OFFICE OF THE INSPECTOR GENERAL

SCHOOL-BASED MEDICAID REPORTS

A CONSOLIDATED REVIEW

ACKNOWLEDGEMENTS

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HEALTHY SCHOOLS CAMPAIGN

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TABLE OF CONTENTS

INTRODUCTION

The Office of the Inspector General (OIG) audits school-based Medicaid programs on behalf of the Center for Medicare and Medicaid Services (CMS). These in-depth reviews involve different scopes and methodologies. The final report includes the OIG's findings and any state agency comments. Depending on the outcome, the audit may recommend the state refund a certain amount to CMS. It is then up to CMS to determine if, when and how much of the amount to collect.

For the purposes of this analysis, we reviewed 33 OIG reports conducted over a 21-year period (2000-2021). The total recommended refund amount was $1,184,920,464.

Our report focuses on OIG findings and does not delve into whether those findings were appropriate. This report should serve only to clarify what the OIG looks for. Sample checklists are included to help guide states toward developing robust internal guidance and policies that meet OIG expectations.

By the Numbers

$1,184,920,464 recommended to return to CMS

33 reports

Spanning 21 years

STATE AGENCY RESPONSE

The full reports, including state agency responses, are included in **Appendix A**, along with the year the report was issued and the time period the report covers. For states with more than one report, the state abbreviation is followed by the year (e.g., the 2011 Kansas report is listed as KS11). Note that some states have changed their school-based Medicaid programs since the issuance of their reports.

The majority of state agencies (26 out of 33) disagreed with some or all of the OIG findings and/or recommendations. With few exceptions, the OIG did not change their findings based on this disagreement. There were only five instances where the OIG re-evaluated their findings based on state agency comments - and even these five were only minor revisions to a small number of sample items. No state agency ever successfully argued for the reversal of an interpretation of regulations or rules.

All references to regulations or rules included in the reports are listed in **Appendix B**.

OIG AUDIT METHODOLOGIES

The OIG tailors the audit methodology to a specific goal, such as reviewing a state's Random Moments in Time Study (RMTS) program. The OIG might expand the scope and methodology type as the audit progresses.

Methodologies

- Review of RMTS methodology, participant list and funding sources for the participant list (AL, KY, MS and NC).
- Review of RMTS methodology and responses (100% of Medicaid-reimbursable moments, a random sample or both), as well as documentation from Local Education Agencies (LEAs) (KS14, NE, NJ19 and NY).
- Review of a set number of RMTS moments from across the state (CO).
- Review of both RMTS moments statewide and the larger LEAs (MA, MI and TX).
- Review of "student months," which are all the claims submitted in one month for one student. These months can be pulled either from specific LEAs, randomized from the entire state or selected after placing the LEAs into strata based on size (AZ10, CT, IL, MD and OR).
- Review of a few specific LEAs (generally either the two or three largest by student population or largest by Medicaid reimbursement) (CO, ME, NV, RI, VT and WA).
- Review of LEAs and statistically random "student months" (WI).
- Review of Medicaid Administrative Claiming (MAC) files, observation forms and the RMTS methodology (AZ13).
- Review of MAC files, observation forms, RMTS methodology and specific LEA claims (KS11).
- Review of individual claims (FL).
- Review of rate calculations (KS06, UT, NJ17 and WV).
- Review of specific beneficiaries (OK).
- Review of a strata of transportation claims and accompanying documentation (NH).

OIG AUDIT METHODOLOGIES

Trends from the Methodologies

- If RMTS moments are to be reviewed, the OIG typically reviews 100% of the moments coded as Medicaid-reimbursable. It is critical that all reimbursable moments are coded correctly and that documentation is readily available to back up these moments.

- When choosing LEAs to review, the OIG typically looks at the two or three largest by either student population or total reimbursement (these often tend to be the same LEAs). The OIG rarely pulls significant information from smaller LEAs.

- The methodology to review "student months" means that it is critical that make-up sessions be clearly documented as such. The "student month" methodology relies on pulling all services billed for one student during one month; therefore, a make-up service from the previous month could result in the appearance that a student is receiving extra services beyond the plan of care.

- Methodologies tend to progress in trends by time. For a better sense of the possible methodologies for an upcoming audit, review the previous four to five years of audits reports.

"OTHER MATTERS"

In several reports, the OIG chose to list compliance issues in the "Other Matters" section. While these items are of concern, they are not taken into account when determining a suggested refund amount.

In some cases, the OIG stated that the reason for listing items here is that they were not directly tied to the purpose of the audit. In other cases, the reason appears to be that the issue violates an OIG federal requirement interpretation, but the state agency had explicit permission from CMS to operate that way.

The following states had findings listed in "Other Matters":

Massachusetts
Oregon
Texas

Throughout the report, they are identified with an *

MAJOR FINDINGS

8 or more states

Insufficient Documentation

AZ10, AZ13, CT, FL, IL, MA*, MD, ME, NJ17, NJ19, NY, OR, RI, TX* and WI

Findings

- Random Moments
  - No documentation available to back-up Random Moments.
  - The documentation for a Random Moment did not sufficiently justify it as a Medicaid-billable moment.
  - The Cost Allocation Plan (CAP) called for retaining the student name for each moment to provide an audit trail, but the contractor did not collect this information.
  - No documentation to support the sample universe determination.
- Service Provision
  - No service provision documentation available.
  - The service provision documentation was lacking one or more required elements.
  - Billed for services in which the service provider's notes indicated different types of services billed to Medicaid (e.g., documenting an individual session but billing for a group session).
- IEP or Plan of Care
  - No IEP or Plan of Care made available.
  - The IEP or Plan of Care does not adequately justify the service delivered.
  - The IEP or Plan of Care did not cover the service date.
  - IEPs were missing signatures in compliance with state handbook guidelines.
- Other Matters
  - In the Massachusetts, they did not retain RMTS documentation, however, it was noted that the CMS-approved RMTS Guide does not require school districts to maintain documentation supporting the RMTS participants' responses.
  - In Texas, 94% of the moments were unsupported by documentation.

Learning Takeaways

- Provide LEAs with explicit checklists for RMTS required documentation. Be clear what type of documentation is required for each type of answer.
- Provide LEAs with explicit checklists that clearly identify all requirements for service documentation and plans of care.
- Provide LEAs with explicit guidelines on what documentation must be retained and for how long.
- Ensure that the training covers both service documentation and other records such as payroll and retirement costs. Records must be kept five years from the final cost settlement.
- Work with LEAs to support the development of templates and systems that meet documentation requirements but also reduce LEA administrative burden.
- Provide training (multiple times per year) on documentation requirements and assess the effectiveness of training. Assess LEA's level of mastery of the required knowledge and continue training until mastery reaches a high rate.
- Regularly audit LEAs for compliance to the clearly communicated standards.

Services Provided or Billed on a Day the Student was Not in Attendance

AZ10, CT, IL, MD, ME, OR*, RI, TX* and WI

Findings

- LEAs were unable to produce attendance records that proved the student was in attendance the day the service was billed. This includes LEAs that could not produce any attendance records.
- LEAs billed for a service on a day the student was marked absent.
- LEAs billed for services provided on a school holiday.
- LEAs billed for services provided on a weekend.
- Medicaid-billable Random Moments were included for days school was not in session.
- Other matters
  - Oregon did not have any attendance records, and at the time, according to the OIG, it was not a requirement that they be kept, so this was only noted in the "Other Matters" section.
  - The two LEAs reviewed in Texas had billed for services on weekends and were unable to substantiate a majority of those claims (72% and 97% of the claims were unsubstantiated at the respective LEAs).

Learning Takeaways

- Provide explicit guidelines to LEAs that they must retain attendance records that corroborate Medicaid billings, including the timeline for document retention.
- Consider possible integrations with LEAs Student Information Systems (SIS) and Medicaid billing systems.
- Ensure the RMTS calendars are set individually by each school to account for holidays.
- Think critically (and then provide explicit communication to LEAs) about how to document attendance for services that may have been provided through telehealth outside of school hours during COVID. CMS has made clear that these services are billable with proper documentation.

