FEB 11 2004

TO: Dennis G. Smith
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Dara Corrigan
Acting Principal Deputy Inspector General

SUBJECT: Review of Medicaid Speech Claims Made by School Health Providers in New York State (A-02-02-01030)

We are alerting you to the issuance of the subject final audit report within 5 business days from the date of this memorandum. A copy of the report is attached. This is the first of a series of reports on New York State's Medicaid school health program. We are conducting these audits in response to a request by officials of the Centers for Medicare & Medicaid Services (CMS).

Our objective was to determine whether Federal Medicaid payments for speech services claimed by 711 school and preschool providers in the State from September 1, 1993 through June 30, 2001 were allowable under Federal and State requirements. Federal laws and regulations, State regulations, or the Medicaid State plan require that:

- a referral for speech services be made by an appropriate professional,
- speech services be provided by or under the direction of a certified speech-language pathologist or an individual with similar qualifications,
- the speech services be documented,
- a minimum of two services be provided during the month billed, and
- the services be included in a child's individualized education plan or an individualized family service plan.

We found that 56 of the 100 speech claims in our statistically valid sample were unallowable. Based on our sample, we estimate that $172,553,831 of the total $361,840,184 in Federal Medicaid funding claimed for speech services was unallowable.

Of the 56 unallowable claims, 37 contained more than 1 deficiency. Specifically:

- 42 claims lacked a referral by an appropriate medical professional as required by Federal and State regulations,
- 41 claims did not comply with Federal regulations requiring that speech services be provided by or under the direction of a certified speech-language pathologist or an individual with similar qualifications,

- 5 claims had inadequate documentation on the specific number of services rendered as required by Federal law and regulations,

- 5 claims were not billable because the minimum of 2 monthly speech services were not rendered as required by the State plan, and

- 2 claims lacked an individualized education plan as required by Federal law.

We recommend that the State (1) refund $172,553,831 to the Federal Government, (2) provide proper and timely guidance on Federal Medicaid criteria to schools and preschools, (3) reinforce the need for school health providers to comply with Federal and State requirements, and (4) improve its monitoring of school health providers' speech claims to ensure compliance with Federal and State requirements.

In written comments on our draft report, State officials disagreed with most aspects of the report, including the audit approach, sampling methodology, criteria, and conclusions. The State also expressed concern that we had applied Federal regulations designed for a medical office setting in an educational setting. The State expressed major concern that the results of the audit would negatively affect its ability to continue to provide services to children and recommended that the draft report be withdrawn.

We disagree with the State's comments. We planned this audit in conjunction with CMS and conducted the audit in accordance with generally accepted government auditing standards. Our sampling methodology, criteria, and conclusions are valid. Medicaid school health providers need to follow the documentation standards required of all Medicaid providers.

Furthermore, in finding that 56 of 100 sampled claims were unallowable, we identified deficiencies that could have a direct impact on the quality of services rendered. For example, the lack of supervision of services by a qualified speech pathologist raises concern about the quality of services. We believe that the State needs to strengthen compliance with Federal and State requirements to ensure proper administration of this program.

If, during the resolution process, the State furnishes additional relevant documentation to CMS or if the State can prove that records were destroyed in accordance with established record retention policies, we will assist CMS in recalculating the projected unallowable claim.

If you have any questions or comments about this report, please do not hesitate to call me or one of your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Timothy J. Horgan, Regional Inspector General for Audit Services, Region II, at (212) 264-4620.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

FEB 17 2004

Report Number: A-02-02-01030

Antonia C. Novello, M.D.
Commissioner
New York State Department of Health
Empire State Plaza
14th Floor, Room 1408
Corning Tower
Albany, New York 12237

Dear Dr. Novello:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Medicaid Speech Claims Made by School Health Providers in New York State." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports are made available to members of the public to the extent the information is not subject to exemptions in the Act which the Department chooses to exercise (see 45 CFR part 5).

To facilitate identification, please refer to report number A-02-02-01030 in all correspondence.

Sincerely yours,

Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Ms. Sue Kelly
Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare & Medicaid Services, Region II
Department of Health and Human Services
26 Federal Plaza, Room 3811
New York, New York 10278

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID SPEECH CLAIMS MADE BY SCHOOL HEALTH PROVIDERS IN NEW YORK STATE

FEBRUARY 2004
A-02-02-01030

EXECUTIVE SUMMARY

OBJECTIVE

Our objective was to determine whether Federal Medicaid payments for speech services claimed by 711 school and preschool providers (school health providers) in New York State (the State) were allowable under Federal and State requirements. Our audit period covered September 1, 1993 through June 30, 2001.

The audit was requested by officials of the Centers for Medicare & Medicaid Services (CMS).

SUMMARY OF FINDINGS

Fifty-six of the 100 speech claims in our statistical sample were unallowable under Federal laws and regulations, State regulations, or the Medicaid State plan. The primary Federal regulation governing allowability of speech pathology services is 42 CFR § 440.110(c). Other relevant Federal guidance includes Office of Management and Budget Circular A-87, a 1997 CMS Medicaid school-based technical assistance guide, and Medicaid State operations letters issued by CMS. Further, State regulations issued to the provider community govern the allowability of school health services. Federal laws and regulations, State regulations, or the State plan require that:

- a referral for speech services be made by an appropriate professional,
- speech services be provided by or under the direction of a certified speech-language pathologist or an individual with similar qualifications,
- the speech services be documented,
- a minimum of two services be provided during the month billed, and
- the services be included in a child's individualized education plan or an individualized family service plan (child's plan/family plan).

Of the 56 unallowable claims, 37 contained more than 1 deficiency. Specifically:

- 42 claims lacked a referral by an appropriate medical professional required by Federal and State regulations,
- 41 claims did not comply with Federal regulations requiring that speech services be provided by or under the direction of a certified speech-language pathologist or an individual with similar qualifications,

- 5 claims had inadequate documentation to support the specific number of services rendered as required by Federal law and regulations,

- 5 claims were not billable because the minimum of 2 monthly speech services were not rendered as required by the State plan, and

- 2 claims lacked a child's plan/family plan as required by Federal law.

In our opinion, these deficiencies occurred because:

- the State provided improper or untimely guidance about Federal Medicaid requirements to its schools and preschools,

- school health providers did not comply with guidance they had received, and

- the State did not adequately monitor speech claims from providers for compliance with Federal and State requirements.

As a result, during our September 1, 1993 through June 30, 2001 audit period, we estimate that the State improperly claimed $172,553,831 in Federal Medicaid funding.

RECOMMENDATIONS

We recommend that the State:

- refund $172,553,831 to the Federal Government,

- provide proper and timely guidance on Federal Medicaid criteria to schools and preschools,

- reinforce the need for school health providers to comply with Federal and State requirements, and

- improve its monitoring of school health providers' speech claims to ensure compliance with Federal and State requirements.

STATE'S COMMENTS

In written comments on our draft report, State officials disagreed with most aspects of the report, including the audit approach, sampling methodology, criteria, and conclusions. The State also expressed concern that we had applied Federal regulations designed for a medical office setting in an educational setting. The State expressed major concern that the results of the audit would

negatively affect the State's ability to continue to provide services to children and recommended that the draft report be withdrawn. The full text of the State's comments is included as Appendix E.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We disagree with the State's comments. We planned this audit in conjunction with CMS and conducted the audit in accordance with generally accepted government auditing standards. Our sampling methodology, criteria, and conclusions are valid. Medicaid school health providers need to follow the documentation standards required of all Medicaid providers.

Furthermore, in finding that 56 of 100 sampled claims were unallowable, we identified deficiencies that could have a direct impact on the quality of services rendered. For example, the lack of supervision of services by a qualified speech pathologist raises concern about the quality of services. We believe that the State needs to strengthen compliance with Federal and State requirements to ensure proper administration of this program.

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APPENDICES

Glossary of Abbreviations and Acronyms

ASHA	American Speech-Language-Hearing Association
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
DOJ	Department of Justice
GAO	General Accounting Office
HCFA	Health Care Financing Administration
IDEA	Individuals with Disabilities Education Act
OIG	Office of Inspector General

INTRODUCTION

BACKGROUND

The Medicaid Program

Under Title XIX of the Social Security Act (the Act), the Medicaid program pays the health care costs of persons who qualify because of medical condition, economic condition, or other qualifying factors. Medicaid costs are shared between the Federal Government and participating States. Within the Federal Government, the Medicaid program is administered by CMS.

To participate in the Medicaid program, a State must submit and receive CMS's approval of a State plan. The State plan is a comprehensive document describing the nature and scope of the State's Medicaid program and the State's obligations to the Federal Government. The Medicaid program pays for medically necessary services that are specified in Medicaid law when included in the State plan and when provided to individuals eligible under the State plan.

Medicaid Coverage of School Health Services

Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) amended section 1903(c) of the Act to permit Medicaid payment for medical services provided to children under the Individuals with Disabilities Education Act (IDEA) through a child's plan/family plan.

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

New York's Medicaid Program

In New York State, the Department of Health is the State agency responsible for operating the Medicaid program. Within the Department of Health, the Office of Medicaid Management is responsible for administering the Medicaid program. The Department of Health uses the Medicaid Management Information System, a computerized payment and information reporting system, to process and pay Medicaid claims, including school health claims. Speech claims paid by the State's Medicaid Management Information System show a service date of the first of the month for services generally rendered during that month.

The Department of Health and the State Education Department developed the State's school supportive health services and preschool supportive health services programs. In general, under the school program, 5- to 21-year-old students receive school health services from their local school districts. Under the preschool program, 3- to 4-year-old children receive school health services through their county offices.

The Federal share of school health claims was 50 percent during our audit period. Under the State's Medicaid program, only the Federal share is actually paid to school health providers. The State share is taken from the school district's or county's annual State education aid appropriation. In addition, the State takes back 50 percent of the Federal share from the school districts, leaving them with 25 percent of each claim submitted, and 59.5 percent from the counties (preschools), leaving them with 20.25 percent of each claim submitted.

For the period April 1, 1990 through June 30, 2001, the State received more than $2.5 billion of Federal Medicaid funding for over 15.3 million school health claims. Of this amount, about $2.25 billion was for school districts and approximately $291 million was for preschools. Speech was the largest service category with over $1.1 billion of the $2.5 billion received. Of the $1.1 billion, $361.8 million represented the audit universe for this review.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Federal Medicaid payments for speech services claimed by 711 school and preschool providers (school health providers) in New York State were allowable under Federal and State requirements.

Scope and Methodology

Our audit period covered September 1, 1993 through June 30, 2001. During our audit, we did not review the overall internal control structure of the State or the Medicaid program. Rather, our internal control review was limited to the objective of our audit.

To accomplish our objective, we:

- met with CMS regional and central office officials to plan the audit;
- reviewed Federal and State regulations and guidelines;
- reviewed prior survey work that we had performed at 11 schools and preschools in the State;
- held discussions with State Department of Health and Education Department officials to gain an understanding of the State's school and preschool programs;

- ran computer programming applications at the Medicaid Management Information System fiscal agent that identified 15,311,862 school and preschool claims totaling over $5 billion ($2.5 billion Federal share) for the period April 1, 1990 through June 30, 2001;

- eliminated from our programming applications all duplicate school and preschool claims that were identified in an Office of the State Comptroller audit report (Report 2000-S-1); and

- eliminated claims from six school health providers (New York City Board of Education school and preschool, Ogdensburg, Ithaca, Elmira, and a qui tam preschool provider), which we reviewed separately.

We extracted from the programming applications the speech claims for our September 1, 1993 through June 30, 2001 audit period. These applications identified 1,616,336 speech claims totaling $723,651,467 ($361,840,184 Federal share) made by 711 school and preschool providers. These claims were made on behalf of 86,093 beneficiaries (students). Of the 711 providers, 655 were school districts and 56 were counties. We then used simple random sampling techniques to select a sample of 100 claims from the universe of 1,616,336 speech claims. Appendix A contains the details of our sample design and methodology.

On May 17, 2002, we issued letters to the 72 school and preschool providers in our sample, requesting documentation to support the 100 sampled claims. Appendix B contains the instructions that were attached to our letters. In conjunction with CMS officials, we developed worksheets that contained the criteria applied to each sampled claim. We also reviewed the documentation submitted by the sampled providers to determine if the claims were allowable. If we determined that a claim appeared unallowable based on the initial documentation submitted, we followed up with provider officials to (1) determine if additional documentation existed to support the claim, (2) obtain clarification of the submitted documentation, and (3) verify our review determinations.

In addition, we contacted officials of the American Speech-Language-Hearing Association (ASHA) to determine whether the service provider or the speech pathologist providing direction to the service provider was ASHA certified if the sampled providers did not supply this information. We also used the State Education Department, Office of the Professions Web site to determine whether the service provider was a State-licensed speech-language pathologist if the sampled providers did not supply this information.

We used a variables appraisal program to estimate the dollar impact of the improper Federal funding claimed in the total population of 1,616,336 speech claims.

We conducted our review in accordance with generally accepted government auditing standards. We performed fieldwork at the State Department of Health; the State Medicaid Management Information System fiscal agent; CMS in Baltimore; and the Buffalo City School District, the largest of the 711 providers included in our review.

FINDINGS AND RECOMMENDATIONS

We found significant noncompliance with Federal and State requirements; of 100 sampled claims, 56 were unallowable.

Of the 56 unallowable claims, 37 contained more than 1 deficiency. The schedule below summarizes the deficiencies noted and the number of claims that contained each type of deficiency. Appendix C shows our determination on the allowability of each sampled claim.

Type of Deficiency	Number of Unallowable Claims[1]
1. Speech service referral requirements not met	42
2. Federal provider requirements not met	41
3. No service date delivery documentation and no assurance that services were rendered	5
4. No assurance that a minimum of two monthly speech services were rendered	5
5. No child's plan/family plan	2

In our opinion, these deficiencies occurred because:

- the State provided improper or untimely guidance about Federal Medicaid requirements to its schools and preschools,
- school health providers did not comply with guidance they had received, and
- the State did not adequately monitor speech claims from providers for compliance with Federal and State requirements.

As a result, during our September 1, 1993 through June 30, 2001 audit period, we estimate that the State improperly claimed $172,553,831 in Federal Medicaid funding.

DEFICIENCIES NOTED IN SAMPLED CLAIMS

The sections below discuss the five types of deficiencies noted in the sampled claims and the criteria that we applied in determining the allowability of claims.

[1] Does not total 56 because 37 claims contained more than 1 error.

1. Speech Service Referral Requirements Not Met

Federal regulations require a referral for speech services by a physician or other licensed practitioner (42 CFR § 440.110(c)). (Before April 1995, only a physician could make the referral.) State regulations at 18 New York Compilation of Codes, Rules and Regulations, Title 18, section 505.11 provide that a referral is needed from a physician, a physician's assistant, a registered nurse, a nurse practitioner, or a licensed speech-language pathologist.

We determined that 42 of the 100 sampled claims did not meet Federal and State speech service referral requirements. In some cases, no documentation existed showing that a referral for speech services had been made. In other cases, the referral was not made by an appropriate professional or was not made before the service date.

2. Federal Provider Requirements Not Met

Federal regulations require that speech services be provided by or under the direction of an ASHA-certified speech-language pathologist, an individual with equivalent education and work experience necessary for the ASHA certificate, or an individual who has completed the academic program and is acquiring supervised work experience to qualify for the certificate (42 CFR § 440.110(c)).

We found that for 41 of the 100 sampled claims, Federal ASHA requirements were not met. Of the 41 claims, 32 involved a service provider who was a teacher of the speech and hearing handicapped. For the remaining claims, four providers were State-licensed speech-language pathologists, two had bachelor's degrees in speech, two could not be identified, and one had a master's degree. None of these service providers met the requirements of 42 CFR § 440.110(c).

The 41 claims also did not meet the "under the direction of" requirements of 42 CFR § 440.110(c):

- For 26 claims, either no documentation or unacceptable documentation was provided to show direction.

- For seven claims, provider officials indicated that no direction was given.

- For six claims, written documents were prepared after our May 17, 2002 letter to providers. We did not consider this after-the-fact evidence to be reliable because it was prepared 4 to 8 years after the service dates.

- For two claims, provider officials were unable to identify who rendered the services or provided the required direction. Therefore, they were unable to supply any provider qualifications.

If the school health providers in our sample did not supply information on ASHA certifications, we contacted ASHA officials to determine if either the service provider or the speech pathologist providing direction was ASHA certified. As a result, we allowed 13 claims that would have been unallowable based on documentation submitted by the school health providers.

We also noted that 35 of the 41 unallowable speech claims did not meet the State's own licensing requirements. State regulations (Title 18, section 505.11) and guidelines require that speech services be provided by or under the direction of a State-licensed speech-language pathologist.

3. No Service Date Delivery Documentation and No Assurance That Services Were Rendered

Federal regulations at 42 CFR §§ 431.17 and 433.32, as well as section 1902(a)(27) of the Act and an August 1997 CMS guide entitled "Medicaid and School Health: A Technical Assistance Guide," require that services claimed for Federal Medicaid funding be documented. State guidance issued in November 1992 requires that monthly date-of-delivery documentation be maintained for services billed to Medicaid. This guidance also contains a suggested monthly service reporting form for providers to use. Some of the providers in our sample used this form.

