OFFICE OF THE NEW YORK STATE COMPTROLLER

DIVISION OF LOCAL GOVERNMENT
& SCHOOL ACCOUNTABILITY

Auburn Enlarged City School District

Internal Controls Over Medicaid Reimbursement

Report of Examination

Period Covered:

July 1, 2008 — April 7, 2010

2010M-93

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State of New York
Office of the State Comptroller

Division of Local Government
and School Accountability

April 2011

Dear School District Officials:

A top priority of the Office of the State Comptroller is to help school district officials manage their districts efficiently and effectively and, by so doing, provide accountability for tax dollars spent to support district operations. The Comptroller oversees the fiscal affairs of districts statewide, as well as districts' compliance with relevant statutes and observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving district operations and Board of Education governance. Audits also can identify strategies to reduce district costs and to strengthen controls intended to safeguard district assets.

Following is a report of our audit of the Auburn Enlarged City School District, entitled Internal Controls Over Medicaid Reimbursement. This audit was conducted pursuant to Article V, Section 1 of the State Constitution and the State Comptroller's authority as set forth in Article 3 of the General Municipal Law.

This audit's results and recommendations are resources for district officials to use in effectively managing operations and in meeting the expectations of their constituents. If you have questions about this report, please feel free to contact the local regional office for your county, as listed at the end of this report.

Respectfully submitted,

Office of the State Comptroller
Division of Local Government
and School Accountability

Introduction

Background

The Auburn Enlarged City School District (District) is located in the City of Auburn and the Towns of Fleming, Sennett and Owasco, in Cayuga County. The District is governed by the Board of Education (Board) which comprises nine elected members. The Board is responsible for the general management and control of the District's financial and educational affairs. The Superintendent of Schools (Superintendent) is the chief executive officer of the District and is responsible, along with other administrative staff, for the day-to-day management of the District under the direction of the Board.

There are eight schools in operation within the District, with approximately 4,900 students and 705 employees. The District's annual budget for the 2009-10 fiscal year was approximately $59.1 million which was funded primarily with State aid, real property taxes, and grants.

The District, like other school districts statewide, is able to obtain partial Federal reimbursement for many special education services provided to Medicaid-eligible students by submitting periodic claims documenting the services provided to the New York State Department of Health. Claims must be supported by documentation of the services provided to students, and submitted within two years of the date services were provided. School districts receive Federal reimbursements of approximately 50 percent of the approved claim amounts.

The Director of Special Education (Director) is responsible for ensuring all eligible claims are submitted for reimbursement. In November 2009, the Board designated the Assistant Superintendent of Student Services (Assistant Superintendent) as the new Medicaid Compliance Officer, who is responsible for overseeing the processing of Medicaid services.

The District has contracted with a vendor (Vendor) to provide a Web-based program that providers and District staff use to document special education services that they provide to students. The Vendor is responsible for submitting the Medicaid claims for reimbursement to the New York State Office of the Medicaid Inspector General (OMIG), which reviews and approves the claims. The Vendor also is responsible for reporting to the District on the results of the claims submission process and reconciling the claims that it submits to OMIG to payments the District has received.

Objective

The objective of our audit was to review the District's internal controls over Medicaid reimbursements. Our audit addressed the following related question:

- Is the District claiming the Medicaid reimbursement to which it is entitled for services provided to eligible special education students?

Scope and Methodology

We reviewed the District's Medicaid reimbursement process for the period July 1, 2008 to April 7, 2010. We conducted our audit in accordance with generally accepted government auditing standards (GAGAS). More information on such standards and the methodology used in performing this audit is included in Appendix C of this report.

Comments of District Officials and Corrective Action

The results of our audit and recommendations have been discussed with District officials and their comments, which appear in Appendix A, have been considered in preparing this report. District officials generally disagreed with our findings and recommendations. Appendix B includes our comments on issues raised in the District's response.

The Board has the responsibility to initiate corrective action. Pursuant to Section 35 of the General Municipal Law, Section 2116-a (3)(c) of the Education Law and Section 170.12 of the Regulations of the Commissioner of Education, a written corrective action plan (CAP) that addresses the findings and recommendations in this report must be prepared and provided to our office within 90 days, with a copy forwarded to the Commissioner of Education. To the extent practicable, implementation of the CAP must begin by the end of the next fiscal year. For more information on preparing and filing your CAP, please refer to our brochure, *Responding to an OSC Audit Report,* which you received with the draft audit report. The Board should make the CAP available for public review in the District Clerk's office.

Medicaid Reimbursement

The Medicare Catastrophic Coverage Act of 1988 made it possible for school districts to obtain partial Medicaid reimbursement for many special education services that they provide to Medicaid-eligible students. The State Education Department (SED) and the Department of Health (DOH) jointly established the School Supportive Health Services Program (SSHSP) to help school districts obtain Medicaid reimbursement for diagnostic and health support services[1] provided to eligible students with an Individual Education Plan (IEP) and for case management review, which includes coordinating medical and non-medical procedures for students.

To administer the SSHSP, DOH has developed a monthly fee schedule for reimbursable services. Using the fee schedule, districts can submit claims to Medicaid for the gross amounts eligible for reimbursement. Districts must ensure claims are supported by documentation of the services provided to students, and submit the claims within two years of the date services were provided. Prior to April 1, 2009, the districts received Federal reimbursements of approximately 50 percent of the approved claim amounts. However, because the State was entitled to one-half the Medicaid reimbursements (25 percent of the approved claim) sent to the districts, the State withheld its share from the districts' future State aid. As a result of the American Recovery and Reinvestment Act (ARRA) and a lawsuit settlement between the State of New York and the Federal government, the reimbursement rate has been temporarily increased to over 60 percent until December 2010. Further, the State is no longer entitled to any of the districts' reimbursements for claims with a date of service after July 1, 2009. To ensure that all eligible services are claimed and reimbursed, it is essential that the District identify Medicaid-eligible students with IEPs and the reimbursable services they receive, submit claims for reimbursement of appropriate expenses in a timely manner, reconcile their submitted claims to reimbursement received, and review disallowed amounts to identify claims that can be resubmitted.

We found that the District did not process all of the claims for 26 Medicaid-eligible students with IEPs, identify the Medicaid-eligibility status of 12 Medicaid-eligible students with IEPs or submit claims for services they received, or identify the potential Medicaid

[1] Reimbursable services include physical and occupational therapy, speech pathology, psychological counseling, skilled nursing services, basic and comprehensive psychological evaluations, medical evaluations, medical specialist evaluations, audiological evaluations and transportation.

eligibility status of another six students with IEPs who received free school lunches. The District did not get reimbursed for these services because District officials had not established policies and procedures for controlling the Medicaid reimbursement process. As a result, the District did not claim $43,232 for IEP-related services provided to these students. By extending the error rate we identified in our three samples to their respective student populations, we estimate that the District did not claim $481,501 (25 percent) in potential Medicaid reimbursements for IEP services, Targeted Case Management (TCM) reviews and ongoing service coordination during the 2008-09 year, as shown in the following table.

Table 1: Medicaid-Eligible Students

Medicaid Reimbursement Revenue	Eligible Students Identified by the District	Eligible Students Not Identified by the District	Potential Medicaid-Eligible Students
Sample Totals for IEP Service, TCM and Ongoing Service Coordination	$22,718	$16,596	$3,918
Extension of Sample Error Rate to Respective Population	$214,374	$201,339	$22,556
Total Potential Reimbursement	$237,092	$217,935	$26,474
Grand Total (Eligible & Potential Eligible Students)			$481,501

Because of the two-year window, the District can still submit eligible 2008-09 school year claims[2] for reimbursement. Given that the current reimbursement rate has been temporarily increased to more than 60 percent for services provided through December 2010, it is especially important that the District ensure that it submits all claims for the reimbursable services it has provided to Medicaid-eligible students to maximize Medicaid reimbursement revenue.

Eligible Students Identified by the District

It is important that District officials establish written policies and procedures to define the responsibilities for collecting data and documentation and submitting claims for Medicaid reimbursement. District officials also must monitor the reimbursement process to ensure that the District receives all Medicaid reimbursements to which it is entitled. We found that the District lacked written policies and procedures to define the responsibilities for submitting and processing claims, collecting data and documentation, and monitoring the reimbursement process during the 2008-09 fiscal year. As a result, the District and State potentially lost a total of $237,092 in Medicaid reimbursements for IEP-related services ($137,965), TCM reviews ($40,452) and ongoing service coordination ($58,675). These services

[2] The District may currently submit claims for eligible IEP services and TCM case reviews for identified and non-identified students for reimbursement.

were provided to students who were identified by the District and the Vendor as Medicaid-eligible students with IEPs.

IEP-Related Services — IEP-related services that are eligible for Medicaid reimbursement under the SSHSP include physical and occupational therapy, speech therapy, psychological counseling, and skilled nursing services. We reviewed the case records for 26 of 261 Medicaid-eligible students with IEPs, a randomly selected sample comprising every 10th student from among the 261 students identified as Medicaid-eligible students with IEPs. We found that seven of the 26 students did not have any reimbursable IEP-related services provided to them.

The remaining 19 students received 259 IEP-related services at a cost of $104,268. The District failed to submit claims for 138 of these services totaling $52,374. We found that 95 of the 138 claims totaling $40,928 were eligible for reimbursement in the amount of $10,232. The remaining 43 claims totaling $11,446 were ineligible for reimbursement because the District-provided services did not meet Federal requirements.[3] Therefore, the District could not submit them for reimbursement and the District and State each lost $2,862 more in Medicaid reimbursement for services it provided to these students during the 2008-09 year.

If IEP-related services were provided at the same rate to the remaining 235 Medicaid-eligible students with IEPs, we estimate that the State and District each potentially lost an additional $124,871 in Medicaid reimbursement revenues for IEP-related services because the District did not ensure that student files were complete and up-to-date, that District staff and providers properly documented services provided, or that reimbursement claims were submitted in a timely manner. District officials stated that the majority of the lost revenue is attributed to their inability to obtain parental consent forms as required by SED.

TCM Case Reviews[4] — TCM coordinates medical and non-medical procedures for students. It includes both initial and periodic case reviews and ongoing service coordination. The TCM review process begins when a student is referred to their district's Committee on Special Education (CSE). If the CSE classifies a student as needing special education, the CSE team develops an IEP to address the student's needs and assigns a service coordinator to the student.

[3] These claims were ineligible for submission because the provider was not certified in conformance with Medicaid rules and regulations or because the student's IEP did not cover the period when the service was provided.

[4] Case reviews include annual, amended/requested reviews, triennial re-evaluations, and initials.

Districts may seek reimbursement for the total number of students referred to the CSE, regardless of whether the CSE decides to classify the students as needing special education. The CSE holds meetings at least annually to discuss each referred students' needs.

We reviewed the case records for the same sample of 26 Medicaid-eligible students with IEPs and found that the District did not claim Medicaid reimbursement for 41 of the 44 TCM reviews for these students, and did not provide an annual review for one student as required by law. As a result, the State and District did not receive $3,824 in Medicaid reimbursement for the 42[5] reviews totaling $15,297. Because the District did not seek reimbursement for all completed reviews, we estimate that the District lost an additional $36,628 in Medicaid reimbursement for reviews conducted for the remaining 235 Medicaid-eligible students with IEPs.