Services Overbilled

AZ10, CT, IL, KS06, MD, NV, OR, TX and VT

Findings

- More units were provided than the Plan of Care included.
- The number of units billed was greater than the number of units documented.
- LEAs billed for services that were longer in duration than the service prescribed or provided.
- Services were billed above cost.
- Providers mistakenly claimed costs on dates when services were apparently not provided, relied on inaccurate data for billing purposes, or incorrectly prepared billing sheets.
- Services were double-billed.
- Billed for services that were not approved Medicaid services (written case management).
- Claimed reimbursement for non-allowable expenses, including professional and technical services and school-based activities.

Learning Takeaways

- Provide explicit training to LEAs on matching plans of care to service delivery.
- As billing documentation systems evolve, consider requiring that documentation systems include the plan of care with approved units, and that the billing system puts checks on billing in excess of the plan of care.
- Support LEAs in developing systems that provide checks to billing systems and reduce administrative burdens.

Provider Requirements Not Met

AZ10, CO, FL, IL, MD, ME, NY and RI

Findings

- Speech therapists met state requirements but not Federal regulations (42 CFR § 440.110(c)).
  - This typically occurred because the state did not require an ASHA certification but the federal statute does, and Medicaid requires that providers meet both state and federal requirements.
- Providers did not meet the state Medicaid agency's qualifications for Medicaid-eligible providers.
- State law required certain training for certain providers, and training documentation was lacking or could not be found.
- When certain providers were required to be supervised, there was no documentation of the supervision.
- Unable to locate the licenses for providers.
- The licenses provided were not valid during the time the service was provided.
- The LEA could not provide the driver's license to support the special transportation driver's qualifications.

Learning Takeaways

- Review both state and federal provider requirements for all provider types. Generally, state requirements will match with federal ones, but that was not always the case in these audits.
- Provide LEAs an explicit list of all requirements for each provider type and the documentation they must maintain to back up that certification.
- Carefully review the federal ASHA certification requirements for speech therapists.
- Provide explicit instruction on documentation requirements when supervision is required.
- Develop a system for collecting and maintaining provider licensure/credentials/qualifications.
- Consider implementing some type of licensure/credentials/qualifications check before providers are allowed to bill.

The State Agency Did Not Provide Appropriate LEA Oversight

CT, FL, KS11, KS14, ME, NH, VT, WA and WI

Findings

A consistent theme in the OIG reports is lack of appropriate oversight of LEAs. While explicitly mentioned in only a portion of the reports, it is fair to say that many states struggled with this to a degree.

- The agency did not adequately monitor – or have a formal process in place to monitor – the claims for school-based health services submitted by LEAs.
- The agency did not have a formal process to ensure claims were properly supported with the required service and billing documentation before being submitted to CMS for reimbursement.
- The agency did not adequately monitor school-based service claims for compliance with federal and state requirements.
- The procedures the state agency had in place to monitor the LEAs were not sufficient.

Learning Takeaways

- Dedicate staff to the school-based program, and reduce reliance on outside contractors and consultants for program knowledge.
- Establish formal processes to provide oversight of LEAs.
- Provide regular, mastery-based training to LEAs. Instead of training LEAs on a calendar, consider a training program that assesses LEA's level of mastery of the required knowledge and continues to train until mastery reaches a desired level.
- Provide training that takes into account the different needs of different LEA types (large/small, urban/rural, traditional/charter) and proactively recognizes issues in LEA staffing turnover that need to be compensated for.
- Provide a resource center with a variety of guidance documents.
- Ensure strong collaboration between the state education agency and Medicaid agency to ensure appropriate training and oversight.
- Conduct regular audits for program compliance to standards.

Problems With RMTS Work Schedule

AL, AZ13, KS14, KY, NY, MS, NJ19 and NC

Findings

- A standard work schedule was used for all staff instead of individualized schedules. This meant that not all moments worked were eligible for selection.
- The standardized work schedule was changed each quarter.
- The sample universe did not account for the entire work period.
- The calendar only included days, not start- and stop-times.
- The state agency used an incorrect LEA calendar and sampled on days the individuals in the pool were not working or being paid.

Learning Takeaways

- All RMTS schedules must be individualized to the person and include daily start- and stop-times.
- RMTS schedules should be customizable enough that individuals can have different start- and stop-times on different days of the week, if necessary.
- RMTS schedules must be able to fully capture all hours worked by an individual; this includes evenings and weekends if the state has LEAs that are open during those times (i.e., residential schools).
- RMTS coordinators (or any individual at the LEA who sets the schedules) should receive mastery-based training to ensure they understand the importance of the schedule.
- Participants should have a way to confirm each quarter that their schedule is accurate.

Issues With RMTS Coding

AL, AZ13, CO, IA, KS11, KS14, MS, NC, NE, NJ17, NJ19, NY and TX

Findings

- Activities unrelated to Medicaid-covered services or health issues were inappropriately classified as Medicaid-reimbursable activities.
- Random moments were coded to "IEP Direct Medical Services," a Medicaid-reimbursable code, even though in each case the response indicated that the student receiving direct medical services did not have an IEP.
- Contractor did not code staff travel for the purposes of providing a direct medical service as "direct medical service."
- IEP meetings were incorrectly coded as "Referral, Coordination and Monitoring of Medicaid Services to Medicaid-Enrolled Providers" instead of a non-Medicaid-reimbursable code.
- Evaluations and parental consultations related to direct medical care were coded to "Referral, Coordination and Monitoring of Medicaid Services to Medicaid-Enrolled Providers" instead of "Direct Medical Services."
- The contractor working on contingency improperly coded moments as Medicaid-billable services.
- The contractor coding the moment did not ask enough questions and was not provided with enough documentation to determine how to accurately code the activity.
- Contractor threw out a significant amount of moments without appropriate justification.
- The moment captured an entire day's activities instead of a one-minute time period.
- Non-responses were coded incorrectly (see **Appendix C** for further explanation).
- Employees were sent moments on days they were not scheduled to work, and these responses were not removed from the sample.
- Non-responses were treated two different ways by two different contractors.

Learning Takeaways

- Consistency in coding is critical; consider using a RMTS system that automatically codes responses rather than requiring a contractor to hand-code them.
- Set clear RMTS coding standards, and train both the contractor and the LEAs.
- Be wary of allowing a contractor to work on a contingency basis. [1]
- Ensure the Medicaid agency (rather than a contractor) sets the rules for coding moments in line with CMS guidance.
- Note the following frequently misunderstood activities and their appropriate coding:
  - Non-responses – see **Appendix C**
  - IEP Meetings = Non-Medicaid billable
  - Travel when travel is for the purpose of providing a direct service = Medicaid billable

[1] While some states have been using contingency based contractors, OIG views this as potentially concerning (OMB Circular A-87, Attachment B, section 33, states that for professional and consultant services to be allowable, they must not be "contingent upon recovery of the costs from the Federal Government."). In addition, the OIG is intentionally seeking out states to audit where there is a contingency-based contractor relationship. From the "Why We Did This Audit" of the NJ report: "As part of its oversight activities, the Office of Inspector General (OIG) is conducting a series of audits of Medicaid school-based costs claimed by States that used contingency fee contractors." States using a contingency-based contractor should be aware that not only does the OIG consider this practice concerning, the very existence of a contingency-based contractor relationship may result in an OIG audit.

