings.

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questions from CMS. In addition, the State has made a number of changes to SPA 11-13 in response to CMS comments.

In April 2012, CMS asked the State to take SPA 11-13 "off-the-clock", which tolls the 90-day timeline CMS otherwise would have to review SPAs under 42 C.F.R. § 430.16. On November 26, 2014, CMS informed New Jersey by email that it would review SPA 11-13 after it completed its review of a school-based claiming SPA submitted by New York. New York's SPA was approved in December 2014, but New Jersey is still waiting on a decision on SPA 11-13.

Once SPA 11-13 is approved, it will be effective back to July 1, 2011, and all claims submitted since then (that are in compliance with the SPA) will be entitled to FFP. The State cannot control how long CMS needs to review a SPA, and it should not face a disallowance as it works cooperatively with CMS on approval. A final decision on the permissibility of claims made pursuant to SPA 11-13 cannot be made until CMS makes its final determination on SPA 11-13.

* * * * *

For the foregoing reasons, the OIG should not finalize its draft disallowance recommendation.

If you have any questions, please contact me or Richard Hurd at 609-588-2550.

Sincerely,



Elizabeth Connolly
Acting Commissioner

EC:02
Enclosures



MEMORANDUM

TO: Meghan Davey, Director DMAHS
FROM: Bryan Hawkom, PCG
RE: OIG Draft Report No. A-02-15-01010
DATE: July 12, 2017

You have asked Public Consulting Group (PCG) to respond to the above-referenced draft report of the Office of Inspector General (OIG) regarding the rates set for the State of New Jersey Special Education Medicaid Initiative (SEMI) program (Draft Report). Specifically, you have asked us to explain why PCG believes that its methodology for setting SEMI rates was reasonable, appropriate, and in compliance with the law. We understand that you will be sharing this response with the OIG.

Thank you for this opportunity. We believe it is important to set the record straight on the many erroneous statements and findings in the Draft Report. Leading into and during the September 16, 2015 audit entrance conference and through the August 9, 2016 audit exit conference, the OIG indicated that it had come into the audit with the belief that the reimbursement rates were too high, given that the State had increased the rates after they had been lowered in 2002 following an audit of the prior vendor. It appears from the Draft Report that the audit was performed to support this erroneous premise rather than as an objective review of the facts.

Since 2012, the CMS cost reconciliation process has convincingly demonstrated New Jersey rates established by PCG and approved by the state Medicaid agency are not set too high as claimed by OIG – *the interim billing rates actually are too low when using CMS's own cost settlement methodologies*. This cost settlement process has been the CMS preferred settlement method for the past several years, and the State willingly subscribed to this practice with its 2011 State Plan Amendment. Nothing in the OIG Draft Report acknowledges or contests these facts, or the data reflected in the chart below. The chart shows how the rates generated claims that consistently understated the actual costs for the services.¹

<u>State FY</u>	<u>Medicaid Interim Claims</u>	<u>Total Computable Expenditures</u>	<u>Cost Settlement (Gross)</u>	<u>Cost Settlement - Fed. Fin. Participation ("FFP")</u>
2011 – 2012	\$ 109,620,650	\$ 152,747,356	\$ 43,126,706	\$ 21,563,353

¹ Chart of Cost Settlement Claims Processed and Paid. This chart shows the state fiscal year, the total amount of claims submitted using the rates calculated in 2005, actual allowable costs per cost reconciliation, the resulting settlement amount processed and claimed by the State, and the final cost settlement paid by CMS. Due to the natural lag in the process of retroactive cost settlement claims, the figures for State Fiscal Years 2015-2016 and 2016-2017 have not yet been reviewed and paid by CMS.