The Director stated that the District did not submit claims for reimbursement of TCM reviews for the 2008-09 school year because she believed that TCM reviews were ineligible for Medicaid reimbursement if review participants (e.g., teachers, case workers, or service providers) were paid in full or in part through a Federally-funded IDEA grant.[6] We spoke with officials from DOH and OMIG who told us that the Director's explanation for not submitting reviews for Medicaid reimbursement was incorrect. In February 2010, while we were still on site, the Director reviewed all the TCM review meeting attendance sheets and submitted 195 reviews for reimbursement totaling $69,680, from which the State and District could receive Medicaid reimbursements totaling at least $17,420. We commend the Director for implementing this audit recommendation to obtain additional revenue due the District.

TCM Ongoing Service Coordination — The service coordinator helps a student gain access to the services specified in the IEP; ensures that direct service providers deliver the appropriate services; provides a student, a student's parent, or other responsible individual with information and direction to help them access and use the service(s); and/or informs related service providers about educational, social or medical conditions that affect a student's ability to meet the IEP goals and objectives. A district must obtain parental consent release forms[7] and seek DOH's prior approval to claim Medicaid reimbursement for ongoing service coordination costs.

[5] The 42 reviews consisted of the 41 reviews that the District did not submit and the one annual review that the District did not provide.

[6] The Individuals with Disabilities Education Act (IDEA) authorizes grants to states, institutions of higher education, and non-profit organizations to support research, demonstrations, technical assistance and dissemination, technology, personnel development, and parent-training and information centers.

[7] HIPAA/Family Education Rights and Privacy Act (Buckley Amendment)

We reviewed the case records for the 26 Medicaid-eligible students with IEPs and found that the District and State could have received reimbursements totaling $5,800 for ongoing service coordination for services provided to these students. If the District had submitted for reimbursement for all ongoing service coordination conducted for the remaining 235 Medicaid-eligible students with IEPs, we estimate that the District and State could have received an additional $52,875 in Medicaid reimbursement revenues.

The District did not seek DOH approval for claiming Medicaid reimbursement revenues for TCM ongoing service coordination for these 26 students because the Assistant Superintendent stated it was not cost beneficial and contended that District staff members who acted as District-assigned case managers were not qualified to be service coordinators, even though they functioned as service coordinators.

Eligible Students Not Identified by the District

The first step in the Medicaid reimbursement process starts when the District identifies its Medicaid-eligible IEP students. District officials are responsible for ensuring all Medicaid-eligible students with an IEP are identified, and that these students' eligible service claims are submitted to Medicaid for reimbursement. To identify which special education services are reimbursable, District officials must regularly compare the Medicaid-eligible lists provided by Onondaga Cortland Madison Board of Cooperative Educational Services (OCM BOCES)[8] with the classified student list, generated by the District's annual CSE meeting, which contains the names of all students referred to the District's CSE. By matching the two lists, District officials can identify all the Medicaid-eligible students whose IEP services are reimbursable.

We found that the District did not submit claims totaling $217,935 during the 2008-09 fiscal year for IEP services provided to Medicaid-eligible students because either the District or the Vendor did not identify all the Medicaid-eligible students who received reimbursable IEP services. District officials told us it was their expectation that the Vendor hired to submit Medicaid reimbursement claims was performing this comparison as part of its contracted services with the District. However, in its contract with the District, the Vendor had committed to do such a comparison "where possible" rather than regularly and consistently. District officials provided us with two successive versions of the Vendor's list of Medicaid-eligible students,

[8] On a monthly basis, the Central New York Regional Information Center (CNYRIC) uses information from DOH's Medicaid assistance files to identify Medicaid-eligible students who attend public school districts located outside of New York City. District officials can obtain the Medicaid-eligible list prepared by CNYRIC for their District from the OCM BOCES.

each of which was inaccurate. District officials were unaware of these discrepancies because they did not review the Vendor's reports or compare the Vendor's reports or their classified list to OCM BOCES' list of Medicaid-eligible students.

The Vendor identified 278 IEP students who were Medicaid-eligible. However, we found 17 of the 278 students were not identified on the District's classified list as IEP students, and the dates of birth for three of the students were incorrect.[9] Because of these inaccuracies, we matched students from the District's classified list to the OCM BOCES-prepared list of Medicaid eligible students dated October 2009. We then compared our list of Medicaid-eligible IEP students with the Vendor's list of Medicaid-eligible IEP students and identified an additional 122 Medicaid-eligible IEP students who were not included on the Vendor's list. The services for these 122 students were not submitted for Medicaid reimbursement.

We reviewed the case records for 12 of these 122 students, a randomly selected sample comprising every 10th student from among the 122 students not properly identified as Medicaid-eligible students with IEPs. We determined that the District failed to submit claims for services to these 12 students which would have resulted in $16,596 in Medicaid reimbursement revenue.

The District provided us with an updated Medicaid-eligible IEP student list from the Vendor in March 2010, but the list still failed to identify 19 of the 122 students missing from the Vendor's original list and included an additional 46 students not identified on the original list. District officials stated that 12 of the 19 missing students were preschoolers whose services were not reimbursable to the District. In May 2010, we requested IEPs for 75[10] students to determine if they were Medicaid-eligible IEP students with reimbursable services. We verified that 12 of the students were preschoolers, and that 50 of the remaining 63 students were Medicaid-eligible IEP students with reimbursable services. If IEP-related services were provided to the remaining 148[11] additionally identified Medicaid-eligible IEP students at the same rate as they were provided to the 12 students in

[9] The submission of claims for students with incorrect dates of birth automatically results in the claims being denied.

[10] The 75 students included the 12 students the District stated were preschool students, the 17 students from the original Vendor list who were not on the District's classified list, and the 46 students additionally identified on the second Vendor list.

[11] The 148 additionally identified students include 98 students from the original Vendor list (122 students not identified less the 12 students in our sample and 12 preschool students), 15 of the 17 Medicaid-eligible students not included on the District's classified list who had received IEP services, and 35 of the 46 students from the second Vendor list who had received IEP services.

our sample, we estimate that the District potentially lost an additional $201,339 in Medicaid reimbursement revenues for IEP-related services.

Because the District and Vendor failed to identify all Medicaid-eligible IEP students, the District and State lost $217,935 in estimated Medicaid reimbursement revenues during the 2008-09 school year.

Potential Medicaid-Eligible Students

The District should pursue efforts to maximize Medicaid reimbursement revenue for the services it provides to students. We found that the District provided approximately 1,371 students with free lunches and that 42 of these students had an IEP, but were not listed as Medicaid-eligible on the OCM BOCES list. We reviewed the student files for six (15 percent) of the 42 students, including their free lunch applications. Because these students appear to meet the income requirement for Medicaid eligibility, their IEP-related services may have been eligible for reimbursement if the students had been enrolled in the Medicaid program. The six students had potential claims for IEP-related services, TCM reviews and ongoing service coordination for which the District could potentially have received $3,918 in reimbursement revenues. Furthermore, if the other 36 students had been enrolled in Medicaid, and if the District had submitted their Medicaid claims for reimbursement, we estimate the District could have potentially received an additional $22,556 in reimbursement. Therefore, the District and State potentially lost approximately $26,474 in estimated Medicaid reimbursement revenues during the 2008-09 school year.

Providing families who appear to be eligible with Medicaid enrollment information may benefit both the families and the District. On March 19, 2010 the Assistant Superintendent of Student Services corroborated our conclusion by stating five of the six students in our sample who received free lunches were either Medicaid-eligible during our scope period or had an expired Medicaid benefit number.

Internal Control Deficiencies

During the 2008-09 school year, the Director was responsible for overseeing the operation of the special education program, including the Medicaid reimbursement process. In late 2009, the Board adopted a Medicaid Compliance Program and appointed the Assistant Superintendent as the District's Medicaid Compliance Officer. However, we found the Director and the Assistant Superintendent failed to provide sufficient oversight of District staff, IEP service providers, and the Vendor, as detailed below. As a result, the District did not receive all the Medicaid reimbursement to which it was entitled.

Documentation — Good policies and procedures over the process for claiming reimbursements are essential for districts to obtain the

Medicaid revenues due to them. The documentation requirements for submitting claims for Medicaid reimbursement are detailed and specific. District officials must ensure student files are organized and contain all relevant, required and up-to-date information to support claims submitted for Medicaid reimbursement. Adequate student file documentation includes but is not limited to evaluations, a copy of the student's IEP, medical referrals, progress notes, contact logs, various parental consent forms, meeting minutes, meeting invitation letters, and service logs. District officials must ensure that District personnel and contracted service providers are aware of the types of documentation that service providers must maintain and provide evidence that they delivered services to students.

During our review of 44 students' files, we found the files were not centralized or up-to-date, and were often incomplete and disorganized. Pertinent student information was maintained in various school buildings and in the District office, but sometimes only in the school buildings. For example, although school building special education staff maintained various contact logs and progress notes for their students, they said they were rarely asked to provide this information to the District office. Therefore, the District lacked a single, complete, up-to-date file for each IEP student that contained all the required documentation. Further, we found that supporting documentation in the District office was stored in boxes, instead of filed in the appropriate students' files. We identified the following exceptions in the 44 students' files:

- Parental consent for special education services was missing from six student files.

- There were no service provider logs in the students' files in the District office.

- Required parental consent for a change in CSE meeting attendees was missing for 21 of the 33 meetings that required them.

- For 31 of 44 review meetings not attended by parents, there was no documentation to show that parents had been contacted and agreed to hold the meetings without them.

- Parental consent for reevaluation testing was missing for 11 of 17 reevaluated students.

- Parental consent for changing a student's IEP without a meeting was missing for three of the 21 students whose IEPs were changed.

- Review meeting minutes were often incomplete because IEP changes made during the meeting were not reflected in the minutes.

- One student's file had another student's information in it.

Because the District does not maintain adequate supporting documentation, the District was unable to submit claims for Medicaid reimbursement for all eligible services. In addition, the District risks losing Medicaid reimbursements previously received and being charged fines and penalties for submitting claims without adequate documentation.

Oversight of District Staff and Contracted Service Providers — The Director and the Assistant Superintendent are responsible for monitoring the Medicaid reimbursement process to ensure that District staff and contractors properly document service delivery so the District can be reimbursed for the IEP services it provides. We found that, while the Director provided District staff with necessary information pertaining to IEP service provisions, she failed to provide training or guidance about the type or amount of documentation needed to be maintained or submitted by District service providers for the Medicaid reimbursement process. Therefore, the service providers in the various school buildings maintain and submit service documentation in a different manner. Because the Director failed to provide sufficient oversight of District staff, the staff stated that they were not sure what documentation to submit or when to submit it. Without clear guidance and oversight, District staff may not maintain or submit the appropriate supporting documentation, which can result in lost Medicaid reimbursement revenues.