Incorrect Cost Report Factors

CO, IA, KS11, KS14, MA, NJ17, NY and WA

Findings

- Used free and reduced lunch rate in place of Medicaid percentage.
- "Other Costs" included the total cost of a hospital facility.
- Costs were based on budget estimates rather than actuals.
- The state agency could not validate or provide support that LEAs' IEP ratios were correctly calculated.
- The IEP rate was calculated incorrectly.
- Pension costs were incorporated even though there was no evidence that the state had made regular payments or full annual payments to the fund in nearly 20 years.
- LEAs did not document, and thus could not support, the data used to calculate the IEP ratio.
- LEAs did not use complete and accurate information to calculate their IEP ratio.
- Some cost factors included in the indirect percentage were also claimed as direct costs.
- Interim payments were not reconciled correctly.
- LEAs made errors when reporting personnel costs.
- LEAs did not adequately document and so could not support personnel costs.

Learning Takeaways

- Provide LEAs with explicit instructions on completing the cost report, including the reasoning behind each piece of information. Remember, the person completing the cost report may not be the one most familiar with the program.
- Ensure methods for calculating the Medicaid rate and IEP ratio that are CMS-approved and retain all documentation to provide backup.
- Ensure LEAs do not have cross-over between direct and indirect costs by carefully reviewing with LEAs everything included in the indirect cost percentage.
- Ensure interim payments are accounted for in the cost report/cost settlement process.

MINOR FINDINGS[1]

Fewer than 8 states

Billing

Finding	Examples of State Issues	State(s)
Technical errors	• Rounding errors and omission in the reports submitted by sub-agencies. • Provider charges were not reduced to the lower of the billed cost or the state-wide maximum payment ceiling due to a billing system error. • Clerical error on cost report. • Due to a technical bypass, claims can be submitted after the cost settlement is paid. • The state agency mistakenly claimed excess costs due to a miscommunication between agency staff related to a change in the cost-allocation methodology.	IA, IL, MA, NY, VT
Rates not appropriately developed	• Did not use the indirect cost rate developed by the Board of Education; instead, the state agency created its own methodology to calculate indirect cost. • The agency incorrectly developed payment rates for school-based Medicaid services by using utilization data for services that were not reimbursable under Medicaid. • Fee-for-service rates were incorrectly developed because they included the basic cost of education that is not reimbursable under the Medicaid program. • LEA subcontracted services to private providers at rates below what it charged the Medicaid program. • Rates were developed by a contingency-based contractor and not within the scope of the approved state plan. • The contractor included learning disability teacher-consultant salaries in the development of the evaluations rates. • The contractor incorporated special education services into the rehabilitation rate calculation.	KS06, MD, NJ17, OR, WV, WI
Cost settlement issues	• Some LEAs did not submit annual cost reports. • The state agency did not perform a cost settlement to reconcile interim payments and the actual cost of services. • The state agency was unable to provide support from its internal cost reporting system for the expenditures claimed.	CO, KS14, UT

Billing

Finding	Examples of State Issues	State(s)
Insufficient evidence of state fund participation or federal funds used as matching funds	• A non-public agency was used as a pass-through and, as a result, was unable to certify the state participation. • The LEA received unallowable federal reimbursement in personnel costs for employees whose salaries and benefits were partially funded by other federal sources. • Included claiming for individuals who were paid 100% by federal funds.	CO, IA, KS11, KY, NV
Claimed without appropriate CMS approval	• The agency began claiming under a new methodology before CMS approved it. • The agency used a RMTS methodology without submitting to CMS for approval. • Claimed reimbursement for capital expenditures and debt service that were not approved by CMS. • The contingency-based contractor developed a new rate methodology that was not approved by CMS.	KY, NJ17, NJ19, NV, WV
State agency retained funds the LEAs were entitled to from the FMAP increase	• The state agency incorrectly retained funds related to the Recovery Act FMAP increase. • The enhanced FMAP from the Recovery Act can provide a valuable lesson for ensuring the current FMAP enhancements from the CARES Act are handled correctly. Ensure your state has made a plan for distributing the enhanced FMAP. This was flagged as an issue in the Colorado audit (excerpt below): "When reporting expenditures for Federal reimbursement, apply the FMAP rate in effect at the time the expenditure was recorded in your accounting system." CMS central and regional office officials informed us that because Colorado's SHS program used CPEs for funding purposes, interim payments should have been claimed on the CMS-64 report in the quarter in which the State agency made each interim payment to a particular school district. By contrast, cost reconciliation payments should have been claimed on the CMS-64 report in the quarter in which the service was provided. Contrary to these guidelines, the State agency did not apply the FMAP rate in effect at the time the State agency processed the interim payments. In addition, the cost reconciliation payments were not claimed in the quarter in which the service was provided, resulting in the State agency claiming costs using an incorrect FMAP rate."	CO

Documentation

Finding	Examples of State Issues	State(s)
Transportation issues	• The mileage billed was higher than the mileage documented. • Transportation documentation did not include information that the student had been provided with a Medicaid service that day. • LEAs could not provide documentation to support all of the transportation expenditures claimed. • The LEA did not document, and thus could not fully support, some of the bus driver salaries and benefits expenditures claimed. • The LEA did not document, and thus could not fully support, some of the fuel and maintenance expenditures claimed. • The LEA could not provide trip logs. • The IEP did not authorize special transportation.	AZ10, CO, KS06, MD, NH, RI
The services provided were not listed on the IEP/Plan of Care	• The service provided was not listed in the student Plan of Care.	AZ10, IL, KS06, MD, WI
LEA did not get parental consent to bill	• The required consent to bill was missing.	CT

Guidance and Oversight

Finding	Examples of State Issues	State(s)
State agency did not have appropriate oversight over the contractor	• The agency and the contractor had quality review processes in place; however, these processes were insufficient to ensure that all costs claimed met federal requirements. • The agency did not exercise proper oversight of the contractors to ensure that they followed the approved policies when assigning codes to the RMTS responses and when assigning participants to the RMTS. • The agency did not provide oversight to ensure the contractor was following the approved RMTS methodology. • The state agency did not provide oversight to ensure the contractor was following the approved rate methodology. • The procedures to communicate issues with the contractor were not sufficient.	AZ13, CO, KS11, KS14, NE, NJ19, WV
Incorrect or lacking guidance or manuals	• The state agency issued policy manuals to school-based health providers that included incorrect guidance concerning federal and state requirements. • The agency did not have adequate policies and procedures to monitor the program and to ensure that all costs claimed met federal requirements. • The agency issued incorrect guidance to the LEAs on federal requirements pertaining to provider qualifications. • The agency guide did not adhere to the CMS guide. • Agency procedures were not updated. • Program deficiencies due to agency-issued guidance to LEAs based on a misunderstanding of federal requirements.	AZ10, AZ13, CT, CO, KS11, NH, ME
Contingency based contractor*	• The contingency-based contractor developed a new rate methodology and implemented it without CMS approval. • The agency disregarded CMS' concerns about a contingency-based contractor. *Only Nevada had this taken into account when determining a refund amount - but it was listed as an issue OIG was concerned with in the other two reports. In the New Jersey (2019), it was noted that CMS has also expressed a concern about the contingency based contractor.	NJ19, NV WV

Random Moment Time Study

Finding	Examples of State Issues	State(s)
Employees listed multiple times[2]	• Employees included more than once in the RMTS pool which increases their chances of selection.	AL, AZ13, KY, MS, NC
Did not sample all 4 quarters[3]	• The state agency only sampled 3 quarters (omitting the summer) and used an average of the previous 3 quarters for the 4th quarter data. • The state agency only sampled 3 quarters and therefore missed capturing the beginning of the school year. • In the Massachusetts report, this was noted under "Other Matters".[4]	MA*, NY, NJ19, NV, TX
LEA did not get parental consent to bill	• The required consent to bill was missing.	CT

[2] Ensure contractors have a system in place to check for duplicates at the beginning of each quarter. Since some participants may work in multiple LEAs, consider searching for duplicates by email address (which would be different for each LEA they work at) rather than name (this was the explanation provided by one state for why there were duplicates). If you have participants working at multiple LEAs, be prepared to proactively explain their duplication to the OIG.