2012 – 2013	\$ 128,233,484	\$ 182,176,088	\$ 53,942,604	\$ 26,971,302
2013 – 2014	\$ 129,388,336	\$ 183,582,989	\$ 54,194,653	\$ 27,097,326
2014 – 2015	\$ 154,061,338	\$ 163,170,107	\$ 9,108,769	\$ 4,554,384

In several places, the OIG Draft Report notes that PCG is a contingency fee contractor, with the unstated implication that this status affected the level of the rates that PCG developed. But PCG simply responded according to New Jersey’s Request for Proposals (RFP) for this work. In fact, through contract extensions and RFP processes since the initial RFP, PCG has offered an alternative fixed-fee arrangement, but the State has chosen to continue with contingent-fee compensation. A contingent-fee compensation model is used by many state Medicaid agencies for this type of work, as well as by the federal government, including CMS itself for its Medicaid and Medicare Recovery Audit Contractors (RACs). The RAC auditors, who service specific regions of the country, contracted with CMS during the period of this audit and receive fees of 9%-12.5% for every claim they deny. Putting aside the substantial contingency-fee compensation allowed by CMS for its own RAC auditors, the payment structure for PCG’s services is ultimately not relevant.

Regardless of the compensation methodology, PCG’s approach was conservative. The fact that it received a percentage of the collections did not result in improper rate-setting or claiming. Indeed, PCG and the State took positions that likely resulted in districts not submitting millions of dollars in potential claims. For example, if PCG cannot make a Medicaid “match” for a child, no claims are submitted by PCG for services provided to that child. Similar checks have been in place with respect to parental consent, staff certifications, and other compliance related measures implemented by PCG to help reinforce a culture of compliance across the State.

The graphics in Figure 1 and Figure 2 of the OIG Draft Report, and their surrounding text, likewise unfairly characterize PCG’s role and its fee. PCG was paid a 5% contingency fee by the State in return for performing a wide array of services on behalf of the 300+ school districts that provide health services to special education students and submit thousands of claims each month for Medicaid reimbursement. School personnel are not equipped to perform this work on their own. The services that PCG provides are delivered under the supervision of a group of state agencies and routinely reviewed by the SEMI Work Group comprised of Treasury, Department of Education, Medicaid, and other State personnel. The SEMI Work Group meets monthly to review PCG’s work, make recommendations, and determine policy and procedural changes that PCG then implements. OIG auditors were provided copies of each of the monthly status reports and agendas for these meetings. Working together, these agencies and PCG have implemented an efficient, compliant program that provides significant levels of consistent training, support, guidance, and communication to over 350 local agencies. See Attachment A for more information about the governance structure of the program.

Furthermore, PCG does not “budget” each district’s SEMI revenue, as the Draft Report also asserts. Rather, PCG helps the State carry out state policy, codified in the Fiscal Accountability, Efficiency, and Budgetary Procedures section of the New Jersey Administrative Code (N.J.A.C.), specifically Section 6A:23A-5.3: Failure to Maximize Special Education Medicaid

Initiative (SEMI). Pursuant to its contract, PCG analyzes prior claims and compliance data to prepare draft budget projections for the Department of Education for every school district and agency that participates in the program. The draft projections are reviewed with and approved by the SEMI Work Group and formally communicated to participating districts by the New Jersey Department of Education. School districts have full visibility of the process, as well as appeal rights, and to our knowledge no school district has ever been penalized or lost state funding as a result of not meeting its budgeted reimbursement estimate.²

PCG strongly disagrees with the OIG assertion that the reimbursement rates are set too high, and that our time study process and included costs did not follow federal guidance. And we strongly disagree with any suggestion that there was anything improper in the rate-setting process.

PCG’s methodology for setting SEMI rates for the State of New Jersey was reasonable, appropriate, and in compliance with the law.

Background

PCG has assisted thousands of school districts and tens of thousands of schools across the nation to design, develop, implement, and manage school-based Medicaid programs for the past 25 years. These billing and reimbursement programs have been important vehicles to pay for school nurses and physical, speech, and occupational therapists, as well as for school-based evaluations and treatments for students from low-income families. Although Medicaid spending on school-based health related services represents less than 1% (one percent) of all federal Medicaid expenses, these funds represent deeply needed resources for thousands of the poorest children in our nation’s schools.