The District also contracted with two separate service providers for various IEP-related services: Cayuga-Onondaga BOCES and a second service provider. It is essential that the District have written agreements with its contracted IEP service providers, both to give all parties a clear understanding of the nature and extent of the services to be provided and to enable the District to monitor performance according to agreement terms. However, the District did not have a contract with the BOCES for these services, because the BOCES is exempt from such agreements. The District also lacked a detailed contract with the second service provider that specified the services it would provide and the documentation it would maintain. Although District officials told us that they have not had problems obtaining documentation of contracted provider services for claims submission purposes, documentation from the second provider was not available for our review. The Director and Assistant Superintendent said that the contracted service providers know the District's needs and do

what needs to be done without much input or oversight from them. However, absent a written contract with professional service providers and any monitoring by the District officials assigned responsibility for overseeing IEP services, the District has little assurance that it is receiving all the services the District is paying for.

Oversight of the Vendor — The District also contracts with the Vendor for access to its computerized Web-based program and for the submission of claims for Medicaid reimbursement.

The Vendor is responsible for identifying all Medicaid-eligible IEP students for the District using the District's classified list and the OCM BOCES Medicaid eligibility list. The Vendor also prepares various reports which District officials must review to ensure the Vendor's data is accurate, complete and up-to-date and that all reimbursable claims are submitted for reimbursement. We found that District officials did not properly monitor the Vendor or review the Vendor's reports for accuracy. As a result, the District failed to receive all Medicaid reimbursement revenue due them. Examples of the District's ineffective monitoring of the Vendor include the following:

- The Vendor's list of Medicaid-eligible students with IEPs dated October 2009 failed to identify 145 students, showed incorrect birth dates for three students and included two students that did not have an IEP and 15 students that the District did not list as IEP students on their classified list. Had District officials maintained up-to-date and accurate data about its students, compared the District's classified list to OCM BOCES data on a regular basis, and reviewed the Vendor's reports, they would have identified and corrected these inaccuracies so that claims could have been submitted for the services these students received.

- The Vendor-generated reports that listed the students who did, and did not, have a signed consent for the release of student information were inaccurate. Because the District must have written consent from a student's parent or guardian to bill Medicaid for IEP services, it is imperative that the District identify which students they have a consent form for and which students they need to obtain one for. We reviewed the two Vendor reports and found that four of the 26 students we sampled were listed as missing a consent form, yet a consent form was on file for them. Another two students were not listed on either report and four more students were listed on both reports. Because District officials used these inaccurate reports for identifying students and their services

for reimbursement, not all eligible claims were submitted for Medicaid reimbursement.

- The Vendor's contract states that the Vendor will reconcile claims it has submitted, but it does not clarify how the reconciliation will be done. We found that the Vendor-prepared remittance and billing reports did not reconcile to the OMIG reports of approved claims. Because the Director did not review the Vendor's reconciliations, these discrepancies were not investigated and resolved. Further, we found that the Vendor submitted claims sporadically, rather than submitting them consistently on a monthly basis. For example, the Vendor submitted 14 physical therapy (PT) and 44 occupational therapy (OT) claims in December 2008, another 19 PT and 42 OT claims in May 2009, and 27 PT and 134 OT claims in June 2009 with no submissions in between. PT and OT services are consistently provided to IEP students on a monthly basis. Therefore, claims for these services should also be submitted on a monthly basis. Because the Director did not review the Vendor's remittance and billing reports, the District was unaware of the sporadic submission of claims by the Vendor. The Director's failure to monitor the Vendor has allowed errors and irregularities to go undetected and uncorrected, which resulted in lost Medicaid revenues.

Because the Board did not establish internal control policies and procedures or ensure oversight was provided over the process of submitting claims for Medicaid reimbursement, the District has not maximized its revenue from Medicaid reimbursement.

The New York State Medicaid Plan (State Plan) requires the State to administer Medicaid in accordance with Federal law and policy. As a result of the American Recovery and Reinvestment Act enacted in 2009, the Medicaid reimbursement rate for claims paid between April 1, 2009, and December 31, 2010 has been temporarily increased to over 60 percent. Furthermore, in accordance with statutory changes to Education Law, the State is no longer entitled to any of the districts' reimbursements for claims with a date of service after June 30, 2009. The State is currently developing guidelines for the submission of claims in accordance with the recently approved SSHSP State Plan Amendment (SPA) #09-61 to meet all the requirements of the SPA #09-61.[12] Lastly, according to the terms of a Compliance Agreement

[12] SPA #09-61 defines the services, providers and their qualifications, and reimbursement methodology for the SSHSP and was approved by Centers for Medicare and Medicaid Services on April 26, 2010, with an effective date of September 1, 2009. Services provided between July 1, 2009, and August 31, 2009, do not have Federal approval and may not be submitted for reimbursement.

between the State and Federal governments, there is a requirement that all service providers and all school district staff involved with the reimbursement process must obtain annual training regarding the Compliance Agreement before the district is allowed to submit claims for reimbursement.

Because the guidelines for submitting claims are still being developed, the District has not submitted claims for reimbursable services delivered since the beginning of the 2009-10 fiscal year. When these guidelines become available, District officials should develop policies and procedures that promote careful compliance with the guidelines to help ensure the District receives all the reimbursement revenue to which it is entitled.

Recommendations

1. The Board should establish written policies and procedures that comply with the new Medicaid requirements to ensure that the District claims all Medicaid reimbursements to which it is entitled. These policies and procedures should include the establishment of personnel responsibilities and guidance on determining student eligibility and the claims process, including documentation requirements and timely submission of claims. District officials should also ensure that individuals who process Medicaid reimbursement claims understand these requirements and guidelines, and that District employees, as well as all District service providers, receive the annual training required by the Compliance Agreement.

2. District officials should ensure that the District's list of classified students is periodically compared to the OCM BOCES list of Medicaid-eligible students.

3. District officials should identify families that may be eligible for Medicaid benefits and provide such families with information about Medicaid enrollment.

4. District officials should maintain accurate, complete and up-to-date student files and IEP service delivery information in students' files.

5. District officials should provide guidance to District staff regarding the types of student information and service documentation that must be maintained, and when and how it must be submitted. The Director and Assistant Superintendent should monitor compliance with this guidance.

6. The District should have written agreements with professional service providers that detail the services to be provided and the service documentation to be maintained.

7. District officials should furnish service providers with a customized list of Medicaid-eligible classified students and hold information sessions with service providers to explain proper documentation requirements.

8. District officials should review the Vendor's list of Medicaid-eligible students with IEPs and other Vendor reports to verify that the Vendor's information is correct and complete.

9. District officials should reconcile the amounts claimed for Medicaid reimbursement with the amounts approved and received, and review any rejections or disallowances to determine whether the items may be resubmitted with additional documentation or explanation.

APPENDIX A

RESPONSE FROM DISTRICT OFFICIALS

The District officials' response to this audit can be found on the following pages.

Auburn Enlarged City School District

OFFICE OF THE SUPERINTENDENT OF SCHOOLS

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January 28, 2011

Mr. Edward Grant, Jr., Chief Examiner
Local Government and School Accountability
State of New York
Office of State Comptroller
The Powers Building
16 West Main Street – Suite 522
Rochester, New York 14614

Re: Auburn Enlarged City School District
Response to Draft Report of Examination Concerning Internal Controls Over Medicaid Reimbursement
Audit No. 2010M-93

Dear Mr. Grant:

We would like to thank your staff for their time and responses to our questions regarding the draft report issued by your office. The exit conference held on January 18, 2011 was well attended by District Staff, the District Internal Auditor, School Board Members and our contracted billing firm. We were encouraged by your staff to respond fully to any issues we had with the draft report and were granted a one week extension to do so based on the back and forth discussions during the exit conference. We are taking full advantage of that in our response below, in order to balance out the report and point out to the reader of the report that this is not a simple issue. The rules have been changing every day and during this time period, many of the rules were not known. We also felt it was necessary to point out to the reader the background of some of your findings and recommendations. We take your findings seriously and have a good track record of implementing the necessary changes required to correct any deficiencies.

We understand that this entire audit response letter will be included as an appendix to the final published audit report. The purpose of the below audit responses is to tell you what we think of your draft findings and to allow your office to correct any inaccuracies in your report before it is finalized. It also will help balance the report for the reader, if your office decides not to make any changes.

1) **Acknowledge that New York State was charged under the Federal False Claims Act with filing false Medicaid claims in both The School Supportive Health Services Program and the Preschool Programs.**

See Note 1 Page 40

The draft report letter should acknowledge that prior to the settlement school districts were claiming for Medicaid reimbursement that violated federal Medicaid law. Thus the false claims charges resulted in New York State agreeing to repay over a half billion dollars. This settlement required the State and the City of New York to repay the federal government Medicaid claims of $539,756,349.67. The State was charged with taking money it was not entitled to and is now being forced to repay it. More specifically the settlement document

clearly states the federal position on the operation of the program stating: "The United States contends that the Defendants submitted or caused to be submitted claims for payment to the Medicaid Program, Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v, which violated program requirements..."

Addendums to the settlement included the development of a new State Plan Amendment, which has revised the NYS School and Preschool Supportive Health Services Program, and the implementation of a Program Integrity Agreement between New York State and the Federal government, which includes extensive oversight of the program. This new State Plan Amendment has changed all of the requirements for school districts to bill for Medicaid services. The new system of checks and balances, for schools this includes the new requirement for a Medicaid Compliance Officer, is to ensure that no false claims are made.

2) **Remove the potential Medicaid Reimbursement from the draft report for Targeted Case Management Services (TCM).**

See Note 2 Page 40

OSC, in its draft report, states that because of the two-year window, the District can still submit 2008-09 claims for reimbursement for TCM. The draft letter specifically states that we should be claiming for $40, 452. The Department of Health (DOH) State of New York in a March 19, 2010 letter to the New York State Department of Health and Human Services Center for Medicare and Medicaid Services (CMS) clearly communicated that nothing a school does meets the requirements for TCM within the State Plan Amendment. The following response is taken directly from the NYS March 19, 2010 letter to CMS:

Page: 1

Response: Based on discussion with the State Education Department, it has ~~been~~ determined that the proposed "care coordination" activities are not comprehensive enough to meet federal requirements for Medicaid targeted case management. Subsequently, the enclosed revised SPA pages no longer include "care coordination" as a covered service.

Additionally, per the School Supportive Health Services Program Preschool Supportive Health Services Program (SSHSP/PSHSP), Questions and Answers issued on June 11, 2010, districts can no longer submit claims for targeted case management, retroactively nor in the future. On page 6 of this document, TCM is not listed as one of the 10 Medicaid reimbursable services. The following is what is listed:

Medicaid Covered Services and Provider Qualifications Under SSHSP

18. Q. What Medicaid services are covered under SSHSP?

A. The ten covered services are:

- Physical therapy services
- Occupational therapy services
- Speech therapy services
- Psychological evaluations
- Psychological counseling
- Skilled nursing services
- Medical evaluations
- Medical specialist evaluations
- Audiological evaluations
- Special transportation services

Therefore, we respectfully request that the final audit letter of the Comptroller remove the potential Medicaid reimbursement revenue for TCM. It should be noted that the District has communicated with Connie Donohue, MA, CCC-A, Early Intervention Specialist, from the Department of Health, who has clearly stated, "claims that do not meet the standards outlined in the SSHSP guidance documents should not be submitted or should be voided."