[3] Include all 4 quarters. Although CMS does allow for RMTS methodologies with only 3 quarters, this is acceptable only if the LEAs are not in school during any portion of the missing quarter (or if CMS "concludes that the amounts to be allocated to Federal awards will be minimal, or if it concludes that the system proposed by the governmental unit will result in lower costs to Federal awards than a system which complies with the standards."). Note: Even if CMS has approved a state methodology with only 3 quarters, OIG still considers the methodology invalid if the LEAs are in session any days during the missing quarter and if the state does not have documentation showing CMS approved the methodology **because** it would lower the award amount.

[4] In the Massachusetts audit, OIG noted that "According to State officials, the CMS-approved RMTS plan excludes moments from August and September because (1) there are few, if any, regular school days in the month of August and (2) therapists provide fewer direct services to students in September as opposed to the rest of the school year. As a result, the RMTS is not representative of the cost period (the entire school year) and does not meet the statistical sampling standards set forth in the Cost Principles." OIG further noted that "The scope of our audit did not include determining whether CMS approved the Massachusetts plan under this provision."

Random Moment Time Study

Finding	Examples of State Issues	State(s)
Did not store seed numbers or could not document how the random moments had been generated[5]	• The contractor did not program the RMTS to retain the data needed to recreate the moments. • Proving the methodology was randomized was not enough; seed numbers must be kept to ensure auditors can recreate the exact participant list. • In the Massachusetts report, this was noted under "Other Matters". The report notes that CMS had approved the state's use of Oracle software to generate the sample.	AL, MA*, MS, NC, NJ19, TX
Issues with the CAP (Cost Allocation Plan)[6]	• Alabama did not submit at all until auditors came; this was attributed to staff turnover and lack of knowledge. • Kentucky attributed its lack of CAP submission to lack of awareness of policies and procedures for submitting CAP amendments. • The Mississippi CAP was submitted 3 years after CMS's conditional approval. • The Nebraska approved CAP does not specify general education teachers as participants in either pool, but they were included. • The New Jersey (2019) methodology did not comply with the approved CAP. • The North Carolina CAP was submitted more than 7 years after the CMS conditional approval. Although it was given retroactive approval, the OIG still lists it as a finding due to the lack of prompt submission.	AL, KY, MS, NJ19, NC and NE

[5] This was one of the findings states (through their contractors) attempted to push back on the most. Almost every state submitted some level of statistical analysis, letters from statisticians, additional data, etc. to refute this finding. None of the arguments had any effect on the OIG's stance.

[6] Based on these reports, the CAP amendment is something that may cause confusion at Medicaid agencies. The CAP amendment is separate from the SPA submission and approval and goes to a different office for approval. Each state Medicaid agency will have a different process for submitting CAP amendments.

Random Moment Time Study

Finding	Examples of State Issues	State(s)
Applied one years RMTS results to another	• The state agency applied RMTS results from one year to allocate costs for a different year without adequate justification.	NY
Methodology did not comply with SPA or CAP	• The contractor proposed and used a different RMTS methodology than the one approved by CMS.	NJ19
Problems with the individuals included in the sample universe	• The sample universe did not contain all the job titles of employees whose salaries and wages were allocated on the basis of the sample results, resulting in LEAs overstating salary amounts on the cost settlement document. • The sample universe included contract staff and employees who did not perform Medicaid activities. • Attendant care was removed as an allowable service, but attendant care providers remained in the pool.	AZ13, KS14, MI, NJ19
No method to track substitutions	• The contractor allowed LEAs to make substitutions to the RMTS pool instead of treating vacant position moments as invalid and did not track the substitutions they allowed to be made.	NJ19

Services

Finding	Examples of State Issues	State(s)
Student eligibility requirements not met	• Age requirement not met. • Student was ineligible under IDEA B. • Student was not Medicaid-eligible.	AZ10, OR, RI
Issues with the prescribing or ordering provider	• Services billed were not ordered by a qualified provider. • Plans lacked the appropriate referral or prescription information – the required information was either unavailable for review or lacked the appropriate referral signatures.	AZ10, IL, ME, RI
Billing for services provided to other students for free	• The LEAs billed for services provided to other students for free. These audits were done before the "free care" policy reversal.	OK, OR, RI

SAMPLE PROGRAM CHECKLISTS

The state reports included in our analysis provide a solid foundation for state agencies to conduct an internal review of their own school Medicaid program. Using the pattern of OIG findings, sample checklists are included both for the overall program and for the state agency's relationship with contractors brought on to support one or more aspects of the school-based Medicaid program.

Although many state agencies have pushed back against the reasonableness of OIG findings, their arguments have had little effect on the OIG. States should be aware that once the OIG has listed something as a finding, very few states have been successful in providing a response that resulted in changing that finding.

States that choose to go down that road should review other states in which the same finding was made, and read the state agency responses. By reviewing previously rejected responses, states will have a better sense if the argument it plans to make has already been made – and whether it was deemed successful.

PROGRAM REVIEW CHECKLIST

The following is a suggested list of internal items state agencies should ensure are in compliance. States with a more recently approved state plan amendment (SPA) should attempt to review these policies with a fresh set of eyes, as changes can take place during CMS negotiations that do not get accounted for in every aspect of policy guidance. This review may help to identify areas that were not fully considered or overlooked.

Program Authorization

- ☐ The RMTS methodology and program currently in use reflects the current approved SPA.
- ☐ The RMTS methodology and program currently in use reflects the current approved CAP amendment.
- ☐ The state agency can locate a copy of the letter approving the methodology and program currently in use.
- ☐ The state agency can locate a copy of the letter approving the CAP amendment describing the methodology and program currently in use.

Program Guidance and Oversight

- ☐ The state agency – and not the contractor – is the expert and decision-maker about the school-based Medicaid program.
- ☐ The state agency provides consistent oversight of the contractor.
- ☐ The state agency has formal procedures in place to provide oversight to the LEAs.
- ☐ LEAs have easy access to clear written guidance about what is expected of them.
- ☐ LEAs have access to consistent and on-going program training.
- ☐ The state agency provides explicit guidelines on provider licensure requirements that take into account state requirements, federal requirements, and the required documentation for training and supervision, if appropriate. Be sure to closely review the federal ASHA requirements for speech pathologists and audiologists.

RMTS

- ☐ RMTS participants have individualized schedules in the RMTS system.
- ☐ The RMTS list is checked for duplicates each quarter before moments begin going out.
- ☐ The RMTS seed numbers or all information necessary to reproduce and verify its sample results have been retained.
- ☐ The state's RMTS methodology includes capturing all 4 quarters or the state agency has approval from CMS for using 3 quarters that includes the back-up that it will reduce the Federal award.
- ☐ Any advance notice of RMTS moments has been approved by CMS.
- ☐ The state agency has created clear guidelines for the coding of RMTS moments and is holding the contractor accountable by conducting coding audits.

Other

- ☐ Begin conversations with the state education agency to align on parental consent.
- ☐ Review the state agency's plan for allocating the increased FMAP from the CARES Act to ensure it meets federal requirements.
- ☐ Carefully evaluate any contractor relationship that is contingency-based.

CONTRACTOR REVIEW CHECKLIST

Based on the findings in this report, the following is a suggested list of internal items state agencies should use to review their contractor relationship. Contractors are incredibly useful in managing a program that is such a small part of most states' Medicaid program, but they must be managed effectively; the Medicaid agency, not the contractor, is the expert in the school-based Medicaid program.

Program Knowledge, Guidance and Oversight

- ☐ The Medicaid agency employs staff (outside of the contractors) that deeply understand the school-based Medicaid program.
- ☐ When questions arise about the program, the Medicaid agency staff are able to answer them without (or with minimal support from) the contractor.
- ☐ Program rules, regulations, SPAs, manuals and guidance are written exclusively by the state agency.
- ☐ The state agency has a formal oversight process that is written into the contract and includes previously agreed-upon actions for any found failings.