Our review noted that for 5 of the 100 sampled claims, school health providers submitted no or inadequate documentation to show the specific number of services rendered. Since service delivery documentation was lacking, we had no assurance that services were rendered. For 1 of the 5 claims, the provider consistently billed 20 speech services per month. Based on the attendance records of the student and the service provider, a maximum of 14 services could have been provided during the sampled month.

4. No Assurance That a Minimum of Two Monthly Speech Services Were Rendered

The approved State plan requires that a minimum of two monthly services be provided in order to claim Medicaid reimbursement. Because the five sampled claims noted above lacked service date documentation, we had no assurance that a minimum of two monthly services had been provided.

5. No Child's Plan/Family Plan

Section 1903(c) of the Act permits Medicaid payment for school health services provided to children that are identified in a child's plan/family plan. Under Part B of IDEA, school districts must prepare, for each child, a plan that specifies all needed special education and related services.

For two of the sampled claims, school health providers did not provide a child's plan/family plan.

CAUSES OF UNALLOWABLE CLAIMS

As discussed below, we found three main causes of the unallowable claims.

State Guidance Was Improper or Untimely

Some of the unallowable claims resulted from improper or untimely State guidance to the provider community about Federal regulations and guidelines.

Initial State guidance in 1992 stated that Medicaid-reimbursable speech services needed to comply with Federal regulations found at 42 CFR § 440.110(c). These regulations required that speech services be provided by or under the direction of an ASHA-certified speech-language pathologist. However, in May and June 1994, the State modified its guidance to provide that for purposes of billing Medicaid, an ASHA-certified speech-language pathologist or a State-licensed speech-language pathologist could provide the speech services or the direction. Subsequent guidance to providers also contained this modification.

Additionally, during our audit period, 42 CFR § 440.110(c) required a referral by a physician or other licensed practitioner for speech services. However, the State did not issue guidance to the provider community on this referral requirement until May 1997.

School Health Providers Did Not Comply With Guidance

Unallowable claims were also submitted because school health providers did not comply with the guidance they had received from the State.

For example, the State's guidance specified that speech services must be provided by or under the direction of an ASHA-certified speech-language pathologist or a State-licensed speech-language pathologist. Our review found that providers did not comply with this guidance. Specifically, for 41 and 35 of the 100 sampled claims, respectively, an ASHA-certified or a State-licensed speech-language pathologist either did not provide the speech services directly or did not provide the necessary direction.

The State Did Not Adequately Monitor Speech Claims

The State did not adequately monitor speech claims from its school health providers for compliance with Federal and State requirements. Although the State conducted documentation reviews, these reviews were infrequent. For example, from 1993 to 2001, the State conducted only one documentation review of the Buffalo City School District, the largest provider included in our audit.

According to an April 12, 1999 letter from the State Department of Health, the purpose of the review at Buffalo was to point out potential documentation problems and suggest corrective action. Following the review, a May 24, 1999 letter from the State concluded that "Generally,

district records were well organized and documentation adequately supported Medicaid claims. A number of minor discrepancies were shared with district staff."

However, we found questionable "under the direction of" and speech referral billing practices at Buffalo that, in our opinion, compromised the integrity of speech claims and the school health program. Buffalo officials told us that 1 individual provided direction to more than 140 speech teachers who worked in over 100 buildings. Since 1998, these teachers have provided services to more than 6,000 students annually. Buffalo officials also told us that, for the most part, this individual did not see or render speech services to students. Additionally, we found that this individual used a rubber signature stamp to document direction on service record forms, progress notes, and referrals for speech services.

Further, we found that this individual had referred thousands of students for speech services with one blanket referral. For example, on September 1, 2000, she referred 4,434 students for speech services. The referral states that the designee recommends "that the speech services indicated for each student in the attached document be provided in accordance with the frequency, duration and cycle as indicated on the Individual Education Program." During our site visit, the individual told us that she had not seen many of these students nor had she reviewed their case files before making the September 1, 2000 referrals.

ESTIMATION OF THE UNALLOWABLE CLAIMS

We determined that 56 of the 100 speech claims sampled were not in accordance with Federal and State requirements. Extrapolating the results of our sample, we estimate that the State improperly claimed between $172,553,831 and $233,081,851 in Federal funds from September 1, 1993 through June 30, 2001. The midpoint of the confidence interval amounted to $202,817,841. The range shown has a 90-percent level of confidence with a sampling precision as a percentage of the midpoint of 14.92 percent. The details of our sample appraisal are shown in Appendix D.

RECOMMENDATIONS

We recommend that the State:

- refund $172,553,831 to the Federal Government,
- provide proper and timely guidance on Federal Medicaid criteria to schools and preschools,
- reinforce the need for school health providers to comply with Federal and State requirements, and
- improve its monitoring of school health providers' speech claims to ensure compliance with Federal and State requirements.

STATE'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

In comments dated April 7, 2003, State officials responded to the findings and recommendations in our draft report. Their response was 35 pages long and contained 8 exhibits, including a 1993 training videotape. In summary, State officials strongly disagreed with our findings and recommendations and felt that the report should be withdrawn. State officials also expressed concerns about the fiscal implications that this report could have on the State and on school health providers, as well as on the operations of their school health program. With the exception of the videotape, the State's comments are included in their entirety as Appendix E.

Below are summaries of the main issues raised by the State and the Office of Inspector General's (OIG) response to those comments.

Reasons for the Audit

State's Comments

State officials said that a Department of Justice (DOJ) investigation of three school districts was the primary impetus for our statewide audit of speech claims as well as the five additional school health audits we have planned.

OIG's Response

New York's statement is partially correct. The primary reasons for this audit and the five planned audits were past OIG survey work that found numerous problems with the State's Medicaid school health claims, past CMS reviews dating back to 1993 that found problems with the State's claims, and a DOJ investigation of the State resulting from a Federal false claims action. Additionally, the State accounts for 44 percent of all Medicaid school health payments nationwide.

Audit Period

State's Comments

State officials said that our September 1, 1993 through June 30, 2001 audit period was inconsistent with the audit periods that we used in reviewing other States' school health programs. State officials noted that the audit periods used in other States were usually more recent years, such as 1999 or 2000.

OIG's Response

In consultation with DOJ and CMS, we determined that the audit period September 1, 1993 through June 30, 2001 was appropriate for this audit. Additionally, in response to the DOJ investigation, the State Education Department issued a January 30, 2002 letter to all school health

providers, stating that the Federal Government had requested all providers to preserve all documents related to their Medicaid school health claims from January 1, 1990 forward.

Applicable Federal Regulations

State's Comments

State officials said that Federal regulations found at 42 CFR § 440.110(c) (services for individuals with speech, hearing, and language disorders) did not apply to speech services provided under their school health program. Rather, they stated that Federal regulations found at 42 CFR § 440.130(d) (rehabilitative services) applied. State officials maintained that CMS had applied the wrong Federal regulation to speech services. Furthermore, they said that CMS had supported their contention that 42 CFR § 440.130(d) was the applicable regulation at the outset of their federally approved program. Officials also stated that the application of 42 CFR § 440.110(c) improperly imposed criteria on the delivery of speech services that did not exist under the rehabilitative option in New York's CMS-approved State plan.

State officials noted that 42 CFR § 440.130(d) did not require that rehabilitative services be provided "under the direction of" any particular individual, merely that they be recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law. According to the State, as long as a child's plan/family plan recommended speech services, the recommendation requirement conformed to 42 CFR § 440.130(d) and a referral for speech services was not required. Finally, officials stated that although regulations at 18 New York Compilation of Codes, Rules and Regulations, title 18, section 505.11 provide that the recommendation (referral) for speech services may be made by a physician, a physician's assistant, a registered nurse, a nurse practitioner, or a licensed speech-language pathologist, they acquiesced and promulgated these regulations and guidance in order to receive approval of their State plan amendment.

OIG's Response

We believe that CMS guidance clearly provides that Federal regulations at 42 CFR § 440.110(c) and not 42 CFR § 440.130(d) apply to the State's speech school health claims. In addition, State officials consistently told schools and preschools that speech claims needed to comply with 42 CFR § 440.110(c).

Federal Guidance

State's Comments

According to State officials, one of the most notable problems that hampered their effective administration of the school health program was inconsistent and contradictory Federal guidance. They maintained that a series of reports by the General Accounting Office (GAO) had also criticized the lack of Federal guidance. State officials noted that one of these reports, issued in 1999, contained the following statement: "Inconsistent guidance from HCFA [Health Care

Financing Administration] appears to have heightened school districts concerns that Medicaid reimbursements will have to be returned to the federal government later because of inappropriate documentation requirements."[2]

Additionally, State officials said that their ability to help local providers claim properly had been compromised by the Federal Government's delay in responding to questions involving the interpretation of various Federal regulatory requirements, particularly those related to whether school health services are rehabilitative or corrective in nature. State officials said that when they sought a more definitive interpretation of Federal regulatory requirements to clarify contradictory and inconsistent guidance, the State was denied the opportunity to contest the guidance until the State was harmed by our audit.

State officials also included a chart and scatter plot graph, which they said provided evidence that New York's speech providers had demonstrated consistent improvement since the inception of the program. According to the State, the average number of audit findings per claim decreased from between one and two in the early years to almost zero in the most current year.

OIG's Response

As stated above, we believe that CMS provided clear and noncontradictory guidance to the State. In our opinion, the State's failure to follow this guidance resulted in the submission of unallowable claims to Medicaid. Additionally, contrary to the State's comments, GAO did not make the statement cited by the State; while that quote came from a December 1999 GAO report, it was made by officials from States and school districts, not GAO.

We also note that in response to the GAO report, the HCFA Administrator stated:

> . . . we are concerned that the overall findings seem to indicate that HCFA has provided insufficient guidance to Medicaid agencies and schools on Medicaid coverage and billing requirements. HCFA is unable to provide strict guidelines to all states due to the variations among state programs. Coordination issues need to be resolved at the state and local levels, rather than federal-state level.

The HCFA Administrator went on to state that "This report should also note that the statute does not provide for exemptions from Medicaid requirements for medical services provided in schools. Schools must comply with all Medicaid rules relating to provider qualifications, covered services, and billing and audit requirements, in order to receive Medicaid reimbursement."

Although the GAO reports and testimony fault CMS's oversight and guidance in general, Region II CMS guidance to the State was clear and adequate.

[2] CMS was formerly known as HCFA.

While the chart, the scatter plot graph, and our analysis of deficiencies in the sample indicate some improvement, the error rates in this program remain substantial. For the two largest error categories that we noted, we computed the yearly error rates by dividing the total number of errors in each category by the total number of sampled claims examined. This analysis revealed:

Year	Referral Requirement Error Rate	Federal Provider (ASHA) Requirements Error Rate
1993	100%	50%
1994	80%	47%
1995	60%	60%
1996	47%	26%
1997	38%	63%
1998	33%	50%
1999	33%	56%
2000	8%	8%
2001	20%	30%

ASHA-Certified Versus State-Licensed Speech-Language Pathologists

State's Comments

State officials said that their licensing requirements for a speech pathologist met or exceeded the requirements of a speech pathologist with a certificate of clinical competence from ASHA. Officials stated that our report incorrectly asserted the superiority of ASHA certification in seven areas: (1) the degree accepted for licensure, (2) the quantity of course work required for licensure, (3) the distribution of course work, (4) the quantity of predegree practicum, (5) the specification of disorder types and age groups for the predegree practicum, (6) the amount of supervision during the clinical fellowship, and (7) the quality and quantity of supervision during clinical fellowship. According to State officials, the State's licensure standards were identical to ASHA's 1993 standards. The State noted that ASHA had not required that members certified during or before 1993 meet its newer standards, but rather had "grandfathered" them.

OIG's Response

Although the State devoted a significant portion of its response to the equivalency of a State-licensed speech-language pathologist to an individual who has a certificate of clinical competence from ASHA, we note that a State-licensed speech-language pathologist either delivered the speech services or provided direction for only 6 of the 41 sampled claims questioned by our audit in this area. The remaining 35 claims did not meet the State's licensing requirements.

Moreover, CMS officials advised us that the State had not raised the equivalency issue with them before the State's response to our draft report. The State may wish to submit a formal request to CMS with adequate documentation for a determination on the equivalency issue.

Educational Versus Medical Model

State's Comments

State officials said that consistent with the development of a child's plan for disabled children under IDEA, schools had provided services covered under the school health program since 1975. Officials explained that when schools began to bill Medicaid for these services in 1993, it was both reasonable and consistent with congressional intent that the schools documented and billed these services using an "educational" versus a "medical" model. The educational model focuses on how the services assist the child in meeting long-term goals, as described in the child's plan.

According to State officials, the medical model, in contrast to the educational model, requires schools to focus on technical, medically oriented documentation of individual service dates, with less emphasis on longer term outcomes. Therefore, officials said that the application of a medical model of service delivery, such as that used for hospitals, was patently unfair to school health providers. State officials believed that if we applied an educational model, 95 of the 100 claims sampled would meet Federal requirements.

OIG's Response

Medicaid was established as a payer of medical services, and school health providers that enroll as Medicaid providers are not exempt from Medicaid requirements on the provision of State plan services. Medicaid school health providers need to follow the same documentation standards as all Medicaid providers.

Furthermore, we believe that the State's guidance to school health providers, as well as language in its response, supports our position. Specifically, the State provided guidance on documentation to be maintained by the school districts that we believe is consistent with the types of documentation maintained by traditional Medicaid providers. Additionally, in their response, State officials noted that between 1992 and January 2002, they issued 26 separate communiqués to school districts and counties "to aid the school districts in their application of the medical model of documentation of services."

Additionally, in guidance directed to the State and in its 1997 Technical Assistance Guide, CMS clearly delineated that school health providers were considered medical providers and that they must meet the documentation standards that apply to all Medicaid entities. Finally, the law and regulations allowing Medicaid to be the primary payer for IDEA services provided in schools do not call for or allow a suspension or loosening of general Medicaid requirements. Specifically, the U.S. Department of Education's 1999 final regulations on IDEA found at 34 CFR § 300.142(i) state that "Nothing in this part should be construed to alter the requirements imposed on a State Medicaid Agency, or any other agency administering a public insurance

program by Federal statute, regulations or policy under title XIX, or title XXI of the Social Security Act or any other public insurance program." This section clearly specifies that Medicaid requirements apply to school-based IDEA services.

OIG Sample Design and Methodology

State's Comments

State officials said that both the small sample size of 100 claims and the extrapolation of the sample results to nonaudited providers were invalid and inconsistent with appropriate audit practices. They stated that the audit was conducted using a sample of 100 claims taken out of a total universe of 1,616,336 claims, which represents less than one ten-thousandth of the total claims submitted. Officials said that despite the weakness of the sample, we recommended extrapolating the sample results, which reviewed only 72 of the 711 providers, to the entire program.

OIG's Response

We disagree. We select our samples according to principles of probability; that is, every sampling unit has a known non-zero chance of selection. An estimate made from a sample is valid if it is unbiased or nearly so and if we can compute its margin of sampling error for a given probability.

For simple random sampling, we use a minimum sample size of 100. This approach is consistent with generally accepted statistical practices. Use of larger sample sizes usually has the advantage of yielding estimates with better precision without affecting the estimate of the mean. The expected result of better precision would typically be a larger lower bound for the confidence interval of the estimate. In this audit, the lower bound was used as the amount recommended for monetary recovery. With a larger sample size, the expected result would be a larger lower limit and a larger recommended disallowance.

The low percentage of total items that were sampled is not a relevant statistical issue. Again, an increased sample size affects precision and would be expected to narrow the confidence interval and increase the lower limit. The expected result again would be a larger recommended disallowance.

Documentation Requested by Our Audit

State's Comments

The State said that we had failed to explain to the school health providers audited the types of documentation that we were requesting and that the providers were unaware that alternative documentation could have been submitted to support the sampled claims. According to the State, the providers were not aware of the audit consequences related to their documentation and the potential loss to the State for not supplying this documentation. Also, officials stated that

New York's Medicaid providers were required to maintain records supporting their claims for only 6 years from the date of service. Finally, they said that many districts routinely destroyed records in accordance with either the State's 6-year retention requirement or their own longer retention requirements.

OIG's Response

We disagree. Appendix B contains our instructions on the documentation requested from the school health providers sampled. In our opinion, these instructions were very detailed and gave providers sufficient information on the types of documentation requested. Additionally, in a January 30, 2002 letter, the State Education Department notified school health providers of our statewide audit. The letter stated that the Federal Government had requested all providers to preserve all documents related to school health claims from January 1, 1990 forward and provided an extensive list of the documentation that should be preserved.

Additionally, if we determined that a claim appeared unallowable based on the initial documentation submitted, we followed up with provider officials to (1) determine if additional documentation existed, (2) obtain clarification of the submitted documentation, and (3) verify our review determinations. This followup ensured that providers had submitted all documentation they had available to support the sampled claims.

As a point of clarification, the State sent guidance to its school health providers that documentation must be maintained for 6 years from the date of payment, not the date of service.

Finally, if additional relevant documentation is furnished to CMS during the resolution process or if the State can prove that records were destroyed in accordance with established record retention policies, we will assist the parties in recalculating the sample projection.

OIG Audit Methodology

State's Comments

The State said that we had exaggerated findings by turning one condition into two findings. The State was referring to a finding in our draft report that 41 of the sampled claims did not meet Federal ASHA requirements and that 35 of the 41 also did not meet State requirements.