It should be noted that Connie Donohue is the lead person in the Department of Health for Medicaid and reports directly to the Director, Ronald Bass. Review of a PowerPoint presentation found on the New York State Education Department website: http://www.oms.nysed.gov/medicaid/billing_claiming_guidance/

Materials currently available are:

PowerPoint presentation (*updated September 2010)* titled "SSHSP/Medicaid in Education Training on Compliance Agreement, Written Compliance Policies and Program Update"

demonstrates that Connie Donohue is the lead person handling Medicaid for the DOH as shown on slide 42 of the PowerPoint presentation and anything she says is said as the lead person for the department in this area:

Contacts: Medicaid in Education
medined@mail.nysed.gov

DOH

Connie Donohue 518-473-2160
cjd13@health.state.ny.us

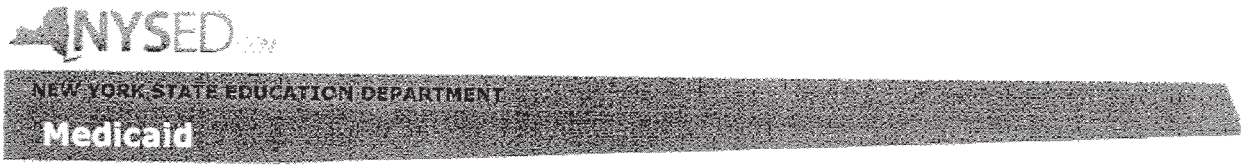
Cristin Carter 518-473-2160
cmc10@health.state.ny.us

Melissa Kannicutt 518-473-2160
mak16@health.state.ny.us

3) **Acknowledge that the Director had not submitted claims for TCM at the time the auditors reviewed the files as she was needing to take the time to cross check attendance to verify that no IDEA grant funded employees participated in the meetings per the State Directive. Because of the two-year window for filing claims, the Director had plenty of time to make sure that no false claims were made.**

See Note 3 Page 40

OSC, in its draft report, claims that the district should file for a total of $36,628 for targeted case management services provided during annual reviews, amended reviews, and triennial reviews required by the Individuals with Disabilities Education Act (IDEA). During the audit and at our meeting on January 18, 2011, district officials outlined directives in conflict with this audit recommendation that it has received from those who supervise the Medicaid program in schools. The New York State Education Department website in its Medicaid link in a paragraph entitled "Medicaid Billing" contains the following question and answer:



Medicaid Billing

Q. Can a school district bill Medicaid for an IEP meeting if ANYONE attending the meeting is paid with IDEA monies?

A. No. If anyone is paid with IDEA monies and they participated in the development of the IEP, then the IEP meeting is not Medicaid reimbursable. The development of the IEP includes the meetings to determine what evaluations and reports should be completed and/or reviewed.

The OSC, in its draft report, states that claims for reimbursement of TCM reviews were submitted and filed as of March16, 2010, and this was reported to the auditors. The total gross claim was $69,680. The delay in filing these meetings was due to the need to cross check attendance to verify that no grant funded employees participated in the meetings being claimed, per the State directive above.

Per that directive, the Director reviewed the attendance of every CSE meeting held during the 08-09 school year and removed any meeting attended by IDEA funded staff from the list submitted for claims. To do otherwise would have constituted a false claim per this directive. Starting with the 09-10 school year, the staff paid with IDEA funds was restructured to eliminate the conflict, nevertheless, the Federal Government has since ruled that filing for TCM is not allowable.

While the Director explained this rationale and the auditors were given the above directive from the State, the OSC draft report states that they spoke to officials from the Department of Health (DOH) and OMIG who told them that the Director's explanation for not submitting reviews for Medicaid reimbursement was incorrect. The District has communicated with Connie Donohue, MA, CCC-A, Early Intervention Specialist, from the Department of Health and Fred Warnecke, Deputy Director of OMIG whom have agreed that it would be a false claim if we knowingly file a claim that does not meet the above State rules. Therefore, it appears that the State and Federal entities are not giving clear direction on the eligibility for reimbursement for TCM.

In an effort to see what other school districts have been doing in regards to Targeted Case Management, the following Responses to the 2005 OSC Medicaid audits were found:

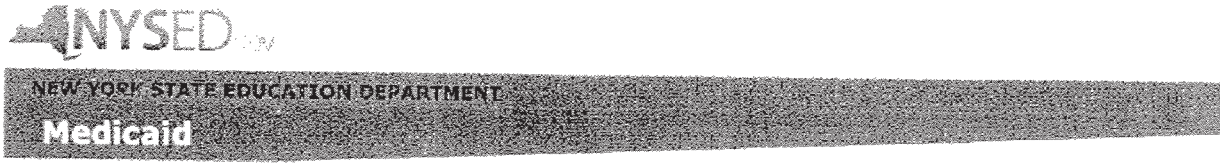
"The district has been charging salaries or portions of salaries to federal grants and, therefore, services performed by these individuals are not eligible to generate further aid or reimbursement through the Medicaid avenue. While we were unable to go back and make adjustments to these grants for prior years … we have reviewed the budgets for those grants and have developed them to permit us to bill for TCM in the future." (Coxsackie-Athens Central School District)

We are sure that the Comptroller does not wish any public school to risk criminal penalties that may accrue for any claim of Medicaid fraud. With this in mind, we ask that the final audit letter of the Comptroller acknowledge this bona fide concern and remove the potential Medicaid reimbursement revenue for TCM. It should be noted that the District has communicated with Connie Donohue, MA, CCC-A, Early Intervention Specialist, from the Department of Health, who has clearly stated, "claims that do not meet the standards outlined in the SSHSP guidance documents should not be submitted or should be voided." During the January 18, 2011 exit meeting, the District asked [redacted] to please identify the officials from the Department of Health (DOH) and OMIG who told them that the Director's explanation for not submitting reviews for Medicaid reimbursement was incorrect. She stated that they had email correspondence from DOH and OMIG. When asked if they would share the correspondence with the District, [redacted] stated that they would not share the emails. The District contacted DOH on January 19, 2011 to ask them about the correspondence indicating that if they gave this direction it was in contradiction to previous requirements. Connie Donohue, MA, CCC-A, Early Intervention Specialist, from the Department of Health, responded on January 20, 2011 in an email by stating, "We have sought a legal opinion about on Medicaid billing when federal funding is available (this is currently with the Division of Legal Affairs)." It should be noted that the District is willing to share this email correspondence. As the DOH is clearly uncertain on direction to give school districts, if Auburn were to file these claims based on the Comptroller's recommendation, the Comptroller would be liable for causing false claims.

4) Acknowledge that the Office of the New York State Comptroller is determining the State rule on Targeted Case Management differently from the Auburn Enlarged City School District's draft report and an audit conducted at the Kingston City School District. Therefore, it is requested that the final report remove the potential Medicaid reimbursement revenue for TCM.

See Note 4 Page 40

OSC, in its draft report, claims that the district should file for a total of $36,628 for targeted case management services provided during annual reviews, amended reviews, and triennial reviews required by the Individuals with Disabilities Education Act (IDEA). During the audit and at our meeting on January 18, 2011, district officials outlined directives in conflict with this audit recommendation that it has received from those who supervise the Medicaid program in schools. The New York State Education Department website in its Medicaid link in a paragraph entitled "Medicaid Billing" contains the following question and answer:



Medicaid Billing

Q. Can a school district bill Medicaid for an IEP meeting if ANYONE attending the meeting is paid with IDEA monies?

A. No. If anyone is paid with IDEA monies and they participated in the development of the IEP, then the IEP meeting is not Medicaid reimbursable. The development of the IEP includes the meetings to determine what evaluations and reports should be completed and/or reviewed.

In a 2005 OSC Medicaid audit of the Kingston City School District, the audit determined the following:

- The Kingston City School District funded the salaries of some related service providers assigned to several ME classified students with federal grant moneys. As a result, the district could not claim Medicaid reimbursement for these students. An alternative would be to reassign ME classified students to providers not paid by federal grant moneys.

This is a clear contradiction from our OSC draft report. Therefore, it is requested that the final report remove the potential Medicaid reimbursement revenue for TCM.

5) Remove the potential Medicaid Reimbursement from the draft report for Ongoing Service Coordination.

See Note 5 Page 40

OSC, in its draft report, states that because of the two-year window, the District can still submit 2008-09 claims for reimbursement for Ongoing Service Coordination. The draft letter specifically states that we should be claiming for $58, 675. Per the School Supportive Health Services Program Preschool Supportive Health Services Program (SSHSP/PSHSP), Questions and Answers issued on June 11, 2010, districts can no longer submit claims for targeted case management, retroactively nor in the future. On page 6 of this document, Ongoing Service Coordination is not listed as one of the 10 Medicaid reimbursable services. The following is what is listed:

Medicaid Covered Services and Provider Qualifications Under SSHSP

18. Q. What Medicaid services are covered under SSHSP?

A. The ten covered services are:

- Physical therapy services
- Occupational therapy services
- Speech therapy services
- Psychological evaluations
- Psychological counseling
- Skilled nursing services
- Medical evaluations
- Medical specialist evaluations
- Audiological evaluations
- Special transportation services

Therefore, we respectfully request that the final audit letter of the Comptroller remove the potential Medicaid reimbursement revenue for Ongoing Service Coordination. It should be noted that the District has communicated with Connie Donohue, MA, CCC-A, Early Intervention Specialist, from the Department of Health, who has clearly stated, "claims that do not meet the standards outlined in the SSHSP guidance documents should not be submitted or should be voided."

6) Acknowledge that the District could not have claimed for Ongoing Service Coordination.

See Note 6 Page 41

OSC, in its draft report, states that the district could have received an additional $52,875 in Medicaid reimbursement revenues via Ongoing Service Coordination claims. During the audit, the Assistant Superintendent shared that the District did not seek Department of Health approval to claim for this service as it had been determined that it would not be cost-beneficial to the district as additional teachers would need to be hired in order for special education teachers to maintain appropriate Ongoing Service Coordination case notes. Specifically, teachers would need additional time within the school day in order to maintain these case notes. At the reimbursement rate during the 2008-09 school year of $0.25 revenue for every $1.00 claimed, it would have cost the District more to hire additional teachers than the potential revenue reimbursement. It should be noted that the cost to the District to hire one first year teacher with zero years of teaching experience would be around $65,000 including salary and benefits. Based upon the Medicaid eligible student population in Auburn, we believe that the District would require at least two additional special education teachers, requiring workspaces and other associated costs. To invest $130,000+ solely to capture a reimbursement of $52,875 would be irresponsible.

The District sought guidance from the NYS Office of the Medicaid Inspector General (OMIG). Fred Warnecke, Deputy Director, stated that Ongoing Service Coordination claims should conform to the requirements in the Medicaid Claiming/Billing Handbook, which reveal the following requirement:

Documentation that ongoing service coordination was provided consists of case notes that meet the following criteria:

1. Issue: - the reason for a coordination contact,
2. Notes: - a brief summary of what transpired during the contact,
3. Action: - an action, reaction, or decision by the coordinator.