RMTS

- ☐ The contractor is required to retain seed numbers or all information necessary to reproduce and verify its sample results for the RMTS moment generator.
- ☐ The contractor is required to have a formal, documented process in place to check the RMTS pool for duplicates prior to the beginning of each quarter.
- ☐ The contractor is required to provide LEAs with a mechanism for individualizing schedules. The schedules must be customizable so all LEA schedule configurations in the state can be included. This includes considerations for part-time staff who may work different hours on different days, and for LEAs that have programs on the weekends or evenings.
- ☐ The state agency sets clear guidelines for the coding of moments and audits the contractor to ensure compliance with those standards.
- ☐ The state agency ensures the contractor maintains appropriate RMTS documentation in accordance with CMS- and CAP-approved methodologies.
- ☐ The state agency, and not the contractor, designs and submits any changes to the RMTS methodology.

Training

- ☐ Training materials provided by the contractor are easily accessible via a website – not just by email – due to staff turnover.
- ☐ Trainings are provided based on the assessed needs of the LEAs rather than on a set schedule. (A consistent training theme was OIG citing a lack of training and the state agency pointing to a single annual training. Rather than focusing on frequency, contractors who provide training should focus on LEA mastery of the training topics – and continue to provide as much training as needed to reach mastery).
- ☐ Training should be created and implemented in conjunction with the state education agency.
- ☐ Training should include explicit checklists that leave no room for interpretation.

Contract Considerations

- ☐ Carefully evaluate any contractor relationship that is contingency-based.
- ☐ The state agency has a way to solicit and act on LEA feedback about the contractor.
- ☐ There is a formal grievance process in place for LEAs to make complaints about the contractor.
- ☐ Consider adding a clause to the contract that holds the contractor financially liable for any errors they make that result in the state agency having to refund CMS.

APPENDIX A: LIST OF REPORTS REVIEWED

State	Year	Time Period Covered	Recommended to Return
Alabama	2016	FFYs 2010 - 2012	$75,274,946
Arizona	2010	January 1, 2004 - June 30, 2006	$21,288,312
Arizona	2013	January 1, 2004 - September 30, 2008	$11,716,850
Colorado	2012	July 1, 2008 - June 30, 2009	$871,246
Connecticut	2020	July 1, 2017 - June 30, 2018	$761,179
Florida	2020	July 1, 2016- June 31, 2017	$1,441,107
Illinois	2003	July 1, 2000 - June 30, 2001	$6,067,669
Iowa	2004	July 1, 1997 - June 30, 2001	$639,682
Kansas	2006	FYs 1998–2003	$18,500,000
Kansas	2011	April 1, 2006 - March 31, 2008	$2,073,526
Kansas	2014	July 1, 2009 - June 30, 2010	$10,748,706
Kentucky	2021	FFYs 2009 - 2014	$29,431,268
Maine	2013	Calendar years 2006 - 2008	$667,569
Maryland	2003	July 1, 1999 - June 30, 2000	$19,954,944
Massachusett	2015	July 1, 2011 - June 30, 2012	$377,095
Michigan	2016	July 1, 2010 - June 30, 2011	$954,408
Mississippi	2017	FFYs 2010 - 2012	$21,199,651
Nebraska	2020	September 1, 2014 - August 31, 2017	$13,157,778
Nevada	2006	CYs 2003 and 2004	$5,793,236
New Hampshire	2012	Calendar years 2006 - 2009	$2,695,809
New Jersey	2017	July 2003 - June 2015	$300,452,930
New Jersey	2019	October 2011 - June 2016	$63,786,406
New York	2021	October 1, 2011 - June 30, 2016	$439,238,640
North Carolina	2016	FFYs 2010 - 2012	$53,719,199
Oklahoma	2002	SFY 2000	$1,902,390
Oregon	2002	State Fiscal Year 2000	$166,671
Rhode Island	2004	July 1999 - June 2001	$1,201,193
Texas	2017	October 1, 2010 - September 30, 2011	$18,925,853
Utah	2007	FFY 2001 - 2005	$36,800,000
Vermont	2006	October 2001 - September 2002	$1,463,395
Washington	2000	SFY 2000	$527,102
West Virginia	2011	July 1, 2000 - June 30, 2003	$22,806,230
Wisconsin	2003	SFY 2000	$315,474

APPENDIX B: FEDERAL REFERENCES

CFR References

42 CFR § 431.306 - Release of information

(a) The agency must have criteria specifying the conditions for release and use of information about applicants and beneficiaries.
(b) Access to information concerning applicants or beneficiaries must be restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the agency.
(c) The agency must not publish names of applicants or beneficiaries.
(d) The agency must obtain permission from a family or individual, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of medical assistance payment under section 1137 of this Act and §§ 435.940 through 435.965 of this chapter.
If, because of an emergency situation, time does not permit obtaining consent before release, the agency must notify the family or individual immediately after supplying the information.
(e) The agency's policies must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials.
(f) If a court issues a subpoena for a case record or for any agency representative to testify concerning an applicant or beneficiary, the agency must inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.
(g) Before requesting information from, or releasing information to, other agencies to verify income, eligibility and the amount of assistance under § 435.940 through § 435.965 of this subchapter, the agency must execute data exchange agreements with those agencies, as specified in § 435.945(i) of this subchapter.
(h) Before requesting information from, or releasing information to, other agencies to identify legally liable third party resources under § 433.138(d) of this chapter, the agency must execute data exchanges agreements, as specified in §433.138(h)(2) of this chapter.

42 CFR § 432.50 - FFP: Staffing and training costs

(a) Availability of FFP. FFP is available in expenditures for salary or other compensation, fringe benefits, travel, per diem, and training, at rates determined on the basis of the individual's position, as specified in paragraph (b) of this section.

(b) Rates of FFP.

(1) For skilled professional medical personnel and directly supporting staff of the Medicaid agency or of other public agencies (as defined in § 432.2), the rate is 75 percent.

(2) For personnel engaged directly in the operation of mechanized claims processing and information retrieval systems, the rate is 75 percent.

(3) For personnel engaged in the design, development, or installation of mechanized claims processing and information retrieval systems, the rate is 50 percent for training and 90 percent for all other costs specified in paragraph (a) of this section.

(4) [Reserved]

(5) For personnel administering family planning services and supplies, the rate is 90 percent.

(6) For all other staff of the Medicaid agency or other public agencies providing services to the Medicaid agency, and for training and other expenses of volunteers, the rate is 50 percent.

(c) Application of rates.

(1) FFP is prorated for staff time that is split among functions reimbursed at different rates.

(2) Rates of FFP in excess of 50 percent apply only to those portions of the individual's working time that are spent carrying out duties in the specified areas for which the higher rate is authorized.

(3) The allocation of personnel and staff costs must be based on either the actual percentages of time spent carrying out duties in the specified areas, or another methodology approved by CMS.

(d) Other limitations for FFP rate for skilled professional medical personnel and directly supporting staff -

(1) Medicaid agency personnel and staff. The rate of 75 percent FFP is available for skilled professional medical personnel and directly supporting staff of the Medicaid agency if the following criteria, as applicable, are met:

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

(ii) The skilled professional medical personnel have professional education and training in the field of medical care or appropriate medical practice. "Professional education and training" means the completion of a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is demonstrated by possession of a medical license, certificate, or other document issued by a recognized National or State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. Experience in the administration, direction, or implementation of the Medicaid program is not considered the equivalent of professional training in a field of medical care.

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

(iv) A State-documented employer-employee relationship exists between the Medicaid agency and the skilled professional medical personnel and directly supporting staff; and

(v) The directly supporting staff are secretarial, stenographic, and copying personnel and file and records clerks who provide clerical services that are directly necessary for the completion of the professional medical responsibilities and functions of the skilled professional medical staff. The skilled professional medical staff must directly supervise the supporting staff and the performance of the supporting staff's work.