OIG's Response

Although we did not exaggerate the findings in our draft report, we modified the presentation in the final report to show the 35 claims as a subset of the 41 claims. In both the draft and the final, we clearly said that each claim could have more than one error. In conjunction with CMS, we developed worksheets that contained the criteria applied to each sampled claim. Appendix C shows these criteria and the order in which we applied the criteria to each sampled claim. If a claim met all of the criteria, we allowed the claim. If it failed one or more of the criteria, we

disallowed the claim and recorded the reason or reasons for the disallowance on our worksheets and on the schedule shown in Appendix C.

Finally, it should be noted that our audit took a conservative approach when questioning claims. For example, if we found that a qualified practitioner had made a speech service referral within 3 years of the service date under review, we allowed the claim.

State Guidance and Monitoring

State's Comments

State officials said that they had provided proper and timely guidance to schools and counties regarding the requirements for speech services. Officials noted 26 separate communiqués issued to school health providers from 1992 through January 2002, as well as workshops, training, and one-on-one school district management reviews. Officials stated that during 2001, staff conducted 56 one-on-one management reviews.

State officials also said that they had appropriately monitored claims for all school health services, including speech. Officials noted that they had conducted reviews at both the early stages of the program and as additional providers enrolled and gained experience in the Medicaid program. They conducted the first wave of documentation reviews in 1995 and began a second wave of much more formal and broader documentation reviews in September 1998. During the second wave, the State reviewed supporting documentation from more than 170 school districts and 20 counties.

OIG's Response

We disagree that the State provided proper and timely guidance to its school health providers. As described earlier, we believe that improper and untimely State guidance caused a significant number of the errors identified by our audit. Additionally, in our opinion, the State did not adequately monitor speech claims for compliance with Federal and State requirements. We believe that our findings at the Buffalo School District provide a good example of weaknesses in monitoring.

Additional Documentation

State's Comments

State officials said that they had provided specific documentation for four sampled cases. They stated that additional documentation was found to support a physician's referral for speech services in three cases and that we had documentation in our workpapers showing that an ASHA-certified speech-language pathologist had provided a referral after April 1995 in one case. State officials also provided an analysis of the questioned cases and asserted that certain findings (1) could be refuted because documentation or alternate documentation was found or (2) could be refuted by documentation not acceptable to OIG.

OIG's Response

The State did not provide any additional documentation as part of its response to our audit. If the State has additional documentation to support any of the claims questioned by our audit, it should furnish this documentation to CMS for evaluation.

Generally Accepted Government Auditing Standards

State's Comments

State officials said that various violations of generally accepted government auditing standards had occurred during our audit. They specifically stated that OIG had violated standards on independence, personal impairments to independence, reporting standards, and fieldwork standards.

OIG's Response

We strongly disagree. There were no personal impairments of the audit organization or of the individual auditor's independence in the conduct of our audit. Additionally, there were no violations of reporting or fieldwork standards. Therefore, we believe that there were no violations of generally accepted government auditing standards.

Provision of Services

State's Comments

State officials said that schools across New York provided "essential health-related services to disabled children." Their comments went on to state that "The draft audit report raises no question that essential SSHS [school supportive health services] services were delivered by service providers in New York, and that disabled children received those services."

OIG's Response

Although this was not the objective of our audit, we do not contest that services were apparently provided for the 95 claims for which service date delivery documentation was submitted. Rather, as stated on page 2 of our report, our objective was to determine whether the State complied with Federal and State rules in providing those services. In finding that 56 of 100 sampled claims were unallowable, we believe that we have identified deficiencies that could have a direct impact on the quality of services rendered. Many cases lacked a referral from a health care professional, which calls into question the need for the services; in numerous instances, a teacher of the speech and hearing handicapped provided the services without the required direction from an ASHA-certified or a State-licensed speech-language pathologist; and two cases lacked a child's plan/family plan, an essential document that specifies the services needed by the child.

Impact of Audit

State's Comments

State officials said that the results of our audit would negatively affect the State's ability to continue to provide services to children.

OIG's Response

While this may be an issue for CMS to consider when it seeks fiscal recoveries, we believe that allowing New York, or other States that may have similar levels of program deficiencies, to continue operating their programs without fiscal sanction would do a disservice to the disabled children who depend on these essential services. The State should be accountable for the substantial Federal funds paid for school-based health services.

In summary, we believe that our findings are valid, and we continue to recommend that the State refund $172,553,831 to the Federal Government. Additionally, we continue to make the three procedural recommendations to strengthen program compliance.

A P P E N D I CES

APPENDIX A

SAMPLE DESIGN AND METHODOLOGY

Overview: A contracted statistical consultant developed the sample design and methodology for our audit of speech claims.

Methodology: The methodology used in the audit was that of full probability sampling, enabling the auditors to compute (1) an unbiased estimate of the total amount of the overpayment for the universe and (2) an estimate of the standard error associated with the estimated overpayment.

Sampling Frame: The sampling frame was Federal Medicaid claims paid for speech services claimed by 711 schools and preschools with service dates from September 1, 1993 through June 30, 2001. This frame contained 1,616,336 claims totaling $361,840,184 of Federal funds.

Sampling Procedures: Since the dollar values of the claims in our sampling frame were narrowly distributed and the variances of the paid amounts were small, a simple random sampling technique of selecting 100 sampled claims was applied.

Random Selection: The claims were sorted by beneficiary identification number and then by service date in ascending order. The claims were then numbered sequentially from 1 to 1,616,336. The random selection numbers were generated by RAT STATS (May 1993 version), an approved software used in sample auditing by the OIG, Office of Audit Services. The random selection numbers were applied to select the claims to be examined in the audit.

Review Process: Documentation to support the claims that were randomly selected was requested from the school and preschool providers. If documentation supporting a sampled claim was not found, the Federal payment for that claim was considered an error.

Analysis of Audit Results: A database was produced showing the amount of the overpayment for each sampled claim. Using RAT STATS, the data in the sample were used to derive statistical estimates of the total amount of the overpayment. The lower limit of a symmetric, two-sided 90-percent confidence interval was reported as the estimate of the total overpayment. Thus, it was possible to state as a statistically valid estimate that with 95 percent confidence, the true overpayment was at least as great as the lower limit.

DOCUMENTATION REQUESTED BY OUR AUDIT

Below are the instructions attached to the letters that we sent to the school health providers in our sample.

Please provide the following documents and information for the claim(s) for Medicaid reimbursement for speech pathology services for the student(s) identified by Enclosure A.

1. The student's Individualized Education Plans or Programs (IEP) or Individualized Family Services Plans (IFSP) recommending the speech pathology services for the relevant time period under review.

2. The evaluation performed of the student's need for the speech pathology services applicable to the time period under review.

3. Service encounter records, logs, or other documentation substantiating that the speech pathology services were rendered and documentation showing the specific number of speech pathology services rendered each month during the time period under review. If a student was provided speech pathology services by the New York City Board of Education, please also provide the Related Service Attendance Forms (RSAF) for the relevant time period.

4. Student and service provider attendance records for the period under review.

5. Documentation sufficient to show whether the speech pathology services were provided on an individual (one-on-one) or group basis during the relevant time period. If this varied from session to session, please provide documents sufficient to show how this varied. In addition, if the speech pathology services were provided on a group basis, please provide documents sufficient to show the number of students in the group.

6. Documentation identifying by name the service provider(s) who rendered the speech pathology services (i.e., who provided the services) to the student during the time period under review. If the service provider varied during the relevant time period, please provide documents identifying each provider and the time period that provider rendered speech pathology services to the student. In addition, with respect to each service provider identified by this documentation, please provide the following applicable to the relevant time period under review:

    (a) Documents sufficient to show the professional qualifications of the service provider for the period under review, including documents showing (i) whether the service provider was a teacher of the speech and hearing impaired/handicapped (hereinafter referred to as "speech teacher") or a speech pathologist, (ii) the professional licenses and certifications held by the service provider during the relevant time period (for example, a New York State speech

pathologist license or a certification provided to a speech teacher), and (iii) if the service provider was a speech pathologist, provide his or her Certificate of Clinical Competence (CCC) from the American Speech-Language-Hearing Association (ASHA). If a speech pathologist does not have a CCC, provide documents showing that he or she met the equivalency criteria, that is, had completed the equivalent educational requirements and work experience necessary for the CCC *or* had completed the academic program and was acquiring supervised work experience to qualify for the CCC.

(b) The service provider's progress notes relating to the speech pathology services rendered to the student during the relevant time period.

7. With respect to each service provider identified in response to paragraph 6 above, who was not a speech pathologist with an ASHA CCC or did not meet the equivalency criteria, please provide documentation identifying by name the speech pathologist who "directed" the speech pathology services rendered to the student. In addition, with respect to each speech pathologist identified by this documentation, please provide the following:

(a) Documents sufficient to show the professional qualifications of the speech pathologist who provided the direction, including (i) the professional licenses and certifications held by the speech pathologist during the relevant time period (for example, a New York State speech pathologist license), and (ii) his or her CCC from ASHA. If a speech pathologist does not have a CCC, provide documents showing that he or she met the equivalency criteria, that is, had completed the equivalent educational requirements and work experience necessary for the CCC *or* had completed the academic program and was acquiring supervised work experience to qualify for the CCC.

(b) Documents reflecting the nature and extent of the direction that the speech pathologist provided to the speech teacher. In particular, please provide the following:

(i) any documents showing that the speech pathologist met with the speech teacher on a regular basis or had periodic contact with the speech teacher concerning the student;

(ii) any documents showing that the speech pathologist was available for consultation to assure that speech pathology services were provided in accordance with the student's IEP or IFSP;

(iii) any documents reflecting any assessments or evaluations performed by the speech pathologist of the student's speech impairment or disability;

(iv) any documents showing the speech pathologist's involvement in deciding the type and extent of the speech pathology services to be provided to the student;

(v) any documents showing the speech pathologist's review of the student's IEP or IFSP;

(vi) any documents showing the speech pathologist's involvement in preparing the treatment plan for the student;

(vii) any documents showing the speech pathologist's involvement in monitoring or evaluating the progress of the speech pathology services being provided by the speech teacher to the Medicaid student;

(viii) any documentation of performance appraisals and evaluations by the speech pathologist of the speech teacher's services to the student;

(ix) any documentation of the speech pathologist's observation of the speech pathology services rendered by the speech teacher to the student;

(x) any documentation of meetings between the speech pathologist and speech teacher (especially, those meetings in which the speech pathologist and speech teacher discussed the speech pathology services rendered or to be rendered to the student);

(xi) any documentation of the speech pathologist's review of the speech teacher's progress notes (especially, those documents reflecting that quarterly reviews were performed);

(xii) any Committee on Special Education (CSE) documents (including, but not limited to, CSE notes, minutes, or records of meetings) that reflect any direction by the speech pathologist to the speech teacher to assure that the appropriate speech pathology services were prescribed and provided based on the student's impairment or disability; and

(xiii) any other documents of any kind reflecting direction by the speech pathologist to the speech teacher to assure that appropriate speech pathology services were prescribed and provided based on the student's impairment or disability.

8. Documentation showing that a physician or other licensed practitioner of the healing arts (within the scope of his or her practice under State law) referred the student for the speech pathology services.

9. Documentation showing that a physician, registered nurse, nurse practitioner or speech pathologist or other licensed practitioner of the healing arts (within the scope of his or her practice under State law) recommended the speech pathology services, including, any order prescribing the service and the IEP reflecting the recommendation.

10. Any external or internal written communications (*e.g*., correspondence, memoranda) or notes relating to the Medicaid claims for speech pathology or other school health services provided to the student.

11. If outside contractors or service providers (such as an independent agency or the Board of Cooperative Educational Services) were used to provide the speech pathology services, please provide a copy of the signed Provider Agreement and Statement of Reassignment.

ALLOWABILITY OF EACH SAMPLED CLAIM

Legend

A	No Documentation
B	No Service Date Delivery Documentation
C	No Assurance That Services Were Rendered
D	Federal Provider Requirements Not Met
E	Speech Services Not Provided by or Under the Direction of a State-Licensed Speech-Language Pathologist
F	No Speech Referral, Referral Not Made by an Appropriate Professional, or Referral Not Made Before the Service Date Under Review
G	No Child's Plan/Family Plan
H	No Identification of or Recommendation for Speech Services in Child's Plan/Family Plan
I	No Assurance That a Minimum of Two Monthly Speech Services Were Rendered

OIG Review Determinations on the 100 Sampled Claims

Claim No.	A	B	C	D	E	F	G	H	I	No. of Errors
1										0
2										0
3										0
4										0
5				X	X					2
6		X	X	X	X	X			X	6
7				X	X					2
8										0
9										0
10				X	X					2
11										0
12										0
13										0
14				X						1
15										0
16				X	X					2
17										0
18				X	X					2
19						X				1
20										0
21				X		X				2

Claim No.	A	B	C	D	E	F	G	H	I	No. of Errors
22				X	X	X				3
23						X				1
24				X	X	X				3
25						X				1
26										0
27				X	X	X				3
28						X				1
29										0
30				X	X	X				3
31										0
32										0
33				X	X	X				3
34										0
35				X	X	X				3
36										0
37				X		X				2
38				X						1
39				X						1
40						X				1
41				X	X					2
42										0
43						X				1
44				X	X	X				3
45						X				1
46				X	X	X				3
47						X				1
48										0
49						X				1
50										0
51				X						1
52				X	X					2
53										0
54										0
55		X	X	X	X	X	X		X	7
56										0
57		X	X	X	X	X			X	6
58				X	X					2
59				X	X	X	X			4

Claim No.	A	B	C	D	E	F	G	H	I	No. of Errors
60										0
61										0
62										0
63										0
64										0
65										0
66						X				1
67				X	X	X				3
68						X				1
69						X				1
70		X	X	X	X	X			X	6
71				X	X					2
72				X	X	X				3
73				X	X	X				3
74										0
75										0
76						X				1
77				X	X	X				3
78						X				1
79										0
80				X	X	X				3
81										0
82										0
83										0
84						X				1
85										0
86				X	X	X				3
87				X	X	X				3
88				X	X	X				3
89										0
90				X	X	X				3
91				X	X	X				3
92										0
93				X	X	X				3
94				X	X					2
95										0
96										0
97		X	X	X	X	X			X	6

Claim No.	A	B	C	D	E	F	G	H	I	No. of Errors
98										0
99										0
100										0
Total	0	5	5	41	35	42	2	0	5	

APPENDIX D

SAMPLE RESULTS AND PROJECTION

The results of our review of the 100 Federal Medicaid speech claims were as follows:

Sample Results

Claims in Universe	Value of Universe (Federal Share)	Sample Size	Value of Sample (Federal Share)	Improper Claims	Value of Improper Claims (Federal Share)
1,616,336	$361,840,184	100	$22,369	56	$12,548

Projection of Sample Results
Precision at the 90-Percent Confidence Level

Point Estimate:	$202,817,841
Lower Limit:	$172,553,831
Upper Limit:	$233,081,851
Precision Percent:	14.92 %

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

April 7, 2003

Timothy J. Horgan
Regional Inspector General for Audit Services
Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

Re: Draft Report Number A-02-02-01030 Entitled: "Review of Speech Claims to Medicaid Made by 711 School Health Providers Within New York State"

Dear Mr. Horgan:

Enclosed is the New York State Department of Health's ("DOH") response to the above-referenced draft report, produced by the Health and Human Services' ("HHS") Office of the Inspector General ("OIG"). As described in the enclosed response, the draft report is flawed in both concept and design, and should be withdrawn, and five related audits should be terminated immediately.

For more than a decade, local school districts in New York State have relied on Congress's promise that it would provide federal Medicaid funds to help fund health services to poor, disabled children in New York State schools. Those funds have proven invaluable in helping local school districts provide the medical services necessary for these children to live healthy lives, while they also receive the free and appropriate public school education to which they are entitled.

As President Bush recently stated in his 2002-03 budget proposal, however, prior administrations "never articulated clear guidance" for this program -- guidance that school districts needed to help them apply Medicaid rules originally designed for the medical office and hospital to the entirely different educational settings of the classroom and local school district office.

Now, more than a decade after Congress made its promise, and with federal guidance still absent, OIG seeks to undercut the promise by seeking the return of nearly $200 million in federal payments for these services. Relying on a sample of only 100 claims provided by 72 providers (out of a universe of 1,616,336 claims!), OIG proposes to disallow more than $183 million in claims submitted by more than 700 school districts across the state.

The draft audit is but the first in a series of OIG audits of more than $1.6 billion in claims submitted by New York State school districts, including three audits that target New York City specifically. OIG appears poised to recommend that local school districts in New York State return as much as $1 billion to the federal government for alleged overpayments. The mere release of the audit report, recommending hundreds of millions of dollars in disallowance, may well disrupt the local budgeting process, and deter school districts from providing critical services to their school children and from continuing to participate in the Medicaid program as intended by Congress.

This unfortunate result should be avoided. As the enclosed response makes clear, OIG's proposed disallowance is not premised on a finding of Medicaid fraud or abuse. In fact, the response demonstrates exactly the opposite: in all but a statistically insignificant handful of cases, documents produced by the districts proved that they had provided the health services in question:

> each poor, disabled child in OIG's sample was referred for speech pathology services by a duly-constituted Committee for Special Education, including appropriate professionals;
>
> each poor, disabled child in the sample received speech pathology services provided by state-licensed speech pathologists, or certified teachers of the speech or hearing handicapped (almost always operating under the direction of a speech pathologist);
>
> each claim in the sample met all of the requirements for providing services to disabled children described in the federal Individuals with Disabilities Education Act;
>
> each claim in the sample was of the type Congress intended to be reimbursed through the Medicaid system.