The District reviewed the following two different samples of case notes:

Sample Ongoing Service Coordination Case Notes

STUDENT NAME: [redacted]
P. **DOB** [redacted]

Person contacted: B. P. **Title:** Therapist **Date Contacted:** 2/24/97

Issue: Follow-up in progress.

Notes: Parent asked for update on Speech: [redacted] continues with speech and language services. Tries hard, progress is slow but consistent.

Action: Will follow up with parent.

ONGOING SERVICE COORDINATION NOTES DOCUMENTATION

SCHOOL:		
STUDENT NAME:	DOB	#:
COORDINATOR NAME:	COORDINATOR TITLE:	

Person Contacted: Date Contacted: / /

☐ Case Wrkr ☐ Physician ☐ OT/ PT ☐ Prin/Assist ☐ Psychologist ☐ Social Wrkr ☐ Speech ☐ Counselor ☐ Nurse/Pract ☐ Parent ☐ Probation ☐ Teacher ☐ Spec Ed Tchr ☐ Aide	Issue: Summary: Action:

The special education teachers do not have time to maintain this level of detail of case notes without additional time added to their schedules. In an effort to further understand how Ongoing Service Coordination is provided, we contacted the Cayuga County Health Department Early Intervention Official, Sue Barrette, whose sole responsibility is to provide this program's mandated service coordination. For Early Intervention, they do employ four people whose sole responsibility is to provide the service coordination.

We also contacted a Medicaid Service Coordinator at the Cayuga Home for Children, Jackie Richards-Wood, who indicated that her current caseload of 20 students is a full time job. She also shared that she spent a day and a half working on paperwork to refer one of her clients to a new program, who happens to be an Auburn student eligible for Medicaid. She also completes daily logs, monthly summaries, annual and semi annual ISP meetings and reports,

Medicaid Home and Community Based Waiver applications, Medicaid and/or food stamp applications. To suggest that our teachers could meet that demand in the 40 minutes given to them for preparation once a day is not reasonable, and to meet with families after school would also result in additional compensation. The only way to meet the demands of providing ongoing service coordination would have been to hire additional staff, and it is unlikely that the revenue provided by Medicaid would have off-set that expense.

In an effort to see what other school districts have been doing in regards to Ongoing Service Coordination, the following Responses to the OSC 2005 Medicaid audits were found:

"In reviewing the documentation and frequency of service necessary to bill for (TCM-ongoing service coordination) the district does not feel the reimbursement rate would justify requesting the Health Department's approval to bill for TCM services at this time. The amount of paperwork, clerical and administrative oversight is not supported by the low reimbursement rate." (Kingston City School District)

"The rate of reimbursement for TCM – ongoing service coordination that districts receive is extremely low when compared to other related services reimbursement rates. The service and documentation necessary to bill Medicaid for on-going service coordination is not cost effective for our district to track and bill for TCM- ongoing service coordination unless the state allows for greater reimbursement to school districts." (New Paltz Central School District)

Our responses to the auditors have been and remain very similar in nature to the responses generated from the Kingston City School District and the New Paltz Central School District. Again, it should be noted that the cost to the District to hire one first year teacher with zero years of teaching experience would be around $65,000 including salary and benefits. Based upon the Medicaid eligible student population in Auburn, we believe that the District would require at least two additional special education teachers, requiring workspaces and other associated costs. To invest $130,000+ solely to capture a reimbursement of $52,875 would be irresponsible. Therefore, we respectfully request that the final audit letter of the Comptroller remove the potential Medicaid reimbursement revenue for Ongoing Service Coordination.

7) Acknowledge billing for services provided by school psychologist is not allowed. Such claims would constitute false claims.

See Note 7 Page 41

OSC, in its draft report, states that 43 claims totaling $11,466 were ineligible for reimbursement because the District provided services that did not meet Federal requirements. This is in reference to counseling provided by district school psychologists. Of the 11 school psychologists on staff that year, only one had the credentials that would allow her to file Medicaid claims for counseling she performed. OMG is suggesting that we provide an "Under the Direction of" model similar to speech therapists that are not licensed. Such a structure is not allowed. Medicaid covered services can only be provided by a psychiatrist, licensed psychologist, licensed clinical social worker, or a licensed master social worker who is supervised by one of the above. The span of control for the supervisor (psychiatrist, licensed psychologist, licensed clinical social worker) is no more than four, possibly five, staff (licensed master social workers).

If Auburn were to implement this approach based on the Comptroller's recommendation, the Comptroller would be liable for causing false claims.

See Note 8 Page 41

8) Recognize that Auburn may not require a parent to enroll in a public health insurance program and has made all parents who apply for the free or reduced lunch program aware of the existence of other programs that may be of assistance to them. Further, the parents of the children have not granted consent to the District to act on the information in the free or reduced lunch application. Lastly, Medicaid outreach activities conducted by school district must be held to a minimum, as they are the funded responsibility of the County Medicaid office and the appropriate State agencies.

The OSC, in its draft report, states that the District and the State potentially lost approximately $26,474 in estimated Medicaid reimbursement revenues during the 2008-09 school year. The report states that providing families who appear to be eligible with Medicaid enrollment information may benefit both the families and the District. Auburn is bound by federal and State law to provide a free and appropriate public education (FAPE) to all children who reside in the district. It may not impede access in any way. In the free and reduced lunch process families are made aware of the existence of other programs like Medicaid and a request is made for their consent so information can be released to other programs. To make this request repeatedly can create a burden on the family and places the District's actions in question. Therefore, a family's refusal to grant consent once must be accepted by the District as the parents informed decision and should not result in the family being contacted again with a request to release the same private information. To do so can easily result in complaints concerning the district provision of FAPE. The Electronic Code of Federal Requirements as shown:

Electronic Code of Federal Regulations

e-CFR™

e-CFR Data is current as of January 13, 2011

Title 34: Education

Browse Next

PART 300—ASSISTANCE TO STATES FOR THE EDUCATION OF CHILDREN WITH DISABILITIES

§ 300.154 Methods of ensuring services.

(d) *Children with disabilities who are covered by public benefits or insurance.* (1) A public agency may use the Medicaid or other public benefits or insurance programs in which a child participates to provide or pay for services required under this part, as permitted under the public benefits or insurance program, except as provided in paragraph (d)(2) of this section.

(2) With regard to services required to provide FAPE to an eligible child under this part, the public agency—

(i) May not require parents to sign up for or enroll in public benefits or insurance programs in order for their child to receive FAPE under Part B of the Act;

(ii) May not require parents to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services provided pursuant to this part, but pursuant to paragraph (g)(2) of this section, may pay the cost that the parents otherwise would be required to pay;

It is requested that the final OSC audit letter recognize that Auburn may not require a parent to enroll in a public health insurance program and has made all parents who apply for the free or reduced lunch program aware of the existence of other programs that may be of assistance to them. The District has added the following paragraph to the Free and Reduced Lunch

Approval Letter: "There are many other supporting services available to residents of the Auburn School District. If you have questions or wish further information on what is available, contact the District at 255-8801. Also, the Human Services Coalition publishes a community services directory, which is available at www.human-services.org or by calling 253-9743." Further, the parents of the children have not granted consent to the District to act on the information in the application. Ultimately, Medicaid outreach activities conducted by school district must be held to a minimum, as they are the funded responsibility of the County Medicaid office and the appropriate State agencies.

9) Acknowledge that the Medicaid-eligible student lists will change each day that they are reviewed and that comparing different lists on different days will yield inaccurate results.

See Note 9 Page 41

The OSC draft report indicated that the District did not identify all the Medicaid-eligible students who received reimbursable IEP services. It also states that three different reports of Medicaid-eligible students were inaccurate. Medicaid eligibility testing is a complex process. The eligibility system is driven by a statewide online/real-time database. Sources of the ever changing information include any county social services intake worker, State employees, child welfare workers, the Social Security Administration, etc. Frequently eligibility information is added with effective dates well in the past. The eligibility matching process used for school Medicaid providers is based on batch matching of files. These are static files of eligibility on a given date. Sometimes referred to as flat files, they are only accurate for the moment in time they were created. They are known to not accurately reflect what is actually on the Medicaid eligibility file used by the State to make the Medicaid payments. The process in and of itself results in a percentage of mismatches for a number of reasons. Files collected at the OCM BOCES Regional Information Center (RIC) are usually a month old by the time the matching is done with the school special education caseload, etc. Even at its most timely operation, information from the matching process will run at least 60 days behind. That is, a child added to the school special education program in one month will most likely be first matched with the Medicaid file the next month and the results transmitted back and updated in the following month.

The OSC draft report stated that they compared the OCM BOCES prepared list of Medicaid-eligible IEP students and identified an additional 122 Medicaid-eligible IEP students who were not included on the Vendor's list indicating that services for 122 students were not submitted for Medicaid reimbursement. Due to the eligibility testing and matching process for school providers being complex and different lists yielding different results, the comparison that the examiners conducted could not produce accurate results. Additionally, claiming during the period in question was suspended, most of the paid claims were disallowed (for all school districts due to the US Attorney threatening additional false claims action) and returned to the district as not meeting federal criteria. Further, the State does have the ability to grant direct access to the Medicaid eligibility file used for claims payment, but has chosen **not to** do that. Such access would eliminate the current convoluted process and greatly improve the timeliness and accuracy of the eligibility identification process. Therefore, it is requested that this claim that the District and the State lost $217,935 be removed from the final audit letter.

10) Acknowledge that the State unilaterally created the entire consent problem of school districts needing to secure "consent to bill Medicaid" and it is their responsibility to fix, as it is required as a condition to receive federal Individuals With Disabilities Education Act (IDEA) funding.

See Note 10 Page 41

During the January 18, 2011 exit meeting, [redacted], stated to the Board of Education that the issues found in the Auburn Enlarged City School District are exactly the same that they have found across all other school districts audited and that the primary issue is districts not securing consents from parents in order to bill for Medicaid. She stated that statewide, there is a 50% rate of return of the consent forms. There are two provisions in the IDEA statute and regulations and one in the FERPA regulations that clearly put the responsibility for addressing the consent issue on the State:

- First the IDEA regulation 34 C.F.R. 300.142(a)(1) places the legal responsibility on the State as follows:

  ``(12) Obligations related to and methods of ensuring services.

  ``(A) Establishing responsibility for services.--The Chief Executive Officer of a State or designee of the officer shall ensure that an interagency agreement or other mechanism for interagency coordination is in effect between each public agency described in subparagraph (B) and the State educational agency, in order to ensure that all services described in subparagraph (B)(i) that are needed to ensure a free appropriate public education are provided, including the provision of such services during the pendency of any dispute under clause (iii). Such agreement or mechanism shall include the following:

  ``(i) Agency financial responsibility.--An identification of, or a method for defining, the financial responsibility of each agency for providing services described in subparagraph (B)(i) to ensure a free appropriate public education to children with disabilities, provided that the financial responsibility of each public agency described in subparagraph (B), **including the State medicaid agency and other public insurers of children with disabilities, shall precede the financial responsibility of the local educational agency (or the State agency responsible for developing the child's IEP).**
  http://www.kinneyassoc.com/MedEdHistory/ideaSTATUTEONceoRESPONSIBILITY.HTM

The State of New York has never fulfilled this obligation. Two easy examples are the failure to cover personal care provided in schools and the failure to pay schools from the Child Health Plus Program. These are two things that are done in many other states, but ignored by New York State. It is requested that the OSC final audit report recognize this, and the district's efforts in spite of the State's refusal to follow the federal law.