(2) Staff of other public agencies. The rate of 75 percent FFP is available for staff of other public agencies if the requirements specified in paragraph (d)(1) of this section are met and the public agency has a written agreement with the Medicaid agency to verify that these requirements are met.

(e) Limitations on FFP rates for staff in mechanized claims processing and information retrieval systems. The special matching rates for persons working on mechanized claims processing and information retrieval systems (paragraphs (b)(2) and (3) of this section) are applicable only if the design, development and installation, or the operation, have been approved by the Administrator in accordance with part 433, subchapter C, of this chapter.

42 CFR § 433.32 - Retaining records

A State plan must provide that the Medicaid agency and, where applicable, local agencies administering the plan will -

(a) Maintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements;

(b) Retain records for 3 years from date of submission of a final expenditure report;

(c) Retain records beyond the 3-year period if audit findings have not been resolved; and

(d) Retain records for nonexpendable property acquired under a Federal grant for 3 years from the date of final disposition of that property.

42 CFR § 433.51 - Public Funds as the state share of financial participation

(a) Public Funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.
(b) The public funds are appropriated directly to the State or local Medicaid agency, or are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.
(c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

42 CFR § 440.10 - Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

A. Physical therapy -
(1) Physical therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a beneficiary by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment.
(2) A "qualified physical therapist" is an individual who meets personnel qualifications for a physical therapist at § 484.115.

B. Occupational therapy -
(1) Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a beneficiary by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.
(2) A "qualified occupational therapist" is an individual who meets personnel qualifications for an occupational therapist at § 484.115.

C. Services for individuals with speech, hearing, and language disorders -
(1) Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment.
(2) A "speech pathologist" is an individual who meets one of the following conditions:
(i) Has a certificate of clinical competence from the American Speech and Hearing Association.
(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate.
(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.
(3) A "qualified audiologist" means an individual with a master's or doctoral degree in audiology that maintains documentation to demonstrate that he or she meets one of the following conditions:
(i) The State in which the individual furnishes audiology services meets or exceeds State licensure requirements in paragraph (c)(3)(ii)(A) or (c)(3)(ii)(B) of this section, and the individual is licensed by the State as an audiologist to furnish audiology services.
(ii) In the case of an individual who furnishes audiology services in a State that does not license audiologists, or an individual exempted from State licensure based on practice in a specific institution or setting, the individual must meet one of the following conditions:
(A) Have a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association.
(B) Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating that supervised clinical experience under the supervision of a qualified master or doctoral-level audiologist); performed at least 9 months of full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a master's or doctoral degree in audiology, or a related field; and successfully completed a national examination in audiology approved by the Secretary.

42 CFR § 447.202 - Audit

The Medicaid agency must assure appropriate audit of records if payment is based on costs of services or on a fee plus cost of materials.

42 CFR § 455.1(a)(c) - Furnished benefits

Have a method to verify whether services reimbursed by Medicaid were actually furnished to beneficiaries.

45 CFR § 75.302 - Financial standards

(a) Each state must expend and account for the Federal award in accordance with state laws and procedures for expending and accounting for the state's own funds. In addition, the state's and the other non- Federal entity's financial management systems, including records documenting compliance with Federal statutes, regulations, and the terms and conditions of the Federal award, must be sufficient to permit the preparation of reports required by general and program-specific terms and conditions; and the tracing of funds to a level of expenditures adequate to establish that such funds have been used according to the Federal statutes, regulations, and the terms and conditions of the Federal award. See also § 75.450.

(b) The financial management system of each non-Federal entity must provide for the following (see also §§ 75.361, 75.362, 75.363, 75.364, and 75.365):

(1) Identification, in its accounts, of all Federal awards received and expended and the Federal programs under which they were received. Federal program and Federal award identification must include, as applicable, the CFDA title and number, Federal award identification number and year, name of the HHS awarding agency, and name of the pass- through entity, if any.

(2) Accurate, current, and complete disclosure of the financial results of each Federal award or program in accordance with the reporting requirements set forth in §§ 75.341 and 75.342. If an HHS awarding agency requires reporting on an accrual basis from a recipient that maintains its records on other than an accrual basis, the recipient must not be required to establish an accrual accounting system. This recipient may develop accrual data for its reports on the basis of an analysis of the documentation on hand. Similarly, a pass-through entity must not require a subrecipient to establish an accrual accounting system and must allow the subrecipient to develop accrual data for its reports on the basis of an analysis of the documentation on hand.

(3) Records that identify adequately the source and application of funds for federally-funded activities. These records must contain information pertaining to Federal awards, authorizations, obligations, unobligated balances, assets, expenditures, income and interest and be supported by source documentation.

(4) Effective control over, and accountability for, all funds, property, and other assets. The non-Federal entity must adequately safeguard all assets and assure that they are used solely for authorized purposes. See § 75.303.

(5) Comparison of expenditures with budget amounts for each Federal award.

(6) Written procedures to implement the requirements of § 75.305.

(7) Written procedures for determining the allowability of costs in accordance with subpart E of this part and the terms and conditions of the Federal award.

45 CFR § 75.364 - Access to records

(a) Records of non-Federal entities. The HHS awarding agency, Inspectors General, the Comptroller General of the United States, and the pass-through entity, or any of their authorized representatives, must have the right of access to any documents, papers, or other records of the non-Federal entity which are pertinent to the Federal award, in order to make audits, examinations, excerpts, and transcripts. The right also includes timely and reasonable access to the non-Federal entity's personnel for the purpose of interview and discussion related to such documents.

(b) Only under extraordinary and rare circumstances would such access include review of the true name of victims of a crime. Routine monitoring cannot be considered extraordinary and rare circumstances that would necessitate access to this information. When access to the true name of victims of a crime is necessary, appropriate steps to protect this sensitive information must be taken by both the non-Federal entity and the HHS awarding agency. Any such access, other than under a court order or subpoena pursuant to a bona fide confidential investigation, must be approved by the head of the HHS awarding agency or delegate.

(c) Expiration of right of access. The rights of access in this section are not limited to the required retention period but last as long as the records are retained. HHS awarding agencies and pass-through entities must not impose any other access requirements upon non-Federal entities.

45 CFR § 75.405 - Allocable costs

(a) A cost is allocable to a particular Federal award or other cost objective if the goods or services involved are chargeable or assignable to that Federal award or cost objective in accordance with relative benefits received. This standard is met if the cost:
  (1) Is incurred specifically for the Federal award;
  (2) Benefits both the Federal award and other work of the non-Federal entity and can be distributed in proportions that may be approximated using reasonable methods; and
  (3) Is necessary to the overall operation of the non-Federal entity and is assignable in part to the Federal award in accordance with the principles in this subpart.

(b) All activities which benefit from the non-Federal entity's indirect (F&A) cost, including unallowable activities and donated services by the non-Federal entity or third parties, will receive an appropriate allocation of indirect costs.

(c) Any cost allocable to a particular Federal award under the principles provided for in this part may not be charged to other Federal awards to overcome fund deficiencies, to avoid restrictions imposed by Federal statutes, regulations, or terms and conditions of the Federal awards, or for other reasons. However, this prohibition would not preclude the non-Federal entity from shifting costs that are allowable under two or more Federal awards in accordance with existing Federal statutes, regulations, or the terms and conditions of the Federal awards.

(d) Direct cost allocation principles. If a cost benefits two or more projects or activities in proportions that can be determined without undue effort or cost, the cost must be allocated to the projects based on the proportional benefit. If a cost benefits two or more projects or activities in proportions that cannot be determined because of the interrelationship of the work involved, then, notwithstanding paragraph (c) of this section, the costs may be allocated or transferred to benefitted projects on any reasonable documented basis. Where the purchase of equipment or other capital asset is specifically authorized under a Federal award, the costs are assignable to the Federal award regardless of the use that may be made of the equipment or other capital asset involved when no longer needed for the purpose for which it was originally required. See also §§ 75.317 through 75.323 and 75.439.