OIG's proposed disallowance is instead premised on OIG's overly technical application of the Medicaid rules, rules designed for hospitals and medical offices, but not for the entirely different culture of the special education classroom. In light of prior administration's persistent failure to provide adequate guidance to school districts, what is surprising is not that OIG could find technical grounds on which to disallow claims, but that, as the enclosed audit response demonstrates in detail, each of the claims satisfies a reasonable interpretation of the Medicaid rules, and a large proportion of the claims satisfy even OIG's hyper-technical approach.

In the circumstances surrounding this program, however, it would be patently unfair for HHS to clarify the rules of this program for the first time through the punitive means of winner-take-

all audits applied to eleven years and $1.6 billion of local school district claims. Taking such an approach would be akin to making up the rules in the middle of the game, with local school districts potentially losing hundreds of millions of dollars because they did not know the rules from the outset. A more reasoned approach -- one that has been applied in other states -- would be to conduct instead a one- or two- year audit, of the kind currently being conducted by HHS' Centers for Medicare and Medicaid Services ("CMS").

This audit is apparently an outgrowth of a civil fraud claim filed in federal court, alleging that upstate school districts engaged in intentional fraud in filing their speech pathology claims. But the audit did not uncover any fraud, and it speaks only to policy issues and technical violations. The fact that a so-called "whistleblower" filed a lawsuit -- with the hope of a receiving a windfall of tens of millions of dollars -- does not seem to be a sound basis upon which to seek the return of hundreds of millions of dollars based on rules made up in the middle of the game, resulting in the evisceration of a program that local school districts rely upon to provide health services to poor, disabled children.

Of course, to the extent that OIG has identified any instances of actual fraud or abuse, the fraud or abuse should be properly pursued. In this audit, however, there is no question that school districts actually provided health services to poor, disabled children. Instead, areas of narrow policy dispute -- the product of failed guidance by previous administrations -- have produced a highly flawed report that, if released, could have serious implications for the State's School Supportive Health Services program.

To the extent that policy issues exist between the State and the federal Department of Health and Human Services, these disputes should be resolved amicably between them, including by an ongoing CMS audit of one or two years of State claims. However, in light of the background, the flawed audit should be withdrawn, and five related audits should be terminated immediately.

Sincerely

Kathryn Kuhmerker
Deputy Commissioner
Office of Medicaid Management

Enclosures

TABLE OF CONTENTS

LIST OF EXHIBITS:

Administration

C – June 4, 1997 Letter from the Health Care Financing Administration to the New York State Department of Health

D – September 4, 2002 Letter From the American Speech and Hearing Association to the federal Office of Inspector General

E – List of Twenty-Six (26) Memoranda and Letters Issued By the New York State Education Department to Providers of School Supportive Health Services

F – 1993 Training Video Entitled "Medicaid Reimbursement for School Districts in New York State", by the New York State Education Department

G – Chart Showing Each Case Disallowed by the OIG and the Reason(s) for Disallowance, Together with the State's Reason(s) for Reversal of Each Finding

H – July 30, 2002 Letter From the Federal Office of Inspector General to the American Speech and Hearing Association

EXECUTIVE SUMMARY

I. Overview

A. Summary Statement of New York's Response

The Office of the Inspector General (OIG) of the federal Department of Health and Human Services has issued a draft audit report which proposes a disallowance of $183 million, or roughly 51 percent of the $362 million in Medicaid claims for speech pathology services provided to disabled children by school districts and counties across New York during a period encompassing nine state fiscal years (9/1/93 -- 6/30/01). As detailed in the body of our audit response, New York objects to this draft audit report in the strongest possible terms and calls for it to be withdrawn for the following reasons:

Fundamental Flaws in Audit Concept and Design: The draft audit is based upon a miniscule statistical sample (100 out of 1,616,336 claims) and extrapolates the sample results from the 72 providers audited to over 600 other providers not included in the audit.

Inconsistency with Audit Approach in Other States: The audit period used in comparable OIG audits in other states focused on the most recent fiscal year completed (i.e., 1999 or 2000). However, in New York the audit extends back to 1993. Furthermore, the sample size was much larger in the other states, and disallowances were limited to the providers actually audited -- unlike the disallowances proposed for New York, which are applied against providers that were never audited.

Inappropriate Application of a "Medical" vs. "Educational" Model: Consistent with the development of an Individualized Education Program (IEP) for each disabled child under the federal Individuals with Disabilities Education Act (IDEA), schools have been providing services covered under the School Supportive Health Services (SSHS) program since 1975. When schools began to bill Medicaid for these services in 1993, it was both reasonable and consistent with Congressional intent that these services were documented and billed by schools using an "educational" model. Therefore, application of a "medical" model of service delivery, such as that used for hospitals, is patently unfair to our schools. Once OIG applies the appropriate educational model (or even a reasonable interpretation of a medical model), 95 out of the 100 claims contained in the sample would meet federal requirements -- the statistical equivalent of full compliance.

Based upon the audit flaws noted above and described in greater detail in the body of our response, the instant draft audit should be withdrawn. Furthermore, the draft audit raises no question that essential SSHS services to disabled children were provided, and that disabled children received those services. Instead, a massive disallowance is proposed that would have a paralyzing impact on New York and its schools based upon an alleged failure to meet highly technical documentation requirements.

B. General History

In 1988, Congress enacted legislation to encourage state and local education agencies across the nation to access federal Medicaid reimbursement for health-related services for disabled children. These health-related services represent an essential element of the educational program required for each disabled child pursuant to the federal Individuals with Disabilities Education Act (IDEA). Pursuant to this legislation, New York received formal federal approval of its efforts to implement what became known as the School Supportive Health Services (SSHS) program in 1995. The federal approval was made retroactive to May 1992, and school districts were permitted to bill for services back to April 1990.

Prior to the federal approval of SSHS in 1995, school districts and counties that offered school age and pre-school programs had begun to enroll as Medicaid providers and bill under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. In 1993, they began billing for various services, including speech pathology, physical therapy, occupational therapy, audiology, nursing, psychological counseling, transportation and medical evaluations. The billing for services under this program was eventually merged into the SSHS program.

It is clear that Congress intended federal Medicaid funds to be used to assist states in the provision of medically necessary services to disabled children in an educational setting consistent with IDEA. Congressional intent is evident in the amendments included in the Medicare Catastrophic Coverage Act of 1988. In this act, Congress amended Title XIX of the Social Security Act by adding a new section 1903(c) (42 U.S.C. 1396b(c)), which provides that:

> *Nothing in this subchapter shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) of this section for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part H of such Act.*

C. Billing for Services under "Educational" vs. "Medical" Model

In accordance with Congressional intent that Medicaid be used to support medically necessary services required by a child's Individualized Education Program (IEP) under IDEA, school districts and counties began billing for SSHS services. This is notable for two important reasons. First, it meant that local educational agencies would finally begin to receive Medicaid payment for costly services that they had been mandated to provide under federal law since 1975. Second, in order to receive these benefits, school districts

would have to learn the technical record-keeping and billing requirements of Medicaid -- one of the most complex programs in the nation. Guided by federal IDEA requirements, school districts had provided the services for at least fifteen years before they could bill Medicaid. Using the IDEA guidelines, schools had developed methods for documenting children's progress in each service area. This IDEA-based method of documentation can be described as an "educational" model. The educational model focuses on how the services assist the child in meeting long term goals, as described in the student's IEP. When services are not adequate and the child does not meet IEP goals, federal law grants parents recourse to a number of legal remedies designed to guarantee that services are provided as required.

In contrast to the "educational" model, application of the "medical" model would require schools to focus on technical, medically oriented documentation of individual service dates, with less emphasis on longer-term outcomes. In addition, many of the modalities for providing health services in schools, such as using federally-prescribed committees on special education to refer children for speech services, or the methods for using schools' personnel to oversee the provision of services, raised questions about how best to comply with technical Medicaid requirements. In light of these factors, compliance with the "medical" model clearly presents a significant challenge for schools. These challenges are at the root of many of the disallowances taken in this audit.

D. Programmatic Context

New York is a national leader in providing educational and health-related services to disabled children. In the 2002-2003 school year, school districts in New York will spend in excess of $6 billion on special education services. In turn, New York receives a relatively modest level of federal support for these essential services, with approximately $540 million in IDEA funding, and approximately $390 million for Medicaid-eligible services under SSHS.

E. Audit History

In the fall of 2001, the federal Department of Justice (DOJ) and the Office of Inspector General (OIG) initiated an investigation of three New York school districts -- Ogdensburg, Ithaca and Elmira -- as a result of a federal False Claims Act "whistleblower" action initiated by a service provider. This investigation appears to have provided the impetus for this audit as well as five additional audits of SSHS by OIG. The six audits (including this one) will address the following SSHS services:

Speech pathology services for all schools/counties other than New York City, Jefferson County, Ogdensburg, Ithaca and Elmira. (The audit is the subject of this response and covers claims for September 1, 1993 through June 30, 2001.)
Speech pathology services for New York City only. (The audit will cover claims for September 1, 1993 through June 30, 2001.)
Transportation services for all schools/counties other than New York City, Jefferson

County, Ogdensburg, Ithaca and Elmira. (The audit will cover claims for September 1, 1993 through June 30, 2001.)
Transportation services for New York City only. (The audit will cover claims for September 1, 1993 through June 30, 2001.)
Retroactive claims for all schools/counties other than New York City, Jefferson County, Ogdensburg, Ithaca and Elmira. (This audit will cover claims for April 1, 1990 through August 31, 1993.)
Retroactive claims for New York City only. (This audit will cover claims for April 1, 1990 through August 31, 1993.)

The current audit was conducted by OIG using a sample of 100 claims for services provided from 1993 through June 2001. The draft audit report from OIG contends that over half of the sample claims are unallowable, thereby resulting in a projected disallowance of $183 million, or roughly 51 percent of the $362 million in claims submitted.

II. Policy Issues

Consistent with federal intent, schools across New York have been providing, and continue to provide, essential health-related services to disabled children consistent with federal Medicaid and IDEA requirements. The draft audit report raises no question that essential SSHS were delivered by service providers in New York, and that disabled children received those services. Instead, the audit disallowance of $183 million is due largely to compliance issues associated with technical documentation requirements.

If the disallowances recommended by OIG are taken, the magnitude of the funds involved will have a paralyzing impact on New York State and its schools and counties. Since the inception of the SSHS program, New York has received approximately $3 billion in federal Medicaid funding, of which $1.6 billion is being audited. If a similar percentage were disallowed in each of the six OIG audits, New York would face a loss of nearly $1 billion. This loss would clearly jeopardize the ability of our schools and counties to provide needed services. Such an action would clearly run counter to the stated intent of Congress and the President that disabled children receive the health-related services they need to fulfill the requirements of their IEP's, and that the use of Medicaid funds should in no way be restricted or prohibited for such covered services.

New York understands the importance of ensuring that its receipt and use of Medicaid funds is consistent with federal intent, as well as statutory and regulatory requirements. New York is steadfast in its commitment to ensure full compliance with these requirements, and it appreciates the importance of vigilant monitoring and oversight to ensure this commitment is fulfilled. However, as discussed below, the ability of the State and our service providers to ensure full compliance with documentation requirements has been affected by a variety of factors outside of our control.

A. Inconsistent/Contradictory Federal Guidance

The initial years of implementation for any program can be difficult, and the SSHS program is no exception. Compliance with documentation and billing requirements was even more difficult for schools and counties, since they were more accustomed to the IDEA-based educational model of documentation than the medical model. Under the educational model, they had provided health-related services under a federal mandate for at least 15 years before Medicaid was made available to pay for the services.

While the State Departments of Social Services (now Health) and Education provided extensive training in billing and documentation retention, one of the most notable problems that has hampered effective SSHS administration in New York is the inconsistent/contradictory guidance that has been provided by federal agencies. This problem is by no means unique to New York. The lack of federal guidance was also criticized in a series of reports produced by the federal General Accounting Office (GAO). In one of these reports, issued in 1999, GAO stated that "Inconsistent guidance from HCFA appears to have heightened school district concerns that Medicaid reimbursements will have to be returned to the federal government later because of inappropriate documentation requirements."

Indeed, President Bush highlighted the problem in his budget proposal for the 2003 fiscal year. The President said, "In past years, billing inconsistencies have plagued the program because the federal government has never articulated clear guidance. In 2002, the Administration will release guides that will address all aspects of school-based Medicaid billing."

While we seriously dispute the methodology and approach of the OIG audit, a review of the draft audit report findings for the sample cases provides evidence that the compliance of New York's SSHS providers has demonstrated consistent improvement since the inception of the program as they became more familiar with requirements of the medical model. The number of audit findings and cases recommended for disallowance in the draft audit report decreases significantly as the cases become more current, as can be seen below:

Year	Total Claims	OIG Recommended Disallowance Percentage	Number of Findings Per Claim
1993-1995	22	90.9%	2.4
1996-1998	47	63.8%	1.5
1999-2001	31	29.0%	0.8

B. Delays in Federal Policy Responses and Reviews

Like other states, New York's ability to help local providers claim properly has been compromised by the federal government's delay in responding to questions involving the interpretation of various federal regulatory requirements -- particularly those related to whether SSHS services are "rehabilitative" or "corrective" in nature. When New York sought a more definite interpretation of these federal regulatory requirements to clarify contradictory and inconsistent guidance, the State was denied the opportunity to contest such guidance until it was harmed by this audit -- a proverbial "Catch 22." The impact of this "Catch 22" is enormous; although New York's earliest claims for SSHS payments date back to 1990, no program audit was commenced by CMS or OIG until the latter part of 2002 -- twelve years later.

As a result of this delay in auditing the program, New York State SSHS providers have been asked to document services that occurred more than a decade ago. While the federal government argues that no statute of limitations applies to Medicaid payments, that position is unrealistic and inequitable to states such as New York that reimburse providers for services validly rendered and then must wait until OIG audits those claims before they can challenge federal interpretations of ambiguous regulations.

In addition, under New York State regulations, Medicaid providers are only required to maintain records supporting their claims for a period of six years from the date of the service. Despite its knowledge of this requirement, OIG is now holding the State liable for any failure by school districts and counties to produce records supporting SSHS payments well after the expiration of the six-year period and, in some cases, for services provided up to eight years earlier.

III. Audit Methodology and Scope

A. Inappropriately Small Sample Size

The OIG audit was conducted using a sample of 100 claims for services provided from September 1993 through June 2001. These one hundred claims were taken out of a total universe of 1,616,336 claims submitted during that time. The sample represents less than one ten thousandth of the total claims submitted. Despite the weakness of the sample, OIG recommends extrapolating the sample results, which reviewed claims submitted by only 72 of the 711 SSHS providers in New York State, to the entire program. Both the small sample size and the extrapolation to non-audited providers are inconsistent with appropriate audit practices, as well as the OIG audits conducted in other states.

B. Period of Time Covered by Audit

Although New York's regulations require providers to keep records for 6 years, OIG's audit covered claims for services rendered as long ago as 1993. Because school districts were not required to maintain records for such distant periods, they were not able to thoroughly document many of the claims made during this period. Despite its knowledge of this requirement, OIG recommends disallowing these claims. In addition, OIG recommends disallowing an artificially high percentage of current claims because school districts could not document those old claims.

C. Inconsistency with Audit Approach in Other States

Recently, OIG has conducted a number of audits of SSHS programs in other states, including Massachusetts, Connecticut and Oregon. However, the audit approach taken by OIG in New York is inconsistent with that used in the other states, and results in a disallowance that is excessively and disproportionately large. Relative to the audits in the other states, the New York State audit used miniscule sample sizes taken from claims for services that were provided as early as 1993, and OIG applied much higher standards of documentation in New York. Despite this weakness in the sample and the uneven treatment between states, the draft audit report recommends extrapolating the audit's findings to hundreds of providers that were never audited.

The audits that OIG conducted in the other states that, like New York, have a fee-for-service program, reviewed claims submitted during a much shorter period of time than in New York. These other audits typically reviewed program information for claims submitted during a one-year period -- not eight years of service as in New York. If OIG had audited New York for the last year of the audit period rather than all eight years, the disallowance amount would be *zero*, due to improvements in documentation compliance over the years. (See Exhibit A hereto).

The audits in other states also focused on more recent periods (e.g., the most recent fiscal year completed -- 1999 or 2000), rather than going back to 1993 as in New York. This audit methodology substantially disadvantages New York State. The longer period covered and the examination of claims that are far older than the six year period that New York requires providers to maintain service documentation made it much more difficult for New York State school districts and preschool Medicaid providers to demonstrate their full compliance.

In addition to the inconsistencies in the length of time and age of claims covered by the audit, OIG's statistical sampling methodology is extremely problematic, relative to the three other states' cases where OIG used a sampling methodology to review claims (i.e., Massachusetts, Connecticut and Oregon). In these other states, the size of the samples used to review claims were much larger relative to the number of claims in the sample universes. In addition, these samples were taken from the claims of individual providers, and only these providers were expected to reimburse the Federal government for

overpayments. In no other case did OIG recommend that claims be disallowed for individual providers that were never audited, as it proposes to do in New York.