This does not allow the State to use consent to block funding from Medicaid. In addition the IDEA regulation specifically says the Medicaid application can be informed consent.

From the 2004 regulation found at
http://www.kinneyassoc.com/MedEdHistory/finalregulations.pdf

"612(a)(12)(A)(i) of the Act provides that the financial responsibility of public agencies (other than an educational agency), including Medicaid and other

public insurers obligated under Federal or State law or assigned responsibility under State policy, must precede financial responsibility of the LEA."

On the Medicaid application: "However, we agree with the commenter that a public agency could satisfy parental consent requirements under FERPA and section 617(c) of the Act if **the parent provided the required parental consent to the State Medicaid agency,** and the consent satisfied the Part B definition of consent in § 300.9."

For the State to contend that its Medicaid application does not meet this requirement does not relieve the State from its burden to assure the financial responsibility of Medicaid, and other responsible public insurance programs, precede that of the LEA.

Allowing consent to block payment is nothing other than a systematic cost shift onto local schools districts of health care costs that belong in other state programs.

- The second provision was in the 2008 regulation issues on FERPA. Found at http://www2.ed.gov/legislation/FedRegister/finrule/2008-4/120908a.pdf. This additional clarification has been totally ignored by the State. Again the result is the State, not Auburn, is failing to meet its obligations under the IDEA.

  "**Therefore, parents can provide consent at intake time to State and local social services and other non- educational agencies serving the needs of students in order to permit their children's schools (or the SEA) to disclose education records to the agency.** For example, parents routinely provide consent to the Medicaid agency that permits that agency to collect information from other agencies on the family being served. In many cases those consents are written in a manner that complies with the consent requirement in § 99.30, and the student's school may disclose information to the Medicaid agency necessary for reimbursement purposes for services provided the student."

Obtaining consent from parents to allow the District to file Medicaid claims for the eligible services we provide remains a huge challenge. We regularly put a consent form and parent letter in every packet prepared for CSE meetings, and make every effort to have the parent sign at the meeting. However, parents do not always attend CSE meetings, so if it is not signed, the consent form is included with the paperwork sent to parents after the meeting is finalized and sent to the BOE for approval. Missing consent reports are printed at various times when other parent communication occurs; parent teacher conferences, when semester report cards are sent home, and prior to annual reviews when teachers work with parents to prepare the upcoming school year's IEP. Despite these efforts, the district struggles to maintain a high rate of return. There are some families who refuse to sign consent, but the majority simply does not respond.

It should also be noted that as of this 2010-11 school year, the District now treats every student who is classified and has an IEP as if they were Medicaid eligible. Consent is pursued for every student multiple times during the year, and the documentation needed to file an actual claim, such as consents, service recommendations (scripts), time/date of service, session notes and CPT codes are entered by providers into the K-Systems database as a potential claim. K-systems then has a system of edits to determine when, if ever, all of the requirements for filing an actual claim have been met, and then the claim is processed. This will allow the District to file retroactively to the beginning of the school year for students who become Medicaid eligible during the school year.

It is requested that the OSC final audit letter acknowledge that the State needs to focus on their responsibility to fix the consent issue, as it is required as a condition to receive federal Individuals With Disabilities Education Act (IDEA) funding. A resolution would be for the State to determine that their Medicaid application meets the requirement for consent.

11) Acknowledge that the District has received conflicting expectations in regards to record keeping by the State of New York Office of Medicaid Inspector General and the State of New York Office of the State Comptroller.

See Note 11 Page 42

The OSC draft report states that the District lacked a single, complete, up-to-date file for each IEP student and that they found supporting documentation in the District office was stored in boxes, instead of filed in appropriate students' files. The State of New York Office of Medicaid Inspector General completed a review of the District's compliance with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program whereby they reviewed payments to the District for SSHSP services paid by Medicaid from April 3, 2005 through April 2, 2006. The final notification of OMIG's findings in a report dated January 23, 2007 stated, "Auburn Enlarged City School District's records were well organized, and in most instances, documentation adequately supported Medicaid claims." In the Director's notes of the exit interview, it was the recommendation of the auditor that we keep all records related to Medicaid reimbursement for a given school year in a central location, and not in the students' folders. We have implemented that practice since, based on that recommendation. The OSC draft report also stated that various contact logs and progress notes are kept by special education staff in their buildings, and that they are rarely asked to provide that information to the district office. All staff, who are directly involved in the filing of Medicaid claims (ST), do submit progress notes and attendance logs annually to the district office, as do related service providers who provide contracted services (OT/PT). In addition, parent contact is also logged within IEP Direct, as are progress notes for all staff. The auditors did not request to see these documents. The district respectfully requests that this section of the report be revised to reflect the conflicting expectations of OMG for record keeping.

As the District has been reviewing the management of the vast information required to make a Medicaid claim, the District is now utilizing additional staff to assist with the inputting of information into K-Systems, and also to reconcile monthly billing and reimbursement. This will allow the district to monitor the need for documentation in a timely manner and take action to secure any needed information. Each therapist is asked to keep their claiming information in K-systems up-to-date, and the Director of Special Education checks their status periodically.

12) Remove the eight bulleted examples identified in the OSC draft report within the Documentation comments within the Internal Control Deficiencies section as none of the citations noted would preclude a Medicaid claim.

See Note 12 Page 42

The OSC, within the draft report identified the following exceptions in the 44 student files reviewed:

- *Parental consent for special education services was missing from six student files.* Students who transfer into the district that were previously identified by other school districts sign an amendment and/or a 30-day placement form signifying their agreement with district programming. This serves as their consent for services.

- *There were no service provider logs in the students' files in the District office.* Service logs are not kept in students' files, as therapist submits them with their caseload as a whole. To file those in student's files would violate confidentiality. As mentioned above, all service logs are kept on file for the required time frame in the district office.

- *Required parental consent for a change in CSE meeting attendees was missing for 21 of the 33 meetings that required them.* When parents attend CSE meetings and the attendance is changed from the meeting notification letter, a form is signed by the parent. If they do not attend, this cannot be done. The district makes every effort to notify parents of exactly who will attend, but emergencies do arise and substitutes are found.

- *For 38 of 44 review meets not attended by parents, there was no documentation to show that parents had been contacted and agreed to hold the meetings without them.* Documentation to show that parents gave consent for the meeting to occur in their absences is not required by the following Commissioner's Regulations:

  200.5(d) Parent participation in CSE meetings. (1) Each school district shall take steps to ensure that one or both of the student's parents are present at each committee on special education meeting or are afforded the opportunity to participate, including:

  (i) notifying the parent(s) of the meeting, consistent with subdivision (c) of this section prior to the meeting to ensure that he or she will have an opportunity to attend;

  (ii) scheduling the meeting at a mutually agreed on time and place and in a location that is physically accessible to the parents; and

  (iii) using other methods to ensure parent participation, including individual or conference telephone calls pursuant to paragraph (7) of this subdivision.

  (3) A school district may conduct a CSE meeting without a parent in attendance if the school is unable to convince the parents that they should attend. In this case, the school must have a detailed record of its attempts, and the results of those attempts to arrange a mutually agreed on time and place.

  (4) A decision may be made by the committee on special education without the involvement of the parents, if the school is unable to obtain the parents' participation in the decision. In this case, the school must have a record of its attempt to ensure their involvement.

  The district's invitation clearly states our willingness to reschedule to a convenient time, and service providers contact parents prior to meeting to discuss recommendations and provide reminders. In addition, for District CSE meetings, the Special Education Office contacts each parent the day prior to every meeting as encouragement to attend.

- *Parental consent for reevaluation testing was missing for 11 of 17 reevaluated students.* Regulations do not require parent consent for re-evaluation if we have made a good faith effort to obtain such consent. It is our consistent practice that three attempts are made; lacking any indication from a parent that they do *not* consent to re-evaluation, we then proceed. The last attempt is sent certified mail from our office, and a copy of that put in the student's folder. Previous attempts are made at the building level, but those efforts are documented in the contact log and process log of IEP Direct.

- *Parental consent for changing a student's IEP without a meeting was missing for three of the 21 students whose IEPs were changed.* In these cases, a consent form was in the students folder, but was either not dated, or the parent failed to check a box to indicate whether or not they agreed or disagree to waive a meeting to discuss the proposed change. The district has since increased its attention to those consents returned, and no changes to IEPs are made until the consent form is accurately completed.

- *Review meeting minutes were often incomplete because IEP changes made during the meeting were not reflected in the minutes.* Parents are provided a copy of the draft prior to the meeting, and in many cases, meet with staff to discuss recommendations and changes to the IEP. Not every single facet of the IEP is reviewed at every meeting, as some of the issues were covered in advance and agreed upon.

- *One student's file had another student's information in it.*

The district strives to follow procedures and regulations as set forth in the Commissioner's Regulations, and appreciates notification of any areas in need of improvement. It should be noted that none of the above deficiencies compromise the district's ability to file Medicaid claims, therefore, we respectfully request that this section be removed.

13) Acknowledge that the three students found to have the wrong date of birth listed were able to have claims filed by the District due to students being assigned a CIN#.

See Note 13 Page 43

The OSC, in its draft report, states that the submission of claims for students with incorrect dates of birth automatically results in the claims being denied. We reviewed the claims filed and the reimbursement received for the three students with inaccurate dates of birth and found that the claims were processed with revenue received. According to our vendor, all three students were assigned a CIN#, which then becomes their identifier, ultimately allowing the claims to be filed. The district requests that the calculations in the final audit report be adjusted to account for these claims.

14) Acknowledge that the District maintained documentation in order to claim for over 20,000 services during the audit period, however, were unable to submit these claim due to not meeting billing requirements and sanctions for false claims.