Over the years, federal Medicaid program requirements have been made increasingly complex and burdensome for schools providing these services, while CMS has been unable to respond promptly to state plan amendment requests. Schools and state agencies are confronted with myriad labor- and technology-intensive requirements that they are not equipped to perform on their own. They have relied on PCG to address and remain compliant with these requirements. PCG offers expertise in areas such as cost accounting, rate setting, service tracking, random time moment sampling (RMTS), teacher and specialist training, and claiming systems.

The State of New Jersey has contracted with PCG to perform certain tasks for its statewide school-based Medicaid program since January 2005. PCG has performed these tasks in a conscientious, professional, and transparent manner, consistent with the requirements of its contract and with state and federal law. An outline of current roles and responsibilities of State agencies and PCG with respect to the program, as described on the State’s website, is contained within Attachment A.

² Pursuant to Section 6A:23A-5.3(c), a participating local education agency “may seek approval from the executive county superintendent to use its own projection of SEMI reimbursement upon demonstration the numbers it used in calculating the projection are more accurate than the projection provided.” Further, at Section 6A:23A-5.3(b), the code provides a mechanism through which local agencies may seek a waiver from their executive county superintendent if “the school district projects, based on reliable evidence, that it will have 40 or fewer Medicaid-eligible classified students” enrolled.

The Medicaid reimbursement rates at issue in the Draft Report were developed by PCG in 2005-06 with the full visibility, cooperation, involvement, and approval of State employees. The rate-setting methodology was described in a 111-page document dated March 2006, *Rate Analysis for SFY 2004*, which was provided to OIG at the beginning of this audit. Discussions among the State, PCG, and CMS likewise have been documented and shared with OIG auditors. PCG consistently responded to OIG requests for information during the course of the audit with relevant documentation during the fall and winter of 2015 and into the spring of 2016. PCG has been transparent and forthright throughout this process, including providing time-study response records in November 2016, after they were discovered following the exit conference.³ PCG otherwise made itself available to OIG to respond to any questions or concerns, and advised OIG that it could contact PCG at any time it wished to discuss these matters.

In the following sections of this memorandum, PCG will point out a number of inconsistencies and errors in the Draft Report, and where the OIG has failed to provide support for its headline findings or certain statements and implications. **At the conclusion of the memorandum, we ask the OIG to retract the Draft Report.**

The OIG Draft Report Findings

At your request, the following narrative addresses OIG draft findings in the order presented in the Draft Report, except for the OIG finding related to the State Plan Amendment and the OIG observation on the maintenance of the time study records, which we understand the State will address separately.

1. OIG Draft Finding: Payment Rates Incorporated Incorrect Random Moment Time Study Activity Codes (pp. 7-8)

The Draft Report is wrong to assert that payment rates incorporated incorrect random moment time study activity codes. In fact, PCG made every effort to reflect CMS guidance, and the rates are fully supported by a proper review and understanding of the underlying documents.

By way of background, the State utilized a generally accepted self-coding methodology during the random moment time study (RMTS) that was conducted during the 2003-04 school year by the State's then-vendor (Maximus, Inc.). As a part of that process, the RMTS respondents:

- a. Independently chose the activity code that corresponded to the specific activity they were performing at the time of the moment;

³ The 2003-04 time study response forms could not be located at the outset of the audit in June 2015. Subsequently, the forms from the first two quarters of the three-quarter study were discovered and were delivered to the OIG in November 2016. To the best of our knowledge these records relating to the first two quarters of the study were complete, and the OIG has not provided any explanation for its assertion that they were not.

- b. Certified the accuracy of the moment through a signature and date on the form; and
- c. Provided a brief written description of the activity they were performing at the time of the moment in an open text response.

Moments were documented by the respondents, on paper, and returned to the vendor.

As part of its due diligence in the subsequent SEMI rate-setting process that it was contracted to perform for the State, PCG (the new vendor) analyzed and adjusted activity codes where needed to more accurately reflect the respondent's written description of the activity, and to comply with CMS guidance contained in the *Medicaid School-Based Administrative Claiming Guide (May 2003)* ("the 2003 CMS Claiming Guide"). Through this analysis and adjustment, some moments were recoded to the Direct Medical Service code, and other moments were removed from the Direct Medical Service code. To be clear, the 46 moments that PCG *removed* from the Direct Medical Services code had the effect of reducing the rate from what it otherwise would have been.