IV. Conclusion of Executive Summary

As stated above, the OIG's audit of Medicaid claims for speech services that were provided in our school districts and counties should be withdrawn, and the other planned audits cancelled. As will be described in the detailed audit response below, the vast majority of the audit findings were the result of inappropriate regulatory interpretations and OIG's misunderstanding of the State's requirements for professional practitioners. In addition, the methodological design of the audit was fundamentally flawed and inconsistent with the methods the OIG has used to audit similar providers in other states.

The audit fails to recognize the essential foundation upon which the School Supportive Health Services program is based: Congress intended to assist school districts with the provision of services required under IDEA and expected that the services would be provided as determined by each local educational agency's Committee on Special Education, in accordance with the provisions of IDEA.

Finally, it needs to be emphasized that the draft audit raises no question that essential SSHS services to disabled children were provided, and that disabled children received those services. Instead, a massive disallowance is proposed that would have a paralyzing impact on New York and its schools based upon an alleged failure to meet highly technical documentation requirements. Because all necessary services were provided, and because of the devastating impact that OIG's flawed audit would have on our school districts and counties, the instant draft audit should be withdrawn.

RESPONSE TO DRAFT AUDIT REPORT

I. Applicable Federal Regulation

A. 42 C.F.R. § 440.110 Does Not Apply to the Speech Services Provided Under New York's School Supportive Health Services (SSHS) Program

New York has consistently maintained that the Health Care Financing Administration (HCFA), now known as the Centers for Medicare and Medicaid Services (CMS), has applied the wrong federal regulation to its analysis of speech service delivery. The applicable regulation is 42 C.F.R. Section 440.130 ("Diagnostic, screening, preventive, and rehabilitative services"). The application by CMS of 42 C.F.R. Section 440.110 ("Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders") improperly imposes criteria on the delivery of speech services that do not exist under the rehabilitative services option in New York's CMS-approved State Plan.

In its recitation of State Plan optional services, Congress has clearly delineated between "therapy" services (including "corrective" services) and "rehabilitative" services. Section 1905(a)(11) of the Social Security Act ("SSA") sets out "physical therapy and related services" as an optional service under a state's program. Speech is a "related" service under this option. The criteria for delivery of services under this option are set forth in regulations at 42 C.F.R. Section 440.110 and include the concept of "services provided by or under the direction of a speech pathologist or audiologist." 42 C.F.R. § 440.110(c).

SSA Section 1905(a)(13) permits a state to include in its State Plan "other diagnostic, screening, preventive, and rehabilitative services...for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." 42 C.F.R. Section 430.130 further defines and describes this option. Section 430.130(d) defines "rehabilitative services" as "...any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." By contrast, Section 430.110, the linchpin of the federal audit, contains no reference at all to "rehabilitative services." Instead, that regulation refers to "corrective" services, services required by an individual to return that individual to full capacity. The distinction between these types of services could not be clearer and was recognized both by Congress in the statute and by the Department of Health and Human Services (HHS) in its promulgation of these regulations. If HHS had wanted Section 430.110 to address criteria for the provision of "rehabilitative" services, it would have said so explicitly.

The determination of whether a service is "corrective" or "rehabilitative" for Medicaid purposes rests upon whether the service would restore a level of functionality that the individual once possessed (i.e., a "corrective" service) or whether the service would allow the individual to achievehis/her optimal level of functionality (i.e., a "rehabilitative" service). It would seem self-evident that health-related services provided to a disable child as part of his/her IEP would, by their very nature, represent rehabilitative services. Since, for the vast majority of disabled children, these health-related services are designed to maximize their level of functionality, they are clearly rehabilitative in nature.

Notably, Section 430.130 does not require that rehabilitative services be provided "under the direction of" any particular individual, merely that they be "recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law." 42 C.F.R. § 440.130(d). Because the concept of diagnosis, screening, prevention and rehabilitation is consistent with the provision of Early and Periodic, Screening, Diagnostic and Treatment services (EPSDT) to persons under age 21 mandated under federal law (SSA § 1905(a)(4)(B)), New York decided to provide SSHS under the "rehabilitative services" option. HCFA agreed with the State's position; the June 2, 1995 letter approving State Plan Amendment #92-42 states: "This is to notify you that New York's State Plan Amendment (SPA) #92-42, reflecting the State's program for Rehabilitative Services for School and Preschool Supportive Health Services, has been approved for adoption into the State Medicaid Plan...." Thus the State's contention that Section 440.130 is the applicable regulation, and not Section 440.110, was supported by HCFA at the very outset of the federally approved program.

In a November 20, 1996 letter to HCFA (Exhibit A hereto), the State reiterated its position that speech pathology services provided by public schools and municipalities to children with developmental disabilities fall under the provision pertaining to "rehabilitative" services at 42 C.F.R. Section 440.130(d). The letter further noted that under Section 440.130(d), there are no professional qualifications listed for the provider of services. All that is required in order to provide services to a handicapped child is a recommendation by a physician or other licensed practitioner of the healing arts, within the scope of such person's practice under State law. The letter maintained that the qualifications of these practitioners, absent specific federal regulations issued pursuant to the Administrative Procedure Act, are under the jurisdiction of the State and not the federal government.

Notwithstanding New York's arguments, HCFA, in a June 4, 1997 letter to the State (Exhibit B hereto), concluded that even though no specific federal standards are included in Section 440.130, the provider qualifications for speech pathology at Section 440.110 would apply even when the speech services are covered in the SPA under the "rehabilitative" option governed by Section 440.130. HCFA maintained that its policy is that services coverable under more than one regulatory authority must meet the requirements of the more specific authority even when covered under a broad coverage category such as the rehabilitation benefit. HCFA offered no statutory or regulatory support for this "policy." The June 4, 1997 letter did, however, express agreement with

the State's position that, if forced by HCFA to adhere to the more specific requirements of Section 440.110, it could "...look to its own State practice laws in order to determine when services are appropriately provided 'under the direction of' a Medicaid qualified speech pathologist, if this was consistent with the State's own laws and regulations." This concession by HCFA further complicated the issue by seeming to apply the "under the direction of" requirement of one optional services regulation (§ 440.110) while simultaneously applying the "within the scope of practice under State law" requirement of a different optional services regulation (§ 440.130).

The State continues to disagree with the federal interpretation as to the appropriate regulatory standard to be applied to the services at issue. The State contends that the applicable governing regulation for provision of these services is solely 42 CFR Section 440.130.

B. The State Complied with the Requirements of Section 440.130

The rehabilitation option regulated by Section 440.130 contains no specific requirements for the qualifications of the hands-on provider of the rehabilitation service. The State's position is that the speech services provided under this option were provided in full conformance with State law in that the services were provided by a professional appropriately authorized by State law to deliver the services. Absent a specific applicable federal requirement, State law as to qualifications controls.

Section 440.130(d) requires that the medical or remedial service be "recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law..." Under the federal IDEA, a Committee on Special Education (CSE) or a Committee on Preschool Special Education (CPSE) recommends appropriate services to be included on a student's Individualized Education Program (IEP) or Individualized Family Services Plan (IFSP). These Committees are required by law to consist of a multidisciplinary panel of licensed practitioners and certified providers. If a child's IEP or IFSP recommends speech services, the delivery of those services qualifies for Medicaid funding under Section 440.130. A "referral" is not required.

Although the draft audit report cites the Department's regulations at 18 N.Y.C.R.R Section 505.11, which require that recommendations for speech services be made by a physician, physician's assistant, registered nurse, nurse practitioner, or licensed speech pathologist, the State promulgated this requirement only to reach agreement on the State Plan Amendment. The State has consistently maintained the position that the CSE recommendation was sufficient under Section 440.130.

C. The State Complied with the Intent of Section 440.110

Assuming, for the sake of argument only, that Section 440.110 is applicable to these speech services, the State has adhered to the intent of the requirements of this regulation. There are three basic requirements contained therein:

the services must be provided by or under the direction of a speech pathologist or audiologist,

b. the speech pathologist or audiologist must be certified by the American Speech and Hearing Association ("ASHA") or have completed the equivalent educational requirements and work experience necessary for the certificate, and,
there must be a referral by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law.

"Under the Direction Of"

In light of HCFA's concession in its June 4, 1997 letter (Exhibit B hereto) that the State could "...look to its own State practice laws in order to determine when services are appropriately provided 'under the direction of' a qualified speech pathologist...", the State determined to use licensed teachers of the speech and hearing impaired to provide speech services 'under the direction of' a Medicaid qualified speech pathologist, in accordance with New York's own laws and regulations. HCFA had authorized the State to determine the meaning of "under the direction of."

Accordingly, the State published regulations at 18 NYCRR Section 505.11(c), which provide that rehabilitative services may be provided by a qualified professional employed by or under contract to a school district. The regulation also states that "[s]peech pathology services may be provided under subparagraph (iv) of this paragraph by a teacher of the speech and hearing impaired under the direction of a speech pathologist. *Under the direction of a speech pathologist* means that a teacher of the speech and hearing impaired may provide services as long as a speech pathologist meets with such teacher on a regular basis and is available for consultation to assure that care is provided in accordance with the individualized education program or an interim or final individualized family services plan. Teachers of the speech or hearing impaired or speech pathologists who provide services or in the case of a speech pathologist under whose direction services are provided must be currently registered and certified in accordance with the New York State Education Law and the rules of the Commissioner of Education."

Although not expressly set forth in the draft audit report, the OIG disallowed cases in the sample because it adhered to different requirements than those contained in the State's regulation. The source of the OIG's additional requirements has not been revealed and, therefore, the State cannot specifically respond.

2. ASHA Certification

42 C.F.R. Section 440.110(c)(2) defines a speech pathologist or audiologist as an individual who: "(i) has a certificate of clinical competence from the American Speech and Hearing Association; (ii) has completed the equivalent education requirements and work experience necessary for the certificate; or (iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate. "

The OIG has concluded, however, based upon a letter from the American Speech and Hearing Association (ASHA) (Exhibit C hereto), which is referenced on page 11 of the draft audit report, that New York State's licensure requirements are not equivalent to ASHA's requirements for a Certificate of Clinical Competence (CCC). New York State contends that its licensing requirements meet or exceed the requirements of a speech pathologist with an ASHA CCC.

The draft audit report incorrectly asserts the superiority of ASHA certification in the following seven areas:

- the degree accepted for licensure,
- the quantity of course work required for licensure,
- the distribution of course work,
- the quantity of pre-degree practicum,
  the specification of disorder types and age groups for the pre-degree practicum,
- the amount of supervision during the clinical fellowship, and
- the quality and quantity of supervision during clinical fellowship.

(a) <u>Degree Accepted for Licensure</u>

The degree level required for licensure in New York equals that required by ASHA.

A CCC requires a Master's degree or a doctoral degree. The ASHA letter states that in NYS, which allows "for a masters degree or its equivalent," it is possible that a NYS licensee may deliver services with a bachelor's degree as the highest degree earned. This is not true. NYS requires a Master's degree or higher. The NYS license for a speech/language pathologist does not authorize a "NYS licensee with a Bachelor's degree" to deliver services. There are no NYS licensees who hold only a Bachelor's degree. The State does, however, accept a Master's degree equivalent to a Master's degree in speech/language pathology. In such a case, an individual with a graduate degree in a field other than speech pathology must obtain the necessary graduate course work and practica in speech/language pathology. Once this is completed, the individual would have a Master's degree as well as the required course work in speech/language pathology and could be eligible for licensure. New York State has not licensed anyone who did not hold a Master's degree.

(b) Quantity of Course Work

Ninety-eight percent of NYS licensed speech pathologists have the requisite course work to meet ASHA requirements.

New York's course-work requirement for licensure complies with the 1993 ASHA standard of 60 semester credit hours. While technically this is 15 hours less than the revised ASHA requirement of 75 semester credit hours, in practicality at least 98 percent of our new (1994 onward) licensees are graduates of ASHA-accredited programs, which have a 75 semester credit hour standard. The other two percent of NYS licensees are individuals who either: (a) graduated from ASHA-accredited programs prior to 1994 (when the ASHA standard was the same 60 semester hours as NYS), the majority of whom do hold an ASHA CCC, or (b) were licensed and worked in another state and are moving to NYS, or (c) graduated from foreign speech/language pathology programs and have the education necessary to meet New York's standards.

(c) Distribution of Course Work

Only two percent of new licensees do not meet the 75 credit-hour standard, and as stated above, the majority of that two percent hold their ASHA CCC.

(d) Quantity of Pre-Degree Practicum

The fact that ASHA has accredited all but one of NYS' licensure-qualifying speech-language pathologist Master's degree programs strongly suggests that it finds New York's requirements at least equal to its own requirements.

The September 4, 2002 letter from ASHA to the OIG states that current "NY licensure requirements do not specify either the extent of supervision or the nature of the clinical experience required during the practicum." (Exhibit C hereto at page 2.) While that statement is true, all but *one* of the speech/language pathologist Master's degree programs in New York are accredited by ASHA. AHSA, therefore, must find the quantity of NYS' pre-degree practicum equal to its own. Notably, 95 percent of NYS graduates since 1994 have had clinical practicum under the ASHA model.

(e) Specification of Disorder Types and Age Groups for the Pre-Degree Practicum

See subsection (d), above, entitled "Quantity of Pre-Degree Practicum."

(f) Amount of Supervision for the Pre-Degree Practicum

See subsection (d) above, entitled "Quantity of Pre-Degree Practicum.

(g) Quantity and Quality of Supervision During the Clinical Fellowship

New York requirements for the clinical fellowship exceed ASHA requirements.

While both the CCC requirements and NYS licensure requirements mandate completion of a full-time clinical fellowship, NYS requires nine months (39 weeks) of full-time experience, while ASHA requires only 36 weeks. Ninety-eight percent of new licensees earn their ASHA CCC concurrently with their NYS license, using the same experience for both credentials. Thus, ASHA accepts NYS standards for the quality of supervision and as well as the quantity of the period of supervision. Individuals who already hold their CCC when applying for NYS licensure are frequently required to do additional weeks of supervised experience in order to meet New York's requirements.

(h) Additional NYS Requirements

Current registration is required to practice in NYS. Effective January 1, 2001, NYS requires speech/language pathologists to obtain 30 continuing competency hours every three years in order to re-register in NYS. The continuing competency requirement has three parts: planning, participating in continuing competency learning activities, and recording what was learned. NYS is the only state that has such a comprehensive continuing competency program. New York's program is different from traditional continuing education programs in that it requires licensees to:

> Prospectively identify those areas of the profession that they wish to pursue for development in the 3-year cycle and identify how that learning will enhance their practice,
> Undertake learning activities during the 3-year cycle (e.g. sponsored continuing education workshops, study groups, mentoring, independent study), and
> Record what they learned. The majority of the learning that takes place for the professional will occur once that individual embarks on practice. Professional competence develops with practice.

Only New York, and neither ASHA nor any other state that we are aware of, has such a plan in place to address the professional competency of the licensee over the span of his/her professional lifetime.

(i) Equivalency

New York's licensure standards (entry level into the profession) are identical to ASHA's 1993 standards. Significantly, ASHA has not made its members certified during or before 1993 meet its newer standards, but rather has "grandfathered" them in. Due to this "grandfathering," a large percentage of individuals who hold the CCC nationwide (and in NYS) are permitted by ASHA to meet less than the current ASHA standards.

It is also important to note that the NYS speech pathology licensure program is accredited by the NYS Board of Regents. The NYS Board of Regents, like ASHA, is a federally recognized education accrediting body without, however, ASHA's inherent conflict of interest, i.e., simultaneously representing and promoting the profession. The NYS Board of Regents' function in the domain of professional licensing is solely public protection. In addition, any proposed changes in federal, state and local laws, regulations or policy require fair hearings and opportunity for public comment. In contrast, ASHA consistently implements standard changes without providing opportunity for fair hearings or public comment periods. The federal government has condoned this practice by requiring practitioners to meet the ASHA standard, regardless of the extent or frequency with which standards changed. Additionally, because ASHA charges its members a fee to join the private organization, some pathologists may simply choose not to become members. Licensure and registration are all that are required by the State; ASHA certification is certainly not a requirement.

New York licensure requirements for speech pathologists meet the requirements for speech pathologists with a CCC from ASHA. And in some instances, as noted above, the State exceeds ASHA requirements. The fact that ASHA has accredited all but one of New York licensure-qualifying speech-language pathologist masters degree educational programs further supports New York's position that its requirements for licensure must at least be equal to ASHA's.

Additionally, the OIG cannot discount New York's position that its requirements for licensure are at least equal to ASHA requirements without evaluating each individual speech pathologist to determine whether that speech pathologist had training and experience equal to ASHA training and experience. Absent such evaluation, the OIG cannot determine that a NYS licensed speech pathologist lacks the proper credentials to provide the services.

Finally, the State takes issue with the fact that during the course of the OIG audit there was no attempt to obtain the State's position on the equivalency of NYS licensing to ASHA certification requirements. This omission contributed to an audit finding determination based upon incomplete information.

C. Referrals

The audit report applies 42 C.F.R. § 440.110(c) to the provision of speech services. Under § 440.110(c), a referral for speech services by a physician or other licensed practitioner is required. To support its position that § 440.110 is the applicable regulation, the audit report points out that "NYS regulations at NYCRR 505.11 and the May 1997 NYS guidance state that the recommendation for speech services can be made by a physician, physician's assistant, registered nurse, nurse practitioner, or licensed speech pathologist," suggesting that the State also believes that § 440.110 applies. The State maintained at that time, and continues to maintain, that these services fall under the rehabilitative services of 42 C.F.R Section 440.130. However, in order to receive approval of the State Plan Amendment, the State acquiesced and promulgated Section 505.11 and the supporting guidance.