(e) If the contract is subject to CAS, costs must be allocated to the contract pursuant to the Cost Accounting Standards. To the extent that CAS is applicable, the allocation of costs in accordance with CAS takes precedence over the allocation provisions in this part.

45 CFR § 75.430(i)(5) - RMTS

For states, local governments and Indian tribes, substitute processes or systems for allocating salaries and wages to Federal awards may be used in place of or in addition to the records described in paragraph (i)(1) of this section if approved by the cognizant agency for indirect cost. Such systems may include, but are not limited to, random moment sampling, "rolling" time studies, case counts, or other quantifiable measures of work performed.

  (i) Substitute systems which use sampling methods (primarily for Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), Medicaid, and other public assistance programs) must meet acceptable statistical sampling standards including:
    (A) The sampling universe must include all of the employees whose salaries and wages are to be allocated based on sample results except as provided in paragraph (i)(5)(iii) of this section;
    (B) The entire time period involved must be covered by the sample; and
    (C) The results must be statistically valid and applied to the period being sampled.
  (ii) Allocating charges for the sampled employees' supervisors, clerical and support staffs, based on the results of the sampled employees, will be acceptable.
  (iii) Less than full compliance with the statistical sampling standards noted in paragraph (i)(5)(i) of this section may be accepted by the cognizant agency for indirect costs if it concludes that the amounts to be allocated to Federal awards will be minimal, or if it concludes that the system proposed by the non-Federal entity will result in lower costs to Federal awards than a system which complies with the standards.

45 CFR § 95.507(a) - CAP

(a) The State shall submit a cost allocation plan for the State agency as required below to the Director, Division of Cost Allocation (DCA), in the appropriate HHS Regional Office. The plan shall:
  (1) Describe the procedures used to identify, measure, and allocate all costs to each of the programs operated by the State agency;
  (2) Conform to the accounting principles and standards prescribed in Office of Management and Budget Circular A-87, and other pertinent Department regulations and instructions;
  (3) Be compatible with the State plan for public assistance programs described in 45 CFR Chapter II, III and XIII, and 42 CFR Chapter IV Subchapters C and D; and
  (4) Contain sufficient information in such detail to permit the Director, Division of Cost Allocation, after consulting with the Operating Divisions, to make an informed judgment on the correctness and fairness of the State's procedures for identifying, measuring, and allocating all costs to each of the programs operated by the State agency.

45 CFR § 95.509 - CAP

(a) The State shall promptly amend the cost allocation plan and submit the amended plan to the Director, DCA if any of the following events occur:

(1) The procedures shown in the existing cost allocation plan become outdated because of organizational changes, changes in Federal law or regulations, or significant changes in program levels, affecting the validity of the approved cost allocation procedures.

(2) A material defect is discovered in the cost allocation plan by the Director, DCA or the State.

(3) The State plan for public assistance programs is amended so as to affect the allocation of costs.

(4) Other changes occur which make the allocation basis or procedures in the approval cost allocation plan invalid.

(b) If a State has not submitted a plan or plan amendment during a given State fiscal year, an annual statement shall be submitted to the Director, DCA certifying that its approved cost allocation plan is not outdated. This statement shall be submitted within 60 days after the end of that fiscal year.

45 CFR § 95.517(a) - CAP

(a) A State must claim FFP for costs associated with a program only in accordance with its approved cost allocation plan. However, if a State has submitted a plan or plan amendment for a State agency, it may, at its option claim FFP based on the proposed plan or plan amendment, unless otherwise advised by the DCA. However, where a State has claimed costs based on a proposed plan or plan amendment the State, if necessary, shall retroactively adjust its claims in accordance with the plan or amendment as subsequently approved by the Director, DCA. The State may also continue to claim FFP under its existing approved cost allocation plan for all costs not affected by the proposed amendment.

45 CFR § 95.519 - CAP

If costs under a Public Assistance program are not claimed in accordance with the approved cost allocation plan (except as otherwise provided in § 95.517), or if the State failed to submit an amended cost allocation plan as required by § 95.509, the costs improperly claimed will be disallowed.

45 CFR § 164.502(e)(2) - Disclosure of information

The satisfactory assurances required by paragraph (e)(1) of this section must be documented through a written contract or other written agreement or arrangement with the business associate that meets the applicable requirements of § 164.504(e).

OMB Circular A-87

Most of the OMG A-87 Circular was relocated to the CFR. Both OMB Circular and CFR references were used in the OIG Reports depending on the year they were issued. For simplicity, all references that were listed as A-87 Circulars have been listed here under their updated CFR citations.

2 CFR Part 225 Appendix A

B(17) - CAP

'Public assistance cost allocation plan" means a narrative description of the procedures that will be used in identifying, measuring and allocating all administrative costs to all of the programs administered or supervised by State public assistance agencies as described in Appendix D of 2 CFR part 225.

C(1) - Allowable costs

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:

a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
b. Be allocable to Federal awards under the provisions of 2 CFR part 225.
c. Be authorized or not prohibited under State or local laws or regulations.
d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
f. Be accorded consistent treatment. A cost may not be assigned to a Federal award as direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost.
g. Except as otherwise provided for in 2 CFR part 225, be determined in accordance with generally accepted accounting principles.
h. Not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award in either the current or a prior period, except as specifically provided by Federal law or regulation.
i. Be the net of all applicable credits.
j. Be adequately documented.

D(2) - CAP

2. Under the coordination process outlined in subsection E, affected Federal agencies will review all new plans and plan amendments and provide comments, as appropriate, to HHS. The effective date of the plan or plan amendment will be the first day of the quarter following the submission of the plan or amendment, unless another date is specifically approved by HHS. HHS, as the cognizant agency acting on behalf of all affected Federal agencies, will, as necessary, conduct negotiations with the State public assistance agency and will inform the State agency of the action taken on the plan or plan amendment.

OMB Circular A-87

2 CFR Part 225 Appendix B

8.h(6) - RMTS

(6) Substitute systems for allocating salaries and wages to Federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort.

(a) Substitute systems which use sampling methods (primarily for Temporary Assistance to Needy Families (TANF), Medicaid, and other public assistance programs) must meet acceptable statistical sampling standards including:

(i) The sampling universe must include all of the employees whose salaries and wages are to be allocated based on sample results except as provided in subsection 8.h.(6)(c) of this appendix;

(ii) The entire time period involved must be covered by the sample; and

(iii) The results must be statistically valid and applied to the period being sampled.

(b) Allocating charges for the sampled employees' supervisors, clerical and support staffs, based on the results of the sampled employees, will be acceptable.

(c) Less than full compliance with the statistical sampling standards noted in subsection 8.h.(6)(a) of this appendix may be accepted by the cognizant agency if it concludes that the amounts to be allocated to Federal awards will be minimal, or if it concludes that the system proposed by the governmental unit will result in lower costs to Federal awards than a system which complies with the standards.

48 CFR § 31.205-33(b) - Contingency contractor

(b) Costs of professional and consultant services are allowable subject to this paragraph and paragraphs (c) through (f) of this subsection when reasonable in relation to the services rendered and when not contingent upon recovery of the costs from the Government (but see 31.205-30 and 31.205-47).

CMS Administrative Claiming Guide

Page 8 - RMTS

In order to ascertain the portion of time and activities that are related to administering the Medicaid program, states must develop an allocation methodology that is approved by the U.S. Department of Health and Human Services. The approved allocation methodology, which may use random moment sampling (RMS), contemporaneous time sheets, or other quantifiable measures of employee effort, is often referred to as a time study. The time study must incorporate a comprehensive list of the activities performed by staff whose costs are to be claimed under Medicaid. That is, the time study must reflect all of the time and activities (whether allowable or unallowable under Medicaid) performed by employees participating in the Medicaid administrative claiming program.