Contrary to the implication in the OIG Draft Report, highlighted in the OIG "Report in Brief," there was nothing improper about the recoding. It was done to promote accuracy and compliance with the 2003 CMS Claiming Guide and was verified by the State. It also was performed in a manner consistent with the centralized coding model that is commonly performed by most states under CMS-approved state plans (e.g., Alabama, Arizona, California, Colorado, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, Nebraska, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, South Dakota, Texas, Virginia, Washington, West Virginia, and Wisconsin). Under that model, a centralized team of experienced coders, not the randomly sampled respondent (a health care provider who may not fully understand the codes), chooses the activity code based upon the written activity description that was provided by the sampled respondent.

PCG also strongly disagrees with the OIG assertion that it did not correctly recode the moments. Indeed, the two specific examples highlighted by the OIG in its Draft Report (at "Figure 3"), and thus likely the OIG's two best examples of alleged PCG miscoding, in fact clearly meet the description of the Direct Medical Services code outlined in the 2003 CMS Claiming Guide.

Specifically, on page 8 of its Draft Report, the OIG cites the following examples as incorrect activity code changes:

Figure 3: Examples of Activity Code Changes

The following responses to the RMTSs were recoded as being directly related to providing health services:

- A social worker indicated that they were “scheduling students to see me” and coded this as “general administration.”
- A social worker indicated that they were “contacting a parent on the phone” and coded this as “development and monitoring of educational and social services.”

Although neither response indicated that the employee was providing health services, PCG recoded the responses to indicate that they were.

These two examples actually demonstrate a misunderstanding in the Draft Report as to what is allowable and what is not. They fall squarely within the CMS guidance regarding the activity code for Direct Medical Services:

School staff should use this code when providing care, treatment, and/or counseling services to an individual. This code also includes administrative activities that are an integral part of or extension of a medical service (e.g., patient follow-up, patient assessment, patient counseling, patient education, parent consultations, billing activities). This code also includes all related paperwork, clerical activities, or staff travel required to perform these activities....

2003 CMS Claiming Guide at 27 (Code 4. Direct Medical Services – U).

Each of the two examples in the Draft Report Figure 3, therefore, are correctly coded as a Direct Medical Service. They are necessary administrative or clerical components in the efficient and effective delivery of medical and mental health services to special needs students, and allowable Direct Medical Services under the 2003 CMS Claiming Guide. The activities are rendered by Medicaid allowable practitioners – social workers.

In total, the OIG Draft Report takes issue with 203 of 988 moments that were coded as Direct Medical Services, but provides no supporting detail to substantiate its assertion except for the two flawed examples in Figure 3 of its Draft Report. Based on the two examples highlighted in the Draft Report, as well as PCG’s review of the actual RMTS responses, the responses were not miscoded.

It may be that the OIG based its draft finding on a review of PCG spreadsheet notations and not the original RMTS responses from the providers. The original response forms from 2003-04 could not be located at the outset of the audit, only the spreadsheets that logged the responses (and other information) in a more limited way. When most of the response forms were

discovered and provided to OIG in 2016 after the exit conference, PCG confirmed that they substantiate the codes that had been assigned in 2005.⁴

2. OIG Draft Finding: Payment Rates Incorporated Unpaid Pension Costs (pp. 8-9)

We also disagree with the OIG Draft Report finding that the State improperly incorporated in the rate-setting calculations \$435,387,077 in purportedly unpaid pension costs.

In performing the rate-setting, PCG reasonably relied on 42 C.F.R. 413.24(a), a CMS regulation that specifically required the use of the accrual method of accounting for Medicare cost data:

Principle. Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting...