Even if, as the audit report contends, 42 C.F.R. Section 440.110 applies, the State has, since the inception of its SSHS program, been in compliance with that regulation's requirement for a "referral by a physician or other practitioner of the healing arts." When the program began, the State believed that the IEP was sufficient to meet the requirements of Section 440.110 because in New York the CSE was to include a physician or other licensed professional (which could include a speech pathologist) as a member at the request of the school district, county or parent. The State asserts that a recommendation from a CSE in the form of an IEP/IFSP was equivalent to a physician referral. In 1997, based upon Federal guidance, the State clarified its position to the school districts, instructing them to require a referral from either a speech pathologist or physician. That guidance remains in effect today; a physician or a speech pathologist makes the referral for speech services provided by the SSHS program in New York State.

II. RESPONSES TO DRAFT AUDIT FINDINGS

A. Responses to Draft Audit Report Category "Reasons Why the Claims Were Unallowable"

The OIG made available to the State their audit work papers and available documentation supporting their findings that 59 cases out of the 100-case sample were not allowable for reimbursement. The State found that although documentation was available either in the OIG work papers or at the school district, the documentation was often not used or interpreted properly by the OIG to determine their findings. The State concludes that this occurred for the following reasons:

(a) The OIG does not completely understand the SSHS program. While attempting to obtain documentation, providers were not asked appropriate questions.
(b) The State found several examples where alternative documentation meets the State and federal requirements. The OIG failed to interpret this documentation correctly.

(c) Provider staff contacted by the OIG did not always understand the questions being asked or were not made aware of what could be supplied to the OIG as alternative documentation to document services.

(d) The OIG excluded State staff from the audit process. Until the draft audit report was released, the State had no avenue to insure that documentation would be complete and interpreted correctly. While the State requested that providers send us copies of all documents provided to the OIG, we learned after the draft audit report was issued that we had not received complete copies of everything that the OIG had received. As a result, the State was unable to fully assess what deficiencies were present.

(e) The OIG often failed to explain to providers what type of documentation was required by the OIG to demonstrate that SSHS documentation had been destroyed pursuant to their own record retention policies. This is a significant issue for New York, since the audit period covered eight years of service and many districts informed the State that their records had been routinely destroyed in accordance with either the State's 6-year requirement for Medicaid document retention, or with their own (longer) retention requirement. The Departmental Appeals Board has repeatedly held that providers may be held harmless from audit disallowances if they can demonstrate that documents supporting Medicaid payments were destroyed in accordance with providers' retention policies.

(f) The OIG did not make clear to the school districts and county agencies the consequences of this audit. Critically, the OIG did not stress to the providers that New York State could face repayment of millions of dollars in overpayments for services the schools and counties had actually provided, simply because they did not have adequate staff or time to search for documents from the early '90's. The significance of the OIG obtaining documentation from the providers rather than the State can be illustrated in just one example: the failure of a school district to provide just one IEP translated into a monetary disallowance to the State of more than three million dollars (sample number 59), over three million dollars for one document that a school administrative assistant may have been too busy to look for carefully because the entity asking for it was the OIG instead of the State, who would have assisted in locating the document and emphasized the importance of it. Yet, the State was wholly excluded from the production process, with devastating economic consequences.

The State has provided specific documentation for four cases; additional documentation was found to support the referral for speech services by a physician (samples 45, 78, 84); and OIG had documentation in its work papers showing that an ASHA certified speech pathologist provided a referral after April 1995, the date the federal change which allowed a licensed professional to make a referral became effective (sample 23).

1. 42 CFR Section 440.130(d) Applies to These Disallowed Claims, Rather than Section 440.110(c). Therefore, the Disallowances Should be Reversed.

42 C.F. R. Section 440.130(d) regulates rehabilitative speech services provided in schools in accordance with a recommendation on an IEP, not Section 440.ll0(c). Section 440.130(d) provides that "Rehabilitative services," except as otherwise provided under this subpart, includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." Because the services provided were rehabilitative in nature, they fall under Section 440.130(d) and the ASHA requirements of Section 440.110(c) do not apply.

The State contends that all 41 findings are incorrect. Six of the findings were for services provided by a NYS-licensed speech-language pathologist. The remaining 35 findings fall under the OIG finding for "under the direction of," below.

2. Section 440.130(d), the Appropriate Section to be Applied Here, Does Not Require That Speech Services be Provided "Under the Direction of" a Speech/Language Pathologist.

Section 440.110(c)'s requirement that services be provided "under the direction of" a speech/language pathologist was implemented by New York only because of guidance from the federal government at the beginning of the program that we believed to be incorrect. As discussed above, the State reasonably believes that 42 CFR § 440.130 applies to these services, and under that section, the State may determine the professional requirements of the provider of the service provider. Pursuant to New York Education Law, a Teacher of the Speech and Hearing Handicapped is professionally qualified to render speech services. Applying § 440.130, rather than § 440.110, to speech services in this audit would require reversal of 32 findings.

We believe that had the State received *proper* federal guidance on this issue early in the program, we could have avoided the enormous monetary impact for failure to meet the standard alleged as appropriate by the OIG in this draft audit report. The federal "guidance" that was provided was contradictory and inconsistent with the clear requirements of 42 C.F.R. § 440.130. Further, the State was not given an opportunity to formally appeal the application of the federal guidance and to defend its own reasonably supported interpretation until it was harmed by this audit. The federal government's failure to provide an administrative remedy to challenge its written "guidance" places states such as New York in a position where claimed funding is at risk, despite states' good faith and well reasoned interpretation of federal laws and regulations. Yet, if this risk is not taken, states will lose considerable program funding because of the improper federal interpretation of program requirements. We find this an unacceptable result in a

partnership program where federal, state and local governments strive to fund high quality medical services to poor--and in this case, disabled-- individuals.

3. Referrals are Not Required.

Title XIX of the Social Security Act, as amended by the Medicare Catastrophic Coverage Act of 1988 (PL 100-360), clarified congressional intent by establishing the IEP/IFSP as the document that authorizes Medicaid funding for health related support services provided to students with disabilities. The Committee on Special Education (CSE), charged with developing the IEP/IFSP, is required by law to consist of a multidisciplinary panel of licensed practitioners and certified providers. The CSE recommends the necessary services as regulated by IDEA. As long as a child's IEP or IFSP recommends speech services, the recommendation requirement conforms to Section 440.130. A referral is not required.

Page 10 of the draft audit report identifies "No Referral for Speech Services was made, the referral was not made by an appropriate professional, or the referral was not made prior to the service date under review" as the reason(s) for disapproving 42 of 100 sample claims in the audit.

IDEA and the guiding federal Medicaid regulations approach the provision of SSHS and PSHS from different perspectives. IDEA addresses the educational service aspect including the referral, evaluation, eligibility, recommendation and implementation stages of the program while the Medicaid regulations address the medical standards for the provision of Medicaid coverable services. This referral/recommendation dispute is an excellent example of the clash of the educational and medical worlds. The failure of the OIG to recognize these incongruities brings the entire audit approach into serious question.

4. An IEP is Equivalent to a Physician Referral.

The draft audit report states that, according to federal regulations, prior to 1995 only a physician could make a referral and that a physician referral was not found for 12 claims. It is the State's position that a physician referral exists for those 12 claims in the form of the IEP/IFSP. The State believes that a recommendation from a CSE/CPSE in the form of an IEP/IFSP is equivalent to a physician referral, since a physician, at the request of the school district, county or the parent, has been a member of CSE/CPSE's. Because an IEP was provided to the OIG for all but two of the 59 claims, the remaining 57 claims should be allowed.

B. General Responses to Draft Audit Report category "Reasons Why the Unallowable Claiming Occurred"

1. New York State has Provided Proper Guidance to Schools and Counties Regarding the Requirements for Speech Services.

The draft audit report claims that two of New York's many letters to providers constituted "improper and untimely" guidance regarding Medicaid reimbursable speech services. We disagree. Both letters simply clarified that NYS-licensed speech/language pathologists could provide both direct speech services and direction to other speech providers. That is consistent with federal regulations at 42 C.F.R § 440.130(d), which provides for "rehabilitative" services. While the OIG claims that speech services are provided pursuant to 42 C.F.R § 440.110(c), NYS has, since the inception of the SSHS program in New York, asserted that such services are provided instead under § 440.130(d). The two letters that OIG refers to in support of its allegation that New York provided "improper guidance" are wholly consistent with "rehabilitative" services under § 440.130(d) and our own State qualifications for licensed speech/language pathologists.

The question of whether NYS must comply with 42 C.F.R § 440.110(c) or § 440.130(d) is significant, because under the latter section, the State-- not the federal government-- has the jurisdiction to determine professional qualifications of providers, absent any specific federal regulations to the contrary. In this case, New York's standards apply, as there are no specific federal regulations governing the qualifications of providers. We believe New York's long-standing position is both reasonable and supported, particularly given HCFA's own classification of these services as "rehabilitative." The fact that HCFA later changed its position on which regulation applies to speech services, without a convincing explanation, does not automatically make the new position the "right" one, particularly because the change in position only underscores the point that there may be reasonable differing interpretations of the regulations. Where such enormous amounts of money are at stake, it is fundamentally unfair for the federal government to disallow payments based on its own evolving notion of which regulation applies. It is a basic tenet of the law that in order to be held to a standard, one must be put on notice of the standard.

2. New York State has Provided Timely Guidance to Schools and Counties Regarding the Requirements for Speech Services.

The New York State Education Department (SED), the Department of Health (DOH) and the former Department of Social Services (DSS) have provided timely and continuing guidance to school districts and counties on the proper methods to provide and document services and to bill Medicaid. Beginning in March 1992, a memo from SED Assistant Commissioner Thomas B. Neveldine notified school districts and counties of the pending State Plan amendment that would soon allow them to bill Medicaid for medically related services provided to eligible students with disabilities. Three separate communications were sent by the State to school districts and counties in 1992, well before any claims were accepted for payment.

Between 1992 and January 2002, SED issued twenty-six (26) separate communiqués to school districts and counties on the implementation of SSHS programs. (A list of those memos and letters is annexed as Exhibit D hereto). These communications were designed, among other purposes, to aid the school districts in their application of the medical model of documentation of services.

As SED and DSS began implementing the SSHS program, staff from both agencies traveled throughout the State presenting at workshops and conducting regional training sessions with county and school district special education, business and technical staff. During 2001-- a typical year-- staff conducted 56 one-on-one school district management reviews, which examined the appropriateness of service delivery and the accuracy of the school districts' billing processes for Medicaid-eligible services. In addition, SED and DSS staff conducted 71 meetings and workshops for school districts and county preschool staff involved in the Medicaid claiming process, as well as for the Regional Information Centers (RIC) and the Central NY RIC. (There are 13 RIC's that act as the upstate SSHS program liaisons between SED, DOH and school districts; their primary focus is the Medicaid claiming process. The Central NY RIC is the clearinghouse for all upstate billings.) Every workshop and training session concluded with the provision of names and phone numbers of SED and DSS/DOH staff available to answer questions. State staff was always "on-call" during business hours to answer questions concerning provision of services, Medicaid billing and related issues. Staff also provided county and school district "one-on-one" training sessions at the provider's request, or initiated by the State. The issues covered at the meetings and workshops included general Medicaid program requirements, specific service standards, discussions of providing speech services "under the direction of" a speech/language pathologist, technical Medicaid claiming assistance, and introduction of new software packages for electronic claims submission. The attendees included school superintendents, special education directors, hands-on service providers, business managers, office managers and billing clerks.

In addition to providing written guidance to providers and on-site training, SED, in cooperation with DSS/DOH, issued an April 1996 Medicaid Claiming/Billing Handbook, with an update in each of the next five years, to be used as a reference by school and county administrative staff.

In addition to written correspondence, in 1993, SED issued a training video to all school districts and counties. (Exhibit E hereto). The video concentrated on the documentation and claiming requirements of the program. In approximately 1997, SED created an Internet website that included, among other things, the Medicaid Claiming/Billing Handbook. As the handbook was updated in hard copy, it was updated on the website. The website has been continuously operational since 1997 and may be accessed at the following address: http://www.oms.nysed.gov/medicaid/.

Since the implementation of the program in 1992, New York State, through the efforts of SED and DSS/DOH, has worked diligently to assure proper and timely guidance of Medicaid criteria to schools and preschools.

3. Any Failure to Follow the State's Guidance was Limited to Isolated Occurrences.

The draft audit report contends, at page 16, that "...for 41 and 35 of the 100 sample claims respectively, an ASHA certified or a NYS licensed speech-language pathologist did not provide either the speech services directly or did not provide the necessary direction." The OIG appears to have deliberately exaggerated this finding by turning one condition into two findings and by making it appear that 76 of the sampled claims purportedly have this weakness. In addition, when the State reviewed the documentation on the sampled cases, it found that in 18 of the 35 cited cases, there was documentation in OIG's possession to refute the OIG finding. Of the 41 cases, 35 were counted by the OIG twice, and in the remaining six cases, additional documentation was found among the documents turned over to the OIG to refute those findings. The age of the case records and the limited time the State was provided for review of the OIG work papers on the remaining 18 of the 41 cases and the remaining 17 of the 35 cases makes it impossible to determine if these have valid findings.

The draft audit report also contends that, although New York issued guidance that required quarterly progress notes, quarterly progress notes were either not prepared or not provided for 15 of the 100 sample claims. While quarterly progress notes were missing for a small percentage of the sampled claims, OIG failed to acknowledge in the draft audit report that none of the 15 cases involved dates after October 1998, when the State Education Department started requiring that progress notes be sent home to parents along with a child's report card. The fact that compliance rose significantly after October 1998 indicates that providers were complying with State guidance and, as a result, improving their efforts at meeting Medicaid billing requirements. Prior to 1998, every IEP was reviewed at least annually and progress notes were provided by each service provider and shared with the parents at such times.

Although the draft audit report states that other provider non-compliance with New York guidance occurred with respect to service delivery documentation, this criticism suggests that providers' failure to provide certain documentation was pervasive. It should be noted that this finding applies to only five cases and all were prior to October 1996, strongly indicating that the providers' compliance with State guidance improved as they became familiar with Medicaid practices. Three of the five were for services in 1994, very early in the program's existence (sample numbers 55, 57 and 70), one was for 1995 (sample 6), and the last was for 1996 (sample 97). To project these five disallowances over the universe of payments in this audit is inequitable, given the clear indicators of improved

compliance by school districts and counties with the State's guidance. In light of the fact that these cases all occurred within the first three years of a new program directed by educators, not physicians and other Medicaid providers who were more familiar with the maintenance of documentation required by the Medicaid program, these disallowances should be withdrawn in their entirety.

4. New York appropriately monitored claims for all school health services, including speech. The reviews were conducted at both the early stages of the program and as additional providers enrolled and gained experience in the Medicaid program.

OIG apparently based its finding that New York did not adequately monitor school claims on its contact with one provider, the Buffalo City School District (BCSD). In 1999, DOH conducted a documentation review at BCSD to determine if any corrective action should be taken by the school district regarding its documentation of claims. The State was faulted by OIG auditors for conducting a corrective action review instead of an audit with potential disallowances. Based on the federal position that 42 C.F.R § 440.110 applies to theses services, which requires ASHA certification of the speech pathologist under whose direction services must be provided, the draft audit report questioned DOH's decision not to disallow BCSD claims.

Two reasons, based entirely on OIG's review of BCSD claims, are given as the cause for disallowances under this category in the draft audit report; "questionable 'under the direction of' and speech referral billing practices." Speech services are provided in the BCSD as follows: each child is evaluated and where appropriate, a recommendation is made for the provision of speech services for the upcoming school year. BCSD has in place a process for the review of all quarterly progress notes by the supervising licensed speech/language pathologist in addition to conducting mandated monthly speech staff meetings and monthly Best Practices meetings. The supervising licensed speech/language pathologist is accessible to all speech staff to address issues and concerns regarding individual students at any time. Speech staff is provided with the appropriate direction.

OIG mistakes referrals for recommendations in the draft audit report. The supervising licensed speech/language pathologist recommends speech services on the IEP only after reviewing the results of testing for each child.

The draft audit report cited BCSD for using a rubber signature stamp for referrals and for referring "thousands of students for speech services with one 'blanket' referral" when, in actuality, all recommendations are made on an individual basis.

The signature stamp was used on a letter notifying parents of further testing and acknowledging that certain documents had been reviewed. OIG auditors did not understand the process. During its review, the State understood that proper recommendations and "under the direction of" requirements were being met. The OIG auditors have criticized State staff because of an apparent failure to recognize the propriety of the process that was being followed. The BCSD provided direction and appropriately monitored claims for speech services.

The State has properly monitored the SSHS program since its inception. In 1995, DSS conducted the first wave of "sample documentation" reviews of counties and school districts to evaluate compliance with Medicaid requirements. These documentation reviews were focused on corrective action. The State undertook this action to aid the school districts in the difficult task of learning and applying the more complex medical model in an educational setting. The State gave an assessment of their work and provided suggestions for improving methodology. The number of school districts and preschool providers enrolled and claiming Medicaid in 1995 was significantly lower than in June 2001, the end of the OIG audit period. School districts and counties were slow to enroll and even slower to begin submitting claims to Medicaid. Therefore, State monitoring of SSHS compliance began when DSS and SED believed it would be most instructive to the service providers. Most of the provider documentation in the earliest reviews was for speech, physical therapy, occupational therapy and transportation services. Not all school districts were billing for all services when they first enrolled and only began submitting claims for additional services as they became more comfortable with the process. As a consequence, the 1995 reviews were somewhat limited in their scope.