See Note 14 Page 43

The OSC, in its draft report, implies that the District simply stopped billing. Contrary to this implication, our service providers maintained records and submitted information into K-Systems (web-based Medicaid management system). We ultimately had over 20,000 service counts that could not be billed due to the various Medicaid requirements. Here is an example of the 20,000 service counts pulled from K-Systems that the District could not bill for:

CIN	Service	Service Month	Service Year	Service Count
BR97047K	Transportation	9	2008	26
BR97047K	Transportation	10	2008	14
BR97047K	Transportation	11	2008	9
BR97047K	Transportation	12	2008	15
BR97047K	Transportation	1	2009	28
BR97047K	Transportation	2	2009	22
BR97047K	Transportation	3	2009	40
BR97047K	Transportation	4	2009	20

BR97047K	Transportation	5	2009	24
BR97047K	Transportation	6	2009	10
BR97047K	Transportation	8	2009	1
BW34963V	TCM Amen/Req Review	2	2009	1
BW34963V	TCM Annual Review	5	2009	1
BY02001D	TCM Amen/Req Review	1	2009	1
BY02001D	TCM Triennial Review	11	2008	1
BY21806W	Transportation	9	2008	35
BY21806W	Transportation	10	2008	36
BY21806W	Transportation	11	2008	26
BY21806W	Transportation	12	2008	24
BY21806W	Transportation	1	2009	25
BY21806W	Transportation	2	2009	15
BY21806W	Transportation	3	2009	32
BY21806W	Transportation	4	2009	27
BY21806W	Transportation	5	2009	28
BY21806W	Transportation	6	2009	15
BY21806W	Transportation	8	2009	1
BY84936P	Transportation	9	2008	34
BY84936P	Transportation	10	2008	34
BY84936P	Transportation	11	2008	26
BY84936P	Transportation	12	2008	24
BY84936P	Transportation	1	2009	15
BY84936P	Transportation	2	2009	14
BY84936P	Transportation	3	2009	29
BY84936P	Transportation	4	2009	27
BY84936P	Transportation	5	2009	36
BY84936P	Transportation	6	2009	19
BZ14711Z	Social Work	9	2008	2
BZ14711Z	Social Work	10	2008	3
BZ14711Z	Social Work	11	2008	2
BZ14711Z	Social Work	12	2008	3
BZ14711Z	Social Work	3	2009	3
BZ14711Z	Social Work	4	2009	4
BZ14711Z	Social Work	5	2009	4
BZ14711Z	Transportation	9	2008	11
BZ14711Z	Transportation	10	2008	10
BZ14711Z	Transportation	11	2008	13
BZ14711Z	Transportation	12	2008	5
BZ14711Z	Transportation	2	2009	2
BZ14711Z	Transportation	4	2009	18
BZ14711Z	Transportation	5	2009	26
BZ14711Z	Transportation	6	2009	14
BZ66593U	Transportation	9	2008	17
BZ66593U	Transportation	10	2008	21
BZ66593U	Transportation	11	2008	16
BZ66593U	Transportation	12	2008	15
BZ66593U	Transportation	2	2009	15
BZ66593U	Transportation	3	2009	21
BZ66593U	Transportation	4	2009	16

BZ66593U	Transportation	5	2009	14
BZ66593U	Transportation	6	2009	10
BZ82175H	TCM Triennial Review	10	2008	1
CA55871Z	Social Work	12	2008	6
CA55871Z	Social Work	1	2009	4
CA55871Z	Social Work	2	2009	1
CA55871Z	Social Work	3	2009	2
CA55871Z	TCM Amen/Req Review	11	2008	1
CA55871Z	Transportation	9	2008	10
CB80125M	Speech Therapy	9	2008	7
CB80125M	Speech Therapy	10	2008	9
CB80125M	Speech Therapy	11	2008	4
CB80125M	Speech Therapy	12	2008	5
CB80125M	Speech Therapy	1	2009	4
CB80125M	Speech Therapy	2	2009	3
CB80125M	Speech Therapy	3	2009	3
CB80125M	Speech Therapy	4	2009	5
CB80125M	Speech Therapy	5	2009	3
CB80125M	Speech Therapy	6	2009	2
CB80125M	Transportation	9	2008	37
CB80125M	Transportation	10	2008	42
CB80125M	Transportation	11	2008	26
CB80125M	Transportation	12	2008	33
CB80125M	Transportation	1	2009	21
CB80125M	Transportation	2	2009	14

It should also be noted that all July 2009 and August 2009 services were barred from claiming due to the false claims settlement. Therefore, it is requested that the final audit report acknowledge that documentation was being maintained, but services were not ultimately claimed due to not meeting new requirements for billing.

15) Acknowledge that the District does have assurance with Cayuga-Onondaga BOCES and Mandel, contracted IEP service providers, that we are receiving all of the services the District is paying for.

See Note 15 Page 43

The OSC, in its draft report, states that the District has little assurance that it is receiving all the services the District is paying for. While the draft report indicated that District officials told OSC that we have not had problems obtaining documentation of contracted provider services for claims submissions purposes, documentation from the second provider was not available for their review. It should be noted that this information was not requested. The auditors can ask for that information at anytime and it would be provided.

The District did not have a contract with the BOCES for IEP services, because BOCES is exempt from such agreements. The District did have a contract with the Mandel Therapy Group. The OSC draft report states that the District lacked a detailed contract with the second service provider that specified the services it would provide and the documentation it would maintain. The following portion of the Mandel contract for the 2008-09 school year does specify the services they would provide:

2. DUTIES AND RESPONSIBILITIES OF THERAPIST

A. Therapist shall provide the Services to the District on a per hour basis, as needed. The parties will determine the number of hours of services required to be performed under this Agreement depending upon the needs of the District and its Students.

B. Therapist represents that it is familiar with and will abide by all relevant federal and New York State statutes and regulations with respect to the provision of the Services to the District, specifically including, but not limited to, the relevant provisions of the following:

1. The Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. section 1400 et seq., and regulations promulgated thereunder;

2. Article 89 of the New York Education Law, section 4401, et seq.; and

3. Part 200 of the regulations of the New York Commissioner of Education, 8 N.Y.C.R.R. section 200, et seq.

C. Indirect and Direct Services: The Services provided by Therapist hereunder includes both direct and indirect services as described in more detail below:

1. Indirect Services: Upon request of the Director of Special Education or his/her designee, Therapist will provide indirect services to the District which shall include, but not be limited to:

a. Consultation to administration on program planning, policy development, and priority setting in therapy and restorative services; and

b. Inservice training in appropriate professional/clinical topic areas.

2. Direct Services: Upon request of the Director of Special Education or his/her designee, Therapist will provide direct services to Students within the District including:

a. Evaluations and treatment in accordance with applicable District requirements, State of New York and federal regulations;

b. Development and implementation of treatment plans and physical therapy, occupational therapy and/or speech therapy services portions of Students' Individualized Educational Programs;

c. Maintenance of appropriate records and preparation of reports on direct service activities in accordance with District policies;

d. Attendance at CSE meetings; and

e. Instruction to parents, staff, or others regarding individual Student's therapy programs.

It should be noted that the contract does not specify the documentation the Mandel therapists will maintain. Therefore, within a Request for Proposal that will be completed this spring, this issue will be addressed. Lastly, while the OSC draft report suggests lack of oversight with contracted service providers, the Director meets with the BOCES Director of Special Education and Dana Mandel frequently throughout the year to clarify expectations, and to revise practices as expectations change.

16) Acknowledge that the Director does have oversight of District Staff.

See Note 16 Page 43

The OSC, in its draft letter, states while the Director provided District staff with necessary information pertaining to IEP service provisions, she failed to provide training or guidance about the type or amount of documentation needed to be maintained or submitted by District service providers for the Medicaid reimbursement process. The Director of Special Education does provide on-going training to staff members directly involved in filing Medicaid claims. The only group who has direct responsibilities for filing claims and maintaining documentation are the related service providers (OT/PT/ST). The Director meets monthly with speech therapists, and the majority of the agendas included discussions about Medicaid processes and procedures. The Director also meets annually with the contracted service providers (OT/PT) to review requirements, and more often with the Vendor providing those services to review new requirements, and to ensure that those therapists are routinely submitting the required documentation. The Director also meets with the building-level CSE Chairpersons to review regulations, although they do not have any responsibilities in the area of Medicaid, other than to facilitate meetings, oversee the IEP review, and to submit meeting paperwork, which includes seeking parental consent to file Medicaid claims to the Special Education office. All invitations and notifications are sent from the district office. The District acknowledges that improvement is needed, specifically in the area of documenting training conversations, but to suggest that no oversight is provided is inaccurate. It is requested that the final audit report note these training and oversight efforts.

17) Acknowledge that the District is responsible to the community not to make false claims to Medicaid.

See Note 17 Page 43

The OSC, in its draft letter, states that because of the two-year window, the District can still submit claims for the 2008-09 school year. In the January 18, 2011 exit meeting, [redacted] was asked to give an example of one service that could still be claimed given the new State Plan Amendment. She was unable to do so and agreed that the new requirements to claim preclude the ability to claim for services from the 2008-09 school year. Ultimately, making a claim for any service during that time frame would constitute a false claim per the Federal False Claims Act. Here is a summary of this Act:

False Claims Act (31 USC §§3729-3733)

The False Claims Act ("FCA") provides, in pertinent part, that:(a) Any person who (1) knowingly presents, or ***causes to be presented****, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;... or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government, is liable to the United States Government for* ***a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person***

....(b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or ***(3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.*** *31 U.S.C. § 3729. While the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729(b). In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.*

If the District has any questions about a service meeting Medicaid requirements, we cannot claim. Based on the False Claims Act, the District would expect that a $10 false claim would result in repaying the $10, paying $30 in damages and paying a $10,000 fine. It should be noted that review of Alert 07-2 issued from the New York State Office of the Medicaid Inspector General (OMIG) and School/Preschool Supportive Health Services Program (SSHSP/PSHSP) Medicaid in Education Unit on February 21, 2007 regarding Medicaid Reimbursement Billing Requirements revealed the following statement: "Effective immediately, no Medicaid claims should be submitted for payment, regardless of the service periods, which do not comply with the requirements contained in the letter. Failure to comply with these requirements will put such claims at risk for disallowances as well as the U.S. Department of Justice potentially charging federal False Claims Act violations against the school district, county or 4201 school. False Claims Act penalties range from a minimum of $5,500 to $11,000 per claim in addition to three times the amount of each claim as well as attorneys' fees and costs." We are sure that the Comptroller does not wish the District to risk the financial or criminal penalties associated with any false claim. Due to the fact that we cannot claim for any service during the 2008-09 school year, we request that you remove any potential Medicaid reimbursement revenue in your final audit letter.

Thank you to your office for the professional manner in which the entrance and exit interview was conducted. While we take pride in our cost effective approach to management of the district's finances and programs and wish to maximize revenue to the District, we will not make false claims. If you would like copies of the documents cited in this letter, please let us know and we will provide them.

Yours truly,

J.D. Pabis
Superintendent of Schools

Salvatore Giangreco, Vice President
Board of Education

APPENDIX B

OSC COMMENTS ON THE DISTRICT'S RESPONSE

Note 1

Our report references the New State Plan Amendment (SPA) #09-61, which was part of the terms of the legal settlement between New York State and the Federal government.

Note 2

Our report stated the District can still submit eligible 2008-09 school year claims for reimbursement because of the two-year window. These eligible claims may be submitted under the old Plan guidelines and are not subject to SPA #09-61. Our report also states that the Director submitted 195 TCM review claims totaling $69,680 from the 2008-09 year in February 2010 (during the two-year window), resulting in potential reimbursements of at least $17,420 of the $40,452, to both the District and State. During our exit conference, District officials stated that they did in fact receive reimbursement for many of these claims.