42 C.F.R. 413.24(a) (emphasis added). The regulation went on to explain that “the term accrual basis of accounting means that ... an expense is reported in the period in which it is incurred, regardless of when it is paid.” 42 C.F.R. 413.24(b)(2) (emphasis added).⁵

The regulation was revised in 2012 to require pension costs to be reported on a cash basis rather than on the accrual basis, but this revision was applicable “for cost reporting periods beginning on or after October 1, 2011” – it did not apply retrospectively. 42 C.F.R. 413.24(a)(2).

Therefore, when the rates were set in 2005, it was allowable for the computation to include the accrued costs listed in the NJ Department of Education Chart of Accounts regardless of whether they had been actually paid. The pension costs were therefore included in the computations.

Moreover, the State has informed PCG that the OIG assertion that “these accrued pension costs remain unfunded” is not accurate, and that 96% of the total liability (\$416M of the \$435M liability) actually was paid by the State in SFY 2003-04 – prior to the rate-setting. Thus, even under the inapplicable cash basis method of accounting, there would be no reason to pull the entire \$435 million out of the cost pool.

⁴ Additional analysis is contained in Attachment B.

⁵ State Medicaid agencies that reimburse providers based on allowable costs rely on Medicare cost-finding requirements at 42 CFR 413.24. PCG correctly followed those CMS requirements as they existed at the time PCG performed its work.

3. **OIG Draft Finding: Evaluation Rate Incorporated Learning Disabilities Teacher-Consultant Salaries (p. 9)**

We also do not concur with the OIG Draft Report finding that the evaluation rate improperly incorporated more than \$61 million in learning disabilities teacher-consultant (LDTC) salaries which PCG allegedly failed to remove from the evaluation account. **In fact, PCG used a reasonable allocation methodology to properly exclude all LDTC salary costs from the calculation of the evaluation rate.**

While there is no dispute that LDTC salaries should be excluded from the calculation of the evaluation rate, school districts often allocated LDTC salaries to both evaluation and instructional accounts. The rate-setting challenge was to extract the LDTC salaries from the evaluation account in the absence of LDTC time-study data and the absence of additional guidance beyond that in the NJ Department of Education Chart of Accounts. PCG was transparent in documenting and discussing with the State how it achieved this result.

To calculate a reasonable evaluation rate, PCG used costs that the school districts placed in an “evaluation account.” Because the districts allocated LDTC costs to both the evaluation account (included in the cost pool) and the instruction account (not included in the cost pool), PCG needed to extract LDTC costs from the evaluation account, before putting the evaluation account funds in the cost pool.⁶ To do this, PCG calculated an allocation rate based on the total amount of school-based salaries in the evaluation account compared to the total amount of salaries in both the evaluation and instructional accounts:

Evaluation:	\$ 340,301,431
<u>Instructional:</u>	<u>\$1,142,425,394</u>
Aggregate:	\$1,482,726,825 ⁷

This yielded a 23% allocation rate for evaluation ($\$340,301,431/\$1,482,726,825$), and a 77% allocation rate for instructional ($\$1,142,425,394/\$1,482,726,825$).⁸

PCG then applied this 23% allocation rate to the \$98,829,596 in total LDTC costs for 2004, and removed \$22,730,807 ($23\% \times \$98,829,596$) from the evaluation account that was added to the cost pool.⁹ The resulting \$317,570,624 ($\$340,301,431$ in the evaluation account, less the \$22,730,807 in LDTC costs) was used as the allowable costs for the calculation of the evaluation rates.¹⁰

Additional detail is provided in Attachment C.

⁶ PCG, SFY 2004 Rate Analysis, at 8.

⁷ PCG, SFY 2004 Rate Analysis, at 8, Exhibit 4.

⁸ PCG, SFY 2004 Rate Analysis, at 8, Exhibit 4.

⁹ PCG, SFY 2004 Rate Analysis, at 8.

¹⁰ PCG, SFY 2004 Rate Analysis, at 8, Exhibit 4.

4. OIG Draft Finding: Rehabilitation Rate Incorporated Costs for Support Services (p. 9)

We also do not concur with the OIG Draft Report finding that the State improperly incorporated in the rehabilitation rate \$75,379,253 in costs for support services. These costs are allowable under the SPA.