A second wave of documentation reviews was initiated in September 1998. DOH (which became the single state agency for the administration of the Medicaid program in 1996) developed a plan to review documentation to determine whether SSHS program providers were maintaining appropriate documentation to support their claims for payment. The State focused on those non-NYC providers that had relatively higher Medicaid claiming amounts. Since the program was still relatively new at the time of the second State document review, our goal was to impress upon the providers the importance of compliance with Medicaid documentation requirements and to provide specific feedback on actual claims that had been submitted for payment. This second round of reviews was much more formal and broader in scope than the 1995 corrective action reviews. The State reviewed documentation supporting claims from over 170 school districts and more than 20 counties in this second round of documentation reviews.

After each documentation review was completed, the State reviewers met with each district and county in the review and directed them to process adjustments or voids for services not provided, for use of incorrect rate codes, and for services provided by an unqualified professional.

C. Specific Responses to Draft Audit Findings (Categories identified below refer to those referenced in Appendix C to the Draft Audit Report)

Annexed as Exhibit F hereto is a chart showing each case disallowed by OIG and the reason(s) for disallowance, together with the State's reason(s) for reversal of each finding. A summary of each challenged category of disallowance appears below. (The number of findings within each disallowance category may not equal the total claim disallowances with that category due to multiple findings for many of the claims.)

Category D -ASHA Equivalency

Out of the 41 cases that OIG auditors said did not meet ASHA requirements, the State has provided documentation that has rebutted all 41 findings:

Reason 6: 37 findings refuted by the "rehabilitative vs. corrective" services argument. Sample ## 5, 7, 14, 16, 18, 21, 22, 24, 30, 33, 35, 37, 38, 39, 41, 44, 46, 51, 52, 57, 58, 59, 67, 70, 71, 72, 73, 77, 80, 86, 87, 88, 90, 91,93, 94, 97.

Reason 8: 33 findings refuted because they are duplicate findings. Sample ## 6, 7, 16, 18, 22, 24, 27, 30, 33, 35, 41, 44, 46, 52, 55, 57, 58, 59, 67, 70, 71, 72, 73, 77, 80, 86, 87, 88, 90, 91, 93, 94, & 97.

Reason 5: 20 findings refuted by SPA 92-42 being in effect. Sample ## 5,14, 18, 21, 35, 46, 51, 52, 57, 58, 59, 70, 71, 72, 86, 87, 88, 90, 94 & 97.

Reason 4: 6 findings refuted by services provided by NYS licensed speech pathologist. Sample ## 10,14; 21,38, 51 & 93.

Reason 1: 2 findings refuted because the date exceeds State retention requirements. Sample ## 35 & 87.

Reason 2: 1 finding refuted because documentation meeting OIG requirements was found. Sample # 14.

2. Category E -- By or Under the Direction of a Licensed Speech Language Pathologist

Out of the 35 cases that OIG auditors determined did not demonstrate that speech services were provided by or 'under the direction of' a NYS licensed speech language pathologist, the State has refuted 33 findings.

Reason 6: 32 findings refuted by the "rehabilitative vs. corrective" services argument. Sample # # 5, 7, 16, 18, 22, 24, 27, 30, 33, 35, 41, 44, 46, 52, 57, 58, 59, 67, 70, 71, 72, 73, 77, 80, 86, 87, 88, 90, 91, 93, 94 & 97.

Reason 10: 18 findings meet NYS 'under the direction of'. Sample ## 16, 18, 22, 27, 30, 41, 44, 46, 52, 67, 70, 73, 77, 86, 87, 90, 93, & 94.

Reason 5: 17 findings refuted by SPA 92-42 in effect. Sample ## 5, 18, 35, 46, 52, 57, 58, 59, 70, 71, 72, 86, 87, 88, 90, 94 & 97.

Reason 7: 2 findings refuted by alternative documentation. Sample ## 27, & 87.

Reason 4: 2 findings refuted by services provided by NYS licensed speech pathologist. Sample ## 10, & 93.

Reason 1: 2 findings refuted because the date exceeds State retention requirements. Sample ## 35 & 87.

Reason 11: 1 finding refuted by documentation not "acceptable" by OIG. Sample # 18.

Reason 2: 1 finding refuted because documentation meeting OIG requirements was found. Sample # 10.

3. Category F – No Referral

OIG auditors reported 42 cases that did not have a referral for speech services by a qualified medical professional. The State has refuted 40 cases.

Reason 6: 37 findings refuted by the "rehabilitative vs. corrective" services argument. Sample ## 6, 19, 21, 22, 23, 24, 25, 27, 28, 30, 33, 35, 37, 40, 43, 45, 46, 47, 49, 57, 66, 68, 69, 70, 72, 76, 77, 78, 80, 84, 86, 87, 88, 90, 91, 93 & 97.

Reason 5: 23 findings refuted by SPA 92-42 in effect. Sample ## 21, 28, 35, 40, 43, 45, 46, 47, 49, 57, 66, 68, 69, 70, 72, 76, 78, 84, 86, 87, 88, 90, & 97.

Reason 2: 7 findings refuted because documentation meeting OIG requirements was found. Sample ## 23, 67, 69, 78, 80, 84, & 93.

Reason 7: 6 findings refuted by alternative documentation. Sample ## 23, 45, 77, 87, 88, & 93.

Reason 3: 6 findings refuted because requirements allowed a medical professional referral after 1988. Sample ## 21, 28, 43, 47, 72, & 76.

Reason 11: 4 findings refuted by documentation not "acceptable" by OIG. Sample ## 30, 44, 73, & 77.

Reason 1: 3 findings refuted because the date exceeds State retention requirements. Sample ## 35, 66, & 87.

4. **Category J – Progress Notes**

Out of the 15 cases that OIG auditors found did not have progress notes, the State has refuted all 15 cases.

Reason 9: 11 findings refuted by progress notes not an issue after 1998. Sample ## 6, 10, 22, 35, 46, 55, 60, 69, 73, 90 & 95.

Reason 7: 4 findings refuted by alternative documentation. Sample ## 4, 5, 60, & 70,

Reason 2: 1 finding refuted because documentation meeting OIG requirements was found. Sample # 97.

Reason 1: 1 finding refuted because the date exceeds State retention requirements. Sample # 35

5. **Category B – "No Service Date Delivery Documentation"**

Reason 2: 1 finding refuted by documentation meeting OIG requirements was found. Sample # 97.

6. **Category C – "No Assurances That Services Were Rendered"**

Reason 8: 5 findings refuted by being duplicate findings. Sample ## 6, 55, 57, 70 & 97.

Reason 6: 1 finding refuted by the "rehabilitative vs. corrective" services argument. Sample # 90.

Reason 5: 1 finding refuted by SPA 92-42 in effect on the date of service. Sample # 90.

Reason 2: 1 finding refuted because documentation meeting OIG requirements was found. Sample # 97.

7. **Category I – "No Assurance That a Minimum of Two Monthly Speech Services Were Rendered"**

   Reason 8: 5 findings refuted by being duplicate findings. Sample ## 6, 55, 57, 70 & 97

   Reason 2: 1 finding refuted because documentation meeting OIG requirements was found. Sample # 97.

8. **Triple findings for one error type**

   Whenever the provider was unable to locate a copy of the service report, the OIG auditors cited the provider for three errors. There were 5 cases cited for Category B (Service Date Delivery Documentation), Category C (No Assurance that Services were Rendered) and Category I (No Assurance that a Minimum of Two Speech Services Rendered).

III. AUDIT STANDARDS

The Inspector General Act of 1978 requires federal inspectors general to comply with the Comptroller General's standards for audits of federal organizations, programs, activities and functions. Generally Accepted Government Auditing Standards (GAGAS) issued by the Comptroller General of the United States delineate the standards that must be followed.

The State believes that during the course of the OIG audit of our SSHS and PSHS programs, the following violations of GAGAS occurred:

Standard 3.12 places responsibility on each auditor and the audit organization to maintain independence so that opinions, conclusions, judgments, and recommendations will be impartial and will be viewed as impartial by knowledgeable third parties.

Auditor independence was compromised when, based on a limited survey, the OIG auditor alleged to CMS that problems with the New York program were so bad that CMS took the unusual step of withholding two quarters of SSHS claims for federal reimbursement. This placed the auditor and OIG, having presented the allegations to both the DOJ and the CMS, in the position of then having to produce sufficient evidence to prove the allegations. This suggests that the audit did not even begin objectively but rather with a purpose and goal that had to be met. Any independence was already lost.

Standard 3.16 b. addresses situations where an auditor's preconceived ideas toward individuals, groups, organizations, or objectives of a particular program could bias the audit.

There is no question that this audit was undertaken with preconceived ideas that could bias the audit beginning with the scope of the audit. New York State is the only state of which we are

aware whose SSHS program is being audited back to the inception of the program. The audit appears to be driven by maximizing the potential recovery of funds while eviscerating the SSHS program. This bias is reinforced by the secretive manner in which the audit was conducted. None of the assumptions, testimonial evidence or auditor conclusions were shared with the State prior to the issuance of the draft audit report.

This practice is in direct conflict with **Standard 7.4,** which encourages discussion of "... findings, judgments, conclusions, and recommendations with persons who have responsibilities involving the area being audited." There was no attempt to obtain information from the State on the testimonial evidence obtained by the OIG from ASHA. This evidence was taken at face value without any indication in the audit report that ASHA's determination could be biased. It is reasonable to conclude that an organization that could stand to gain both in stature and financially through increased enrollment as a result of audit findings would have, at a minimum, a potential to be biased.

The fact that there was no attempt to obtain additional evidence on this issue ignores **Standard 6.54 f,** which recognizes that testimonial evidence received from an individual that is biased is less reliable than testimonial evidence where no bias exists. Reliance on the ASHA testimony is further brought into question by the manner in which the OIG auditor requested the evidence. The OIG letter to ASHA requesting the evidence said:

> "It is our understanding that NYS officials believe that their licensed speech pathologists are equivalent to and meet the requirements of a speech pathologist with a CCC from ASHA. Although we do not agree, OAS felt it is necessary to consult with ASHA officials on this question. Please provide us with a written response.
>
> On a final note, DOJ has "stepped aside" with respect to its investigation of NYS's school health claims to Medicaid. However, CMS officials have requested that OAS continue with its audits of this area." (See letter of July 30, 2002 from John Berbach to James Potter, annexed as Exhibit G hereto.)

The OIG auditor tarnished his ability to obtain impartial testimony by stating the OIG position on the issue in his request. Additionally, the auditor attempted to substantiate the OIG's position by mentioning DOJ's involvement in the audit. These actions, aimed at influencing ASHA's response to the OIG inquiry, call into question the impartiality of the auditor and strongly suggest a bias on his part.

Standard 6.46 requires that sufficient, competent, and relevant evidence be obtained to afford a reasonable basis for the auditor's findings and conclusions. Additionally, **Standard 7.18** requires, in part, that reported findings are provided in a fair presentation and in proper perspective.

Through the OIG's omissions, these standards have not been met in the OIG draft audit report. The report refers to a 1995 letter from HCFA that describes the term "under the direction of" and uses this description to support audit disallowances. The audit failed to consider a June 1997

letter from HCFA that states that New York should use its own regulation to determine "under the direction of." By ignoring the 1997 letter, the OIG was able to chose the definition of "under the direction of" most likely to support audit disallowances. Also, the OIG auditors did not accept alternative documentation such as signed statements from direct service providers, attesting that requirements were met.

Finally, by excluding the State from participation in the fieldwork process, **Standard 7.4** was again violated. The OIG contacted only the school districts and county preschool providers to obtain documentation. State Medicaid program staff invested significant resources in educating these providers concerning Medicaid; however, as a group, they are new to the program. Medicaid and Education use different jargon. A Medicaid "referral" is significantly different than a "referral" in the Special Education environment. The OIG is not familiar with the Education environment; as a result, many opportunities to provide sufficient documentation were missed because neither party understood the other's language. The State Medicaid program staff is well aware of this and is fluent in both languages because the Medicaid and Education Agencies have been working together for over 10 years and have first-hand experience with the difficulties that arise when attempting to mesh the educational and medical models. Nevertheless, OIG discussions with State Medicaid program staff were virtually nonexistent throughout this audit.

Failure to follow the above-cited standards has resulted in a draft audit report that contains unsupported findings of errors, inflates errors that were found, reaches conclusions based on biased testimony, and draws conclusions without supporting facts. This failure to follow GAGAS has jeopardized the continuance of a valuable program in New York State and casts a shadow on the validity of the audit findings.

IV. CONCLUSION

The OIG draft audit report entitled "Review of Speech Claims To Medicaid Made by 711 School Health Providers Within New York State" should be withdrawn. As New York has described in this detailed audit response, the vast majority of the audit findings were the result of inappropriate regulatory interpretations and the OIG's misunderstanding of the State's requirements for professional practitioners. In addition, the methodological design of the audit was fundamentally flawed and inconsistent with the methods the OIG has used to audit similar providers in other states.

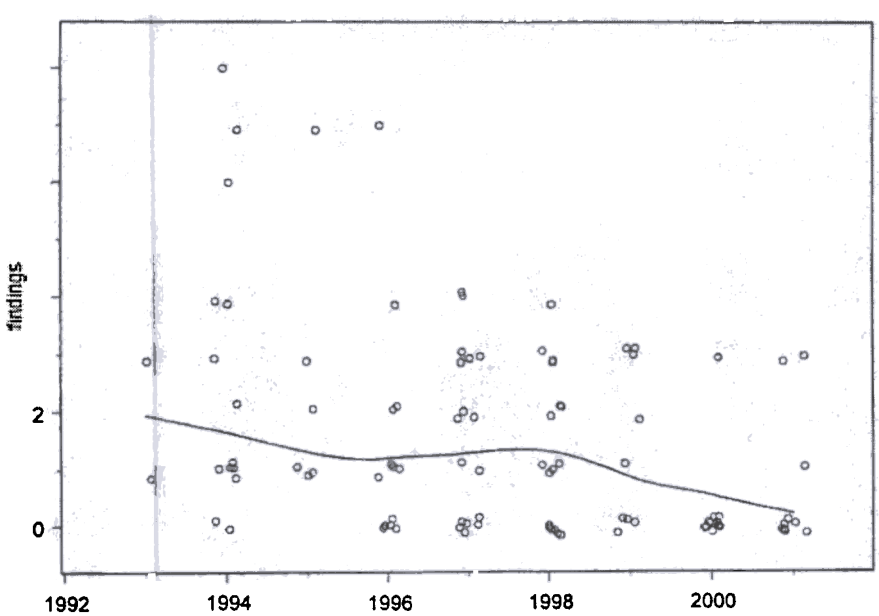
The audit fails to recognize the essential foundation upon which the School Supportive Health Services program is based: Congress intended to assist school districts with the provision of services required under IDEA and expected that the services would be provided as determined by each local educational agency's Committee on Special Education, in accordance with the provisions of IDEA.

Finally, the draft audit raises no question that essential SSHS services to disabled children were provided, and that disabled children received those services. Instead, a massive disallowance is proposed that would have a paralyzing impact on New York and its schools based upon an alleged failure to meet highly technical documentation requirements.

A

The draft audit report findings for the sample cases show that the New York State SSHS program has vastly improved over the years. The number of audit findings and cases disallowed in the draft report decreases significantly as the cases become more current. If the State's interpretation of federal regulations is applied, the improvement in program compliance is even more dramatic. In order to accommodate simultaneously two federal agencies, CMS and the Federal Department of Education, school districts and preschool providers needed time to learn the Medicaid documentation requirements and to change their own processes and systems, which were originally established to meet educational requirements.

Statistical analysis of the OIG findings shows a significant decrease in findings the more recently the service was provided. The scatter plot below demonstrates this fact. The horizontal axis is the year of service and the vertical axis is the number of findings. Each claim in the 100-claim OIG sample is shown. In the early years, the average number of OIG findings is between one and two findings The average in the final year approaches zero findings. The scatter plot clearly demonstrates that if OIG had audited New York's SSHS claims in the same manner as they did other states, the findings would be reduced to *zero*.[See Section III (B), below].



B

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

NOV 25 1996

November 20, 1996

Arthur J. O'Leary
Associate Regional Administrator
United States Department of Health
and Human Services
Health Care Financing Administration
Division of Medicaid
Region II
Federal Building
26 Federal Plaza
New York, New York 10278

RE: Services under SPA 92-42

Dear Mr. O'Leary:

The purpose of this letter is to provide a formal response to a letter from the Health Care Financing Administration (HCFA) to the New York State Department of Social Services (DSS) setting forth an interpretation of HCFA regulations at 42 C.F.R. 440.110 and 42 C.F.R. 440.130.

The Department of Health (the State, the Department or DOH), as successor to DSS as single state agency for Medicaid, disagrees with the interpretation of these regulations set forth in the HCFA letter of February 8, 1995, to DSS. In addition, the Department takes issue with the HCFA interpretation of the same regulations contained in Medicaid State Operations Letter (MSOL) 93-54, dated September 3, 1993.