Note 3

We recognize that the Director reviewed TCM meeting attendance sheets and submitted 195 reviews for reimbursement in February 2010. We commend District officials for following our suggestion to submit claims for these services, which did result in reimbursement. Examiners provided District officials with the names of the DOH and OMIG staff we contacted, and the email response from these officials, regarding the ability of districts to submit claims for services delivered by grant-funded providers. Our email response from Fred Warnecke stated that his office (OMIG) has always told districts that if a service provider was paid with Federal money, such as a grant, they could not also submit for Medicaid reimbursement. However, Mr. Warnecke sought clarification from Ronald Bass (NYS DOH – Office of Health Insurance Programs, Bureau of Policy Development and Coverage, and Connie Donohue's supervisor), whose response was that grant funding of a service provider did not prohibit districts from seeking Medicaid reimbursement.

Note 4

The Kingston audit was conducted in 2005 and was based on the available criteria from OMIG at the time. As Note 3 stated, OMIG provided inaccurate guidance pertaining to TCM reviews to both OSC and districts.

Note 5

The District can still submit eligible 2008-09 claims for reimbursement because of the two-year window. In fact, District officials did submit eligible IEP service and TCM case reviews for identified and non-identified students for reimbursement. Since the District did not seek DOH approval for claiming Medicaid reimbursement revenues for TCM ongoing service coordination, the District cannot submit claims for these services and lost $58,675 in Medicaid reimbursement.

Note 6

During our audit, the Assistant Superintendent stated that claiming reimbursement for ongoing service coordination was not cost beneficial, and that District staff who acted as District-assigned case managers were not qualified to be service coordinators, even though they functioned as service coordinators. However, the Assistant Superintendent did not provide us with documentation to show that the District had performed such a cost benefit analysis; therefore, we could not assess the District's analysis.

Note 7

We do not recommend submitting these claims for reimbursement. In fact, the report states that the 43 claims totaling $11,446 were ineligible for reimbursement because the District-provided services did not meet Federal requirements. Therefore, $2,862 in Medicaid reimbursement was lost to the District and State. Footnote 3 stated these claims were ineligible for submission because the provider was not certified in conformance with Medicaid rules and regulations or because the student's IEP did not cover the period when the service was provided.

Note 8

Our report states only that the District should provide families of students with IEPs who receive free lunches, and could be eligible for Medicaid, with Medicaid enrollment information. While providing such information could benefit both the District and families, we recognize that such efforts should never create a burden for families.

Note 9

We disagree with District officials that Medicaid-eligible lists changed significantly on a daily basis. Each day there is the possibility that a student's Medicaid eligibility may change; however, this does not occur on a large scale. Therefore, large changes to the Medicaid-eligible lists reviewed by the vendor in any given month, such as the discrepancies we found, are uncommon. District officials were unable to provide us with a complete and accurate list of Medicaid-eligible IEP students. The vendor-prepared list of Medicaid-eligible students with an IEP, dated October 30, 2009, did not identify all students. When we provided a list of the 122 unidentified students to District officials, the Assistant Superintendent concurred that the vendor's report was inaccurate and incomplete. Although the Assistant Superintendent provided us with another vendor report, we still identified additional Medicaid-eligible IEP students. District officials made several unsuccessful attempts to reconcile the reports' inaccuracies.

Note 10

Our report does recognize that obtaining parental consent is a problem for districts seeking Medicaid reimbursement.

Note 11

We found that records relating to Medicaid claims for the 2008-09 school year were not centrally located, were disorganized, and were stored in boxes. We did not review records from April 3, 2005 through April 2, 2006, the period covered by the OMIG review, so we cannot comment on the state of those records. However, the OMIG report did cite the District for having insufficient documentation to support some of its claims, which resulted in the District being required to pay back the reimbursement received for the unsupported claims.

Note 12

The following addresses the specific points in section 12 of the response letter where District officials disagree with the bulleted examples in our report.

- *Parental consent for special education services*: Five of the six students were not transfer students and did not have consent forms on file. For the one student who was a transfer student, the District is still required to obtain parental consent after the initial 30-day transfer period. In this instance the period had expired. The forms referenced are not valid substitutes for a signed parental consent form after that time.

- *Service provider logs in the students' files*: The District did not maintain service logs either in individual students' files or in a separate District file. Repeated requests to the Director, as well as our own review, did not produce these logs. The District's response does not cite a basis for such logs violating confidentiality, and the Medicaid handbook issued by SED does not contain a confidentiality clause. It is the responsibility of District officials to ensure that all sensitive or confidential information is adequately secured.

- *Parental consent for a change in CSE meeting attendees*: District officials are held responsible by SED for maintaining documentation of parental consent for all substitute attendees at CSE meetings.

- *Documentation that parents had been contacted and agreed that review meetings could be held without them*: The CSE may hold review meetings without the parents, but District officials must be able to prove that they attempted to contact them. We found no record of the District's attempts to obtain parental participation in review meetings.

- *Parental consent for reevaluation testing*: The District is correct in that regulations do not require such parental consent. However, the SED regulations do state that a good-faith effort to obtain such consent must be made and documented. District officials did not provide us with any documentation showing that they did so.

- *Review meeting minutes not reflecting IEP changes made*: All changes should be discussed at the review meeting and recorded in the minutes, even if they are discussed in other venues.

Note 13

Our audit report identified three students' dates of birth as being incorrect and determined that their claims would be automatically denied. District officials are able to review denied claims and resubmit them with additional information, such as the CIN number described in the District's response. Because we did not include these three students' services in the lost reimbursement revenue amounts, no adjustment is necessary.

Note 14

We reviewed and commented on the documentation maintained for the 44 students sampled. We cannot comment on whether the District maintained documentation in order to claim for over 20,000 services. However, our report states in Footnote 12 that services provided between July 1, 2009 and August 31, 2009 do not have Federal approval and may not be submitted for reimbursement.

Note 15

Because the District lacked detailed written agreements with its contracted IEP service providers to give all parties a clear understanding of the nature and extent of the services to be provided, we were unable to determine if the District received all the services it paid for. In addition, on March 1, 2010, examiners requested documentation from the Director for the second service provider. The Director stated she received this documentation from the second service provider and forwarded a copy to the third-party vendor for entry into the Web-based program. However, the Director did not supply us with this documentation during audit fieldwork.

Note 16

During our audit, District service providers stated, and showed us, that service documentation was maintained and submitted in a different manner at each school building. Furthermore, District staff told us they were not sure what documentation to submit or when to submit it. Such inconsistency and uncertainty reflects a lack of sufficient direction and oversight by the individual who manages the process.

Note 17

Our report stated the District can still submit eligible 2008-09 school year claims for reimbursement because of the two-year window. These eligible claims may be submitted under the old Plan guidelines and are not subject to SPA #09-61. SPA #09-61, which defines the services, providers and their qualifications, and reimbursement methodology for the SSHSP, was approved by Centers for Medicare and Medicaid Services on April 26, 2010, with an effective date of September 1, 2009. We reiterated this fact at the exit conference on January 18, 2011. The District's assertion that it could not claim for any services during the 2008-09 school year as a result of Medicaid Alert 07-2 is not accurate. Medicaid Alert 07-2 was a follow-up notice to a February 6, 2007 NYSED letter, entitled Medicaid reimbursement billing requirements, which suspended the submission of claims for speech, counseling, evaluations and transportation until further notice. Medicaid Alerts 08-1 through 08-7 and 09-1 provide new guidelines for the submission of 2008-09 claims, lifting the suspension for most claims.

APPENDIX C

AUDIT METHODOLOGY AND STANDARDS

Our overall goal was to assess the adequacy of the internal controls put in place by officials to safeguard District assets. To accomplish this, we performed an initial assessment of the internal controls so that we could design our audit to focus on those areas most at risk. Our initial assessment included evaluations of Medicaid reimbursement and special education.

During the initial assessment, we performed a trend analysis on the District's Medicaid reimbursements over a five-year period (July 1, 2004 through June 30, 2009). To perform the trend analysis, we obtained a summary of Medicaid claims by service and school year (July 1, 2004 to September 21, 2009) from the Office of the Medicaid Inspector General. In addition, we obtained the total K-12 population, the number of individuals with an IEP, and the number of Medicaid-eligible students.

After reviewing the information gathered during our initial assessment, we determined where weaknesses existed, and evaluated those weaknesses for the risk of potential fraud, theft and/or professional misconduct. We then decided on the reported objective and scope by selecting for audit the area most at risk. We selected Medicaid for further audit testing.

- We assessed the internal controls over the identification, monitoring, and preparation of claims for Medicaid reimbursement.

- We interviewed District personnel and service providers involved in the Medicaid reimbursement process, and tested selected records and transactions. We reviewed the lists of Medicaid-eligible students, students with IEPs, and students receiving free or reduced lunches and compared these listings to identify students whose IEP related services were potentially eligible for reimbursement.

- We matched the BOCES prepared list of Medicaid eligible students against the District's prepared list of students with IEPs and compared this list to the Vendor's list of Medicaid-eligible students with IEPs and identified an additional 122 Medicaid-eligible students. We also identified 17 students that were not listed as IEP students by the District.

- We reviewed the case records and billing summaries for 12 (10 percent) of the additionally identified 122 Medicaid-eligible students with IEPs to determine the amount of claims not submitted for reimbursement. The 12 students in this sample were randomly selected from among the 122 non-identified students.

- We reviewed the second Vendor listing of Medicaid-eligible IEP students and found 19 of the 122 previously identified students were not listed and an additional 46 students were not on the original listing.

- We requested 75 IEPs from the District but were only provided 68 for review. We reviewed the 68 IEPs to determine if the additionally identified students from our previous testing were Medicaid-eligible IEP students.

- We estimated the same rate of services were provided to the 160 Medicaid-eligible students with IEPs we additionally identified from our review of Vendor and District listing and IEPs and calculated the amount of potential billable services and reimbursement.

- We compared the list of students with IEPs to the list of students receiving free lunches and identified 42 students that may be eligible for Medicaid. We reviewed the case records and billing summaries for six of these students and estimated the amount of billable services for the remaining 36 students.

- We reviewed the case records and billing summaries for 26 (10 percent) of the 261 District identified Medicaid-eligible students with IEPs. The sample was a randomly selected sample comprising every 10th student. We determined the total amount of billable IEP-related services and the number of claims not submitted for reimbursement. We estimated the same rate of services were provided to the remaining 235 Medicaid-eligible students with IEPs and calculated the amount of potential billable services and reimbursement.

- We calculated the number of months a student was eligible for the service during the 12 month audit period for the 44 students in our three samples to determine the amount of unclaimed reimbursement for TCM ongoing service coordination. We then multiplied the number of eligible months by the reimbursable rate of $100. We calculated the average number of months of TCM ongoing service coordination for the 44 students in our samples and projected this rate for the remaining 431 students in our three sample populations and multiplied it by the reimbursable rate.

- We determined the number of reviews conducted for the 44 students in our three samples and multiplied them by the corresponding rates to determine the amount of unclaimed reimbursement for the TCM initial and periodic reviews. We then projected the same rate of reviews for the remaining 431 students in our three sample populations and calculated the potential amount of unclaimed reimbursement.

We conducted our performance audit in accordance with generally accepted government auditing standards (GAGAS). 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 D

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APPENDIX E

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