The OIG misinterprets the purpose of the DOE account from which the costs were taken. The State included costs from a DOE account for “Other Support Services – Students – Extraordinary Services,” 11-000-217-XXX, consistent with the methodology used by the previous vendor and approved by CMS. The description of this account states that it “is used to record the costs of services other than related services provided to students as a result of an I.E.P. that are unique to individual students, such as one-to-one aides.” This account is not, however, limited to costs for one-to-one aides; it also includes costs for *additional* rehabilitation services such as audiological services, psychological counseling, and psychotherapy.

The assertion in the Draft Report that the 11-000-217-XXX account is strictly for costs for “services other than related services” incorrectly assumes that the reference to “related services” is limited to non-health related services and thus not allowable in the calculation. To the contrary, the costs for the additional Rehabilitation Services covered in the SPA – audiological services, psychological counseling, and psychotherapy – would be included in account 11-000-217-XXX. **This account therefore should be included in the calculation of the Rehabilitation Services rate in order to account for all Rehabilitation Service costs, just as it was included in the previously CMS-approved methodology.**¹¹

5. OIG Draft Finding: Office of Inspector General Calculation of Unallowable Costs (p. 9)

For all of the foregoing reasons, we do not concur with the OIG Draft Report finding of inflated payment rates or its calculation of more than \$220 million in unallowable federal Medicaid funds claimed. After careful consideration of the OIG Draft Report, we stand by our rate calculations and claims.

¹¹ Furthermore, as noted in the Chart of Accounts, the coding of salaries for educational staff is generally done at a more discrete level than through the use of object code 100, which was used for the services in question. For example, object code 101 is used to identify the salary costs for teachers and object code 106 is used for “other salaries – instruction,” which further guidance indicates is the object code used for the coding of instructional aides. The coding of salaries under account 11-000-217-XXX to object code 100 corroborates that these are not salaries of educational or instructional aide staff.

6. OIG Draft Finding: Payment Rates Incorporated Non-Medicaid-Related Costs (p. 10)

We also do not concur with the OIG draft finding that the State's payment rates incorporated non-Medicaid-related costs. Specifically, we reject (A) the statement that the use of a single Direct Medical Service code in the pre-existing time study led to inflated rates, and (B) the suggestion that unallowable educational costs were incorporated into the rates.

First of all, the pre-existing 2003-04 time-study data was used in the 2005 rate-setting for several reasons: it was the most accurate and current data available to the State at the time; it met the CMS statistical validity requirements in place at the time; and utilizing an existing time study was more efficient, and less disruptive for school staff and providers.

Although the study was designed for documenting time related to claiming Medicaid administrative costs, it captured far more comprehensive data due to the detailed CMS code structure that was utilized. If the results of a survey meet the statistical validity threshold, then the data captured at any additional discrete level outside of the original purpose of the survey -- such as Direct Medical Services -- also meets that same statistical validity threshold. Utilizing the comprehensive time study also ensured that activities would not be coded into more than one activity and thus create duplication in federal reimbursement.¹²

The authors of the Draft Report are also mistaken in asserting that the use of one activity code for all Direct Medical Services in the time study meant that the eventual rate calculation included non-Medicaid eligible costs and that unallowable funds therefore were claimed. This assertion misses the fact that the time study was not the sole basis for determining the amount of federal reimbursement that was claimed by the State.

Notably, the 2003 CMS Claiming Guide includes a single code for Direct Medical Services, and New Jersey (like many other states) adhered to this guidance. The code includes all medical services provided within the school setting and does not differentiate between those services that could be reimbursed under the Medicaid program and those that could not. That distinction is irrelevant to the determination of rates.

Furthermore, the purpose of the time study was to determine the percentage of time that staff members spent performing the medical activities required within their scope of practice, and to determine a rate for the provision of Direct Medical Services. That rate was then utilized during the claiming process to seek reimbursement *only when all of the other federal and state billing requirements were met*. The State used the rate only when seeking reimbursement for services outlined in the approved State Plan and only when all requirements were met, including provider certification, Medicaid eligibility, and medical necessity.