Page 9 - Allowable reimbursements

[R]esources should be expended in the most cost-effective manner possible. In determining the administrative costs that are reimbursable under Medicaid, duplicate payments are not allowable. That is, [S]tates may not claim FFP for the costs of allowable administrative activities that have been or should have been reimbursed through an alternative mechanism or funding source . . . . Furthermore, in no case should a program or claiming unit in a local jurisdiction be reimbursed more than the actual cost of that program or claiming unit, including [S]tate, local, and [F]ederal funds

Page 39 - State participation requirement

[I]f the costs of such staff are completely offset (see Section V. C., Offset of Revenues), there would be no purpose to include them in the sample universe. That is, only staff for whom some costs remain after any applicable offsets should be included in the time study. For example, if [F]ederal funding sources or third party payors other than Medicaid meet 100 percent of the costs of social workers, then there would be no reason to include such workers in the time study and they must be excluded from participation. Furthermore, due to the offset, the costs of such staff would also not be included in the costs to be allocated.

Page 41 - Non-response coding

No completed responses should be deleted or ignored.... [A]ll non□responses should be coded to non-Medicaid time study codes

Page 41 - RMTS methodology

OMB Circular A-87 does provide that a less than fully compliant sample can be used if the cognizant agency can demonstrate that the proposed system "will result in lower costs to federal awards than a system that complies with the standards." The "cognizant agency" is defined in OMB Circular A-87 as the federal agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals developed under OMB Circular A-87 on behalf of all federal agencies. Flexibility is afforded, within the bounds of statistical validity. However, the validity and reliability of the sampling methodology must be acceptable to CMS. That is, the state must include details of how its time study methodology will be validated.

Page 42 - Treatment of the summer

If activities are actually performed during the summer period, the application of the results of time studies from the regular school year would not accurately reflect the costs associated with the summer period activities. In that case, a time study would also need to be conducted with respect to the summer period.

CMS Administrative Claiming Guide

Page 42 - Documentation

As with all administrative costs that are related to time study activities, there must be documentation of the costs for which FFP will be claimed under Medicaid. Documentation to be retained must support and include the following: the sample universe determination, sample selection, sample results, sampling forms, cost data for each school district, and summary sheets showing how each school district's claim was compiled

Page 44 - CAP

In accordance with the federal regulations ... and OMB Circular A-87, a public assistance CAP must be amended and approved by the DCA within DHHS before FFP would be available for administrative claims in the Medicaid program.... CMS does not have direct authority for approval of the public assistance CAPs; that is the purview of the DCA

CMS Technical Guide

Page 15 - Provider qualifications

In order for schools or school providers to participate in the Medicaid program and receive Medicaid reimbursement, they must meet the Medicaid provider qualifications. It is not sufficient for a state to use Department of Education provider qualifications for reimbursement of Medicaid-covered school health services.

Page 16 - Provider qualifications

Further, Medicaid regulations [42 CFR § 440.240] require that provider qualifications be uniform and standard. This means that states cannot have one set of provider qualifications for school providers and another set of provider qualifications for all other providers. Schools should check with the state Medicaid agency to determine specific state requirements regarding provider qualifications for participation in the Medicaid program.

Page 41 - Documentation

A school, as a provider, must keep organized and confidential records that detail client specific information regarding all specific services provided for each individual recipient of services and retain those records for review . . . . Relevant documentation includes the dates of service. . . .

APPENDIX C: CODING OF NON-RESPONSES

The treatment of non-responses was one of the few areas in which the OIG reports offered several interpretations. All relevant passages have been included below so each state can decide what makes the most sense for them. Ultimately, the best approach to treating non-responses – as detailed in the AZ13 audit – is to ensure that your CMS-approved methodology and your approved CAP both address how you plan to handle non-response moments, and then to address them in strict accordance with that approved plan.

NC Audit

"Improper Treatment of Invalid Responses: One contractor treated moments selected for occupied positions for which no response was received as invalid responses, but another contractor treated such moments as non-Medicaid moments. Non-responses must be treated the same by all contractors in order to assure statistical validity and to comply with the approved cost allocation plan."

AL Audit

"The CMS Guide states, "No completed responses should be deleted or ignored.... [A]ll non-responses should be coded to non-Medicaid time study codes" (page 41). Additionally, the CMS Guide instructs that the random moment sample "must reflect all of the time and activities (whether allowable or unallowable under Medicaid) performed by employees participating in the Medicaid administrative claiming program" (page 8).

Improper Treatment of Invalid Responses: Responses for moments that occurred when the employee was not scheduled to work, for moments selected for vacant positions, and for moments selected for occupied positions for which no response was received were all treated as invalid responses (see below). While the first two types of response were properly treated as invalid, the non-responses should have been kept in the sample and evaluated and coded as non-Medicaid moments.

"Invalid" observations that occurred for a vacant position or for time not scheduled to work should be removed from the sample because sample results are applied to personnel costs, and sample moments for unpaid time distort the results. However, "non-responses" that occurred because (1) the employee in the sampled position did not complete the form; (2) the activity could not be determined; or (3) the observation was otherwise unreliable should have been included in the sample and treated as non-Medicaid reimbursable to ensure proper allocation of costs."

AZ13 Audit

"The CMS guide, section V.A., states: "The burden of proof ... of time study sample results remains the responsibility of the states." Further, section V.B.2. of the guide states that the validity and reliability of the sampling methodology must be acceptable to CMS, and all non-responses should be coded as non-Medicaid activities.

CMS central office and regional officials informed us that section V.B.2. of the guide means that state Medicaid agencies may use alternate methodologies, including oversampling, to factor non-responses into their methodology – but only with prior approval from CMS. That is, any alternate methodology used to compensate for non-responses must be submitted to CMS for review and approval before implementation, and the methodology must be statistically valid and reliable. CMS officials also informed us that observation forms with missing or inaccurate information are considered to be non-responses and should be coded as non-Medicaid activities."

From CMS Guide

"To ensure an adequate number of responses, many schools oversample and/or factor in a non-response rate in their time study methodology. Under this methodology, oversampled responses are sometimes substituted for responses not received. However, oversampled responses should not be substituted for completed responses in which there are no or few reported Medicaid activities in order to increase the Medicaid reimbursable portion of the claim. No completed responses should be deleted or ignored. Another potential problem is employees who are instructed to not complete the time study if they typically do not perform many Medicaid activities. To avoid this, all non-responses should be coded to non-Medicaid time study codes. In addition, codes should be established to fully account for vacations, sick time, lunch hours, and other paid time not at work."

Letter to TX Regarding RMTS

This letter was not used in the TX audit, but rather used by another state in successfully defending their policy to discard non-responses.

"There are three broad categories for responses/nonresponses:

1. Countable Response – A response received within 48 hours that reported a work activity that will be included in this counts used to allocate pool costs.
2. Non-Countable Response – Any response received within 48 hours that reports either a common activity not used to allocate costs – such as leave, at lunch, not scheduled to work, employee terminated, etc. – which documents why a countable response was not reported.
3. Non-Response – No response was received from either the employee or the employee's supervisor during the 48 hours allowed for responding.

The importance of the three types of responses is to help ensure the validity of the sample results. Countable and Non-Countable Responses are valid, from a quality control perspective, and demonstrate that the RMS is operated properly by all involved. Non-Responses are an indication that the system is not functioning properly. The higher the proportion of Non-Responses, the less dependable the results, because it is not known what the results may have been.

Of the nine categories of "Non-Strike Reasons," we found only three that we would categorize as a Non-Response. They are "Missed Observation," "Voided Entry" and "Other." These Non-Responses impact the quality of the RMS results.

The other Non-Strike Reasons, while not countable for allocation purposes, are clear reasons for what was happening at the time the observation was to be made and should be classified as a Non-Countable Response. These Non-Countable Responses do not impact the quality of the RMS results."