¹² Each activity in the time study could be coded to only a single activity code. Those activity codes fell into one of four categories: (1) an activity code that was reimbursable under the Medicaid Administrative Claiming Program (MAC); (2) the Direct Medical Services activity code (utilized by the State to determine SEMI reimbursement rates); (3) an activity code that is not reimbursable under either program; or (4) General Administration, which is redistributed to the three previously outlined categories based on their percentage of the total time.

The OIG asserts that “the rates incorporated some unallowable costs that cannot be quantified,” but fails to provide any specificity or detail to support that statement. It is important to understand that PCG does not simply claim all services on behalf of a school district. There is a detailed process for taking a service record from initial service documentation through to billing:

- a. The LEA must be an approved provider with a provider agreement.
- b. The duration of service and date of service must be documented by the clinician.
- c. The type of service must be documented by the clinician.
- d. The clinician must indicate whether they are providing group or individual service.
- e. The student progress towards his or her goal(s) must be indicated by the clinician.
- f. The clinician must indicate what areas covered or assessed were provided to the student.
- g. The date of service cannot be a weekend.
- h. The date of service cannot be on a day that school was not in session, as indicated by the LEA.
- i. The date of service cannot be a holiday.
- j. The date of service cannot be in the future.
- k. The student must have a valid IEP on the date of service.
- l. The student must be Medicaid eligible on the date of service.
- m. The clinician must have valid Medicaid licensure or certifications on the date of service.
- n. The clinician must have services reviewed and approved by a Medicaid qualified clinician, if required (e.g., service provided by a Physical Therapy Assistant or Speech Language Assistant).
- o. The service cannot be billed if it exceeds service limits, as indicated by the State.
- p. Nursing must have a valid physician authorization on the date of service.
- q. The student must be between the ages of 3 and 21.
- r. The student must have a primary disability/diagnosis indicated.
- s. The student must have active parental consent on the date of service.
- t. The clinician can document only services within his or her discipline.
- u. The clinician can document only services for students on his or her caseload.
- v. The clinician will be warned if a service of a similar discipline has been logged for the same date, to avoid potential duplication.
- w. The service cannot be billed if either the student or the provider was indicated as not being present on the date of service.

- x. Specialized transportation can be billed only if there is another paid service on that same date.
- y. The student must have complete demographic information, including first name, last name, and date of birth.
- z. The clinician must certify that all information entered for the service log is correct, to the best of his or her knowledge.

Unless and until *all* of the parameters above are *all* met, a service is not claimed for reimbursement. For example, and to put these checks into context, *while New Jersey school districts logged approximately 3 million services in FY16, only approximately 1.3 million of those services met all requirements and were submitted for reimbursement.*

The OIG also makes the claim that time-study respondents were instructed to code IDEA evaluations as Direct Medical Services, and speculates that they may have included evaluations that actually were educational in nature. As to this claim, it is important to understand how schools operate when it comes to evaluations. Licensed specialists such as Speech Therapists, Occupational Therapists, Physical Therapists, and Social Workers are utilized by school districts to evaluate the *medical* needs of a student as they pertain to the provider’s specialty and scope of practice. School districts are not utilizing these *medical* professionals to support academic evaluations in the classroom, and the suggestion that they are is unfounded. Also, evaluations are claimed for federal reimbursement only when a medical evaluation had been conducted for the child, and the child and provider meet all other reimbursement requirements as outlined in the SPA. The OIG has provided no data to support the assertion that non-allowable evaluations have been included in the time study results or claimed for reimbursement.

7. OIG Draft Finding: Unsupported Random Moment Time Studies (pp. 11-12)

Finally, we do not concur with the OIG draft finding as to “unsupported” random moment time studies.

a. OIG Draft Assertion: Most Sample Moments Not Considered

The OIG Draft Report unfairly states that PCG “discarded” most of the sample moments in the time study, and suggests that doing so “could have created an invalid and biased sample that produced inaccurate results.” To the contrary, **PCG deliberately excluded MAC-only sample results in order to obtain a more accurate direct service percentage for SEMI providers.**

The 2003-04 time study included both SEMI-eligible staff as well as staff that were eligible only for reimbursement under the MAC program. Under the approved State Plan, MAC program staff are not eligible to bill services under the SEMI program. Consequently, including the time of MAC program staff in the calculation of the SEMI rates would not produce an accurate representation of the time that SEMI providers spent delivering medical services to students. The objective was an accurate calculation which included neither MAC costs nor MAC program time.

It is not a valid criticism to say that the direct medical percentage (the amount of time staff members spend providing Direct Medical Services to students) increases when MAC-only staff are removed from the sample (from 16% to 51% according to OIG), for several reasons:

- There are significantly more MAC-only providers than SEMI providers in the time study population from which the sample was drawn. MAC-only providers outnumber SEMI-eligible providers by a ratio of about 3:1, because MAC-only providers include staff members such as Principals, Assistant Principals, Special Education Administrators, Special Education Teachers, Interpreters, and other specialists who are more prevalent in schools than the specialized and licensed SEMI-eligible staff such as Speech Therapists, Occupational Therapists, Physical Therapists, Psychologists, Social Workers, and Nurses.¹³
- MAC-only respondents never would be eligible under the SPA to bill Direct Medical Services, so including their responses in the calculation of the direct medical percentage would have greatly *underrepresented* the time that SEMI-eligible staff spend providing direct medical services. The 16% figure that would have resulted from including MAC-only staff demonstrates why that approach would be incorrect. Indeed, it would be concerning to school districts and taxpayers if Direct Medical Service providers in New Jersey schools spent only 16% of their time providing the medical services for which they were hired.
- Still, utilizing only the responses from SEMI-eligible staff members more than satisfied the required level of statistical validity. CMS at the time required that sample results meet a minimum of a 95% confidence level with an error rate of +/-5% for the period of time that the sample size represented. Given the number of SEMI-eligible staff members in the State of New Jersey and the number of one-minute units of time across the school year, a 95% confidence level with an error rate of +/- 5% required that a minimum of 385 moments be obtained in order to reach statistical validity. As noted in the OIG Draft Report, the number of moments completed by SEMI-eligible staff during the time studies conducted over the year totaled 1,575 *moments*. Because all of these moments were utilized to determine the Direct Medical Service percentage, more than four times the required number of moments needed to obtain the CMS required statistical validity level were actually used to set rates ($1,575/385 = 4.09$).

¹³ Given that the sample is random and that the population of moments sampled generally correlates to the percentage of the population in the pool, only one in four moments will have the opportunity to be coded to direct medical services in the general results, since only one in every four moments is randomly assigned to a SEMI-eligible provider. Thus the 16% figure actually represents only one-fourth of the time that would be expected to be received from the SEMI-eligible staff, and an extrapolated direct medical percentage of 64% ($16\% \times 4$) would be expected. A 51% figure for SEMI-eligible providers is well *below* that expectation.

b. OIG Draft Assertion: Financial Impact of Unsupported Costs on Payment Rates Cannot Be Calculated

The OIG Draft Report also claims that it cannot determine whether PCG correctly used the time studies or whether its modified sample was valid and unbiased, or the impact of the unsupported time studies on the payment rates, because the State did not provide complete time study documentation. We reject that claim as well. **The OIG has had access to all of the time study data, prior to the issuance of these draft findings, except for the participant response forms from one of the three 2003-04 time study quarters. As importantly, we have no reason to believe that the one quarter would be statistically at variance from the two RMTS quarters from the same school year produced to the OIG.**

Conclusion

For the reasons outlined above, PCG strongly disagrees with the findings in the OIG Draft Report and it should be withdrawn. PCG followed available federal guidance in our time study and rate-setting activities, and our methodology for setting the SEMI rates was reasonable, appropriate, and in compliance with the law. The results of the annual cost settlements support this conclusion.

We are available to discuss this response at your convenience.