The State's Medicaid program includes speech pathology services provided by public schools and municipalities to children with disabilities under the rehabilitative option of federal regulations set forth at 42 C.F.R. 440.130. Federal financial participation (FFP) for these services is claimed for eligible children in accordance with approved State Plan Amendment (SPA) 92-42. The regulation at 42 C.F.R. 440.130 is silent about the professional qualifications of the provider of service. The Department maintains that professional qualifications of providers under the rehabilitation option are under the jurisdiction of the State and not under federal jurisdiction, in the absence of specific federal regulations issued pursuant to the Administrative Procedure Act.

The letter indicated that the provider qualifications of 42 CFR 440.110(c)(1) apply even though rehabilitative speech services are provided pursuant to 42 CFR 440.130(d). We interpret the omission of rehabilitative services from the definition of services for individuals with speech, hearing, and language disorders in 42 CFR 110(c)(1) as intentional, and not providing the type of exception which would bring the professional qualifications of such providers under federal jurisdiction.

We also disagree with how you interpret "under the direction of" as it applies to providers of speech pathology services in 42 CFR 440.110(c). We believe that "direction" allows for flexibility in degree based on the qualifications of the individual receiving the direction, and have adopted State conforming regulations at 18 N.Y.C.R.R. 505.11(c). The HCFA letter provides that the speech pathologist must observe the certified teacher of speech and hearing handicapped providing care to the child, have some input into the type of care provided, and take ultimate legal responsibility for the care provided. However, HCFA interprets the regulation in such a way that "direction" in fact means "direct supervision" of the teacher by the speech pathologist. We view this an overly narrow interpretation of the regulation and statute. If the regulation were intended to impose the requirement of direct supervision, then the regulation would have included the word "supervision," as do other HCFA regulations. See section 405.2452 of Title 42 CFR.

The Department believes that Congress has made it clear that it is a sound exercise of public policy to shift payments for medically necessary services included in Individual Education Programs under the Individuals with Disabilities Education Act (IDEA) for Medicaid recipients from education funding sources to Medicaid ones. The HCFA's interpretation of the regulations is inconsistent with that view. The Department intends to pursue all appropriate rights and remedies to challenge the interpretation and any associated loss of FFP.

You may contact Julie Elson of my staff if you have any questions about the content of this letter. She may be reached at 518-474-2262.

Sincerely,

Ann Clemancy Kohler, Director
Office of Medicaid Management

ACK/GM/CM/AAP/SVL/

cc: Jane Salchli
Robert Scalise

C

DEPARTMENT OF HEALTH & HUMAN SERVICES

Financing Administration

Refer to MOB:JMS

Region II
Federal Building
26 Federal Plaza
New York NY 10278

JUN 04 1997

Ann C. Kohler, Director
Office of Medicaid Management
New York State Department of Health
Corning Tower, Room 1441
Empire State Plaza
Albany, NY 12237

Post-it™ Fax Note 7671	Date 6/19/97 # of pages ▸
TO MIKE ALBINO	From SARAH VANLEE
Co./Dept. DSJ-QAA	Co.
Phone # 39059	Phone # 37978
Fax # 63528	Fax # 32602

Dear Ms. Kohler:

This is in response to New York State's request that we review the policies previously stated concerning HCFA's interpretation of regulations at 42 CFR 440.110 and 440.130. The State's Medicaid program includes speech pathology services provided by public schools and municipalities to children with disabilities under the rehabilitation benefit option at 42 CFR 440.130(d). New York questions the provider qualifications for these services provided under the Medicaid rehabilitation benefit. The State maintains that professional qualifications of providers under the rehabilitation option are under the jurisdiction of the State in the absence of specific Federal rehabilitation regulations specifying qualifications of providers.

Federal regulations at 42 CFR 440.110(c) provide that services for individuals with speech, hearing, and language disorders be provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician. A speech pathologist or audiologist is defined as an individual who has a certificate of clinical competence from the American Speech and Hearing Association, has completed the equivalent educational requirements and work experience necessary for the certificate, or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

Regulations at 42 CFR 440.130(d) provide that rehabilitation services include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level. There are no Federal provider qualification standards included in the regulatory language at 440.130(d). However, HCFA previously set forth the policy that services coverable under more than one regulatory authority must meet the requirements of the more specific authority, even when covered under a broad coverage category such as the rehabilitation benefit. As such, the provider qualifications for speech pathology services at 42 CFR 440.110(c) would apply even when the services are covered in the State's Medicaid plan under 42 CFR 440.130(d) (rehabilitation). By adhering to this policy, HCFA is assured that quality is not compromised by allowing less stringent provider qualifications to apply with respect to services for which very specific qualifications were developed.

In addition, New York disagrees with our policy interpretation of "under the direction of" as it pertains to providers of speech pathology services in 42 CFR 440.110(c). We advised New York that

the term "under the direction of" a speech pathologist means that the speech pathologist must see each patient at least once, have some input as to the type of care provided, and review the patient after treatment has begun, as well as assume legal responsibility for the services provided.

While we continue to maintain that the specific qualifications at 42 CFR 440.110(c) must be met by providers of speech pathology services in order to maintain quality assurance, regardless of which benefit authority is used for coverage under Medicaid, we believe that it would be reasonable for New York to look to its own State practice laws in order to determine when services are appropriately provided "under the direction of" a qualified speech pathologist. Therefore, the State could utilize its school employees to provide speech pathology services "under the direction of" a Medicaid qualified speech pathologist, if this was consistent with the State's own laws and regulations.

We hope this information will be useful in responding to New York State. If you have any questions or need additional information, please contact Jane Salchli of my staff at (212) 264-2775.

Sincerely,

Arthur J. O'Leary
Associate Regional Administrator
Division of Medicaid

cc: Julie Elson

D

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

September 4, 2002

John W. Berbach
Audit Manager
OIG Office of Audit Services
U.S. Department of Health & Human Services
8 Automation Lane
Albany, New York 12205

Dear Mr. Berbach:

The American Speech-Language-Hearing Association (ASHA) is pleased to provide, at your request, a comparison of requirements for the Certificate of Clinical Competence in Speech-Language Pathology and the requirements for a State of New York (NY) license in speech-language pathology. However, many of the same issues also hold for the requirements for audiologists. It is our understanding that this comparison will be used to determine equivalency of these two credentials and compliance with 42 CFR Part 440.110(c).

Our analysis indicates that a New York state-licensed speech-language pathologist is not equivalent to an individual who holds the Certificate of Clinical Competence (CCC). The differences are substantive and should not be deemed equivalent for any purpose.

Degree
CCC requirements dictate that applicants have a master's or doctoral degree. The New York state licensure requirements allow for a master's degree or "its equivalent." Therefore, it is possible that a New York licensee may deliver services with a bachelor's degree as the highest earned degree. The CCC requires a graduate degree.

Course Requirements
In addition to the degree requirement, the CCC requires that applicants have completed 75 semester credit hours. New York only requires 60 semester credit hours, 20% less than the CCC.

The CCC requirements are delineated even further in terms of a minimum distribution of the required course work hours. At least 27 of the semester credit hours must be obtained in basic science course work, including 6 semester hours in biological/physical sciences and mathematics, 6 semester hours in the behavioral and/or social sciences, and 15 credit hours in basic communication processes. At least 36 of the hours must be obtained in professional course work.

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SUITE 715
WASHINGTON, DC 20001
FAX 202-624-5995

New York licensure requirements stipulate that there be 12 semester hours in basic communication processes and 30 hours in professional course work, without any requirement for courses in the biological/physical sciences and mathematics. A New York applicant can qualify for a license with 15 fewer hours (or five 3-credit hour courses) in the basic sciences and basic communication processes and 6 fewer hours (or two 3-credit hour courses) in professional course work than what is required for the ASHA CCC. New York state course work requirements are clearly less stringent in terms of both quantity and minimum course work distribution.

Pre-Degree Practicum

CCC requirements stipulate that applicants must complete 350 hours of clinical practicum under the supervision of a CCC holder (250 hours of which are at the graduate level) plus 25 hours of supervised clinical observation for a total of 375 clock hours. NY requires 300 hours of clinical practicum under the supervision of a state licensee. The NY requirement is again 20% less than the CCC requirement.

In addition to requiring more hours, the CCC requirements mandate that all observation and clinical practicum hours be supervised by an individual who holds the CCC in the appropriate area of practice and that "the applicant must have experience in the evaluation and treatment of children and adults and with a variety of types and severities of disorders of speech, language, and hearing." In addition, clinical experience should include both individual and group client contact.

Current NY state licensure requirements do not specify either the extent of supervision or the nature of the clinical experience required during the practicum. Therefore, it is possible that a student can spend his or her entire 300-hour practicum experience with just one disorder in a single age group with only occasional supervision and still qualify for a NY state license. Again, the NY state requirements for student practicum are less stringent than the CCC in terms of both quantity and quality.

Clinical Fellowship

Both the CCC requirements and NY licensure requirements mandate the completion of a 36-week full-time clinical fellowship. CCC requirements set out very specific parameters for the supervision and evaluation of the fellowship as well as the content of the experience. CCC requirements mandate that such experience be supervised by an individual who holds the CCC in the area for which certification is sought and that the clinical fellowship supervisor engage in no fewer than 36 supervisory activities during the clinical fellowship experience, including 18 on-site observations of direct client contact as well as 18 other monitoring activities. Using a rating scale of specified skills, the supervisor must also conduct three formal evaluations of the applicant's progress in the development of these professional skills. CCC requirements also state that 80% of the work week must be in direct client contact related to the management process of individuals who exhibit communication disabilities.

A NY license requires only that the professional experience be supervised by a state licensed practitioner and that such supervision include "meeting with and observing the applicant on a regular basis." There is no definition for "regular basis," no specification of the nature of the meeting or the observation, no designated rating scale, and no minimum number of hours in direct clinical activities. While the length of the clinical fellowship is the same for the ASHA CCC as for a NY license, only the ASHA CCC provides any assurances for the quantity and quality of the supervision.

National Examination
For the ASHA CCC, the applicant must pass a standardized and validated national examination administered by the Educational Testing Service (Praxis II Subject Assessment/Speech-Language Pathology). New York also requires passing a national examination.

Summary
New York state licensure requirements in speech-language pathology are less stringent than ASHA's requirements for the CCC in the areas of:

- degree accepted
- quantity of course work (20% less)
- distribution of course work
- quantity of the pre-degree practicum (20% less)
- specification of disorder types and age groups for the pre-degree practicum
- amount of supervision for the pre-degree practicum
- quantity of supervision during the clinical fellowship
- quality of supervision during the clinical fellowship

The number of semester hours, as well as the specific distribution of course topics of the CCC, are specifically designed to ensure that the independent practitioner has a broad background and skill set in the evaluation and treatment of individuals with communication differences and disorders. In addition, the strict supervision requirements of the clinical practicum and clinical fellowship and the requirement that the applicant gain experience in the evaluation and treatment of children and adults with a variety of types and severities of disorders of speech, language and hearing ensures that the holder of a CCC will be fully prepared to care for a wide variety of potential clients and their disorders.

The CCC is a nationally validated standard with documented studies that provide compelling evidence that the component requirements of the CCC provide a valid measure for competent practice. Even a minor deviation from these component requirements has potential for impact on this validity. The long list of differences between NY licensure and the ASHA CCC lead us to only one conclusion: NY licensure is not equivalent to the ASHA CCC.

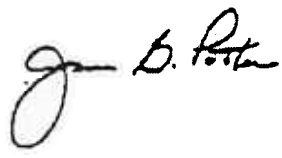
If New York state licensure requirements are deemed equivalent to the CCC for the purposes of providing Medicaid services in the schools, the quality of services provided to children in NY state schools would be compromised. These services are already compromised by New

York's liberal interpretation of 42 CFR Part 440.110(c) that allows speech services to be provided "under the direction of" a qualified speech-language pathologist. In the absence of any clear federal interpretation of "under the direction of," the New York Department of Education has allowed schools to devise an overly-broad interpretation as to how much direction is required of the qualified speech-language pathologist. Under New York State Social Services regulations, Chapter II, Part 505.11, "state licensed speech-language pathologists must have filed in the district office the manner in which he/she will be accessible to the Teacher of the Speech and Hearing Handicapped." Examples of this are "weekly team meetings, access by telephone on a scheduled basis, individual meetings with teachers or any other method where accessibility is demonstrated." There is no requirement for actual observation of the student by a qualified speech-language pathologist who is to be directing the care being provided.

It is clear that by loosening the supervisory role to the extent that "any other method" is deemed an example of acceptable behavior creates opportunities for abusive behavior in the Medicaid school-based system. In many cases, children are receiving services from Teachers of the Speech and Hearing Handicapped, a position that requires only a bachelor's degree, without the full benefit of adequate supervision. In addition, the lax supervision requirement also places the supervising speech-language pathologist in the potentially unethical position of never actually evaluating or observing the child being treated.

We appreciate the opportunity to provide this information. Should you need further information or have any questions, please contact me at (301) 897-0125 or by email at jpotter@asha.org

Sincerely,



James G. Potter
Director
Government Relations and Public Policy

E

- March, 1992

To: District Superintendents, Presidents of Boards of Education, Superintendents of Schools, Office of Special Education Services Commissioner's Advisory Panel
From: Thomas B. Neveldine, Assistant Commissioner
Subject: Implementation of Procedures for Medicaid Reimbursement for Related Services Provided to Children with Disabilities

- April 1992

To: District Superintendents of Schools and Public Schools
From: Arthur L. Walton, Deputy Commissioner
Subject: Medicaid Reimbursement for Health Related Support Services

- November 1992

To: District Superintendents, Presidents of Boards of Education, Superintendents of Schools, Commissioner's Advisory Panel for Special Education Services
From: Thomas B. Neveldine, Assistant Commissioner
Subject: Implementation of Procedures for Medicaid Reimbursement for Health Related Support Services Provided to Students with Disabilities

- October 1993

To: District Superintendents, Presidents of Boards of Education, Superintendents of Schools, Commissioner's Advisory Panel for Special Education, Directors of RICs
From: Thomas B. Neveldine, Assistant Commissioner
Subject: Recent Revisions to the Current Medicaid Payment Process....

- February, 1993

To: RIC Directors
From: The State Education Department
Subject: Submission of Magnetic Provider Agreement

- June, 1994

To: District Superintendents, Presidents of Boards of Education, Superintendents of Schools, Commissioner's Advisory Panel for Special Education, Directors of RICs, NYS Speech Hearing and Language Association, Teachers of the Speech and Hearing Handicapped

From: Thomas B. Neveldine, Assistant Commissioner
Subject: Updates and Clarification on the current Medicaid payment process

- June, 1994

To: District Superintendents of Schools, Selected Superintendents of Schools
From: Arthur L. Walton, Deputy Commissioner
Subject: Additional Revenues for Districts through the use of Medicaid

- June, 1994

To: District Superintendents, Presidents of Boards of Education, Superintendents of Schools, Commissioner's Advisory Panel for Special Education, Directors of RICs, Superintendents of State-Operated and State-Supported Schools, Directors of Approved Preschool Programs, Directors of Special Education, Teachers of the Speech and Hearing Handicapped, Preschool Special Education Advisory Council, SETRC Project Directors and Training Specialists, ECDC Project Directors and Coordinators, Chairpersons on the Committee for Special Education, State Board for Speech-Language Pathology and Audiology, County Preschool Administrators
From: Thomas B. Neveldine, Assistant Commissioner
Subject: Clarification of the Guidelines for the Billing of Medicaid for Speech Services

- September, 1994

To: District Superintendents, Presidents of Boards of Education, Superintendents of Schools, Commissioner's Advisory Panel for Special Education, Directors of RICs, Chairpersons on the Committee for Special Education, Executive Directors of Approved Private Schools
From: Thomas B. Neveldine, Assistant Commissioner
Subject: Medicaid Reimbursement for Eligible School-Age Students Receiving School Supportive Health Services from Articles 28, 31, and 16 Facilities

- September, 1994

To: District Superintendents, Presidents of Boards of Education, Superintendents of Schools, Commissioner's Advisory Panel for Special Education, Directors of RICs, Chairpersons on the Committee for Special Education, Superintendents of State-Operated Schools, Directors of Special Education, School District Business Officials
From: Thomas B. Neveldine, Assistant Commissioner
Subject: Medicaid Billing for Students in State Operated Schools

- August, 1995

To: District Superintendents, Presidents of Boards of Education, Superintendents of Schools, Commissioner's Advisory Panel for Special Education, Directors of RICs, Chairpersons on the Committee for Special Education, Directors of Special Education, School District Business Officials
From: Thomas B. Neveldine, Assistant Commissioner
Subject: Updates and Clarification on the current Medicaid payment process and implementation of procedures for Medicaid reimbursement for SSHSP

- August, 1995

To: Chief Elected Officials of the County Selected District Superintendents
From: Robert J. Scalise Coordinator, Finance Unit, Office of VESID
Subject: Processing of Medicaid Claims for Services Provided to Preschool Students with Disabilities Pursuant to Section 4410 of the Education Law.

- October, 1995

To: District Superintendents, Presidents of Boards of Education, Superintendents of Schools, Commissioner's Advisory Panel for Special Education, Directors of RICs, Chairpersons on the Committee for Special Education, Superintendents of State-Operated and State-Supported schools, Directors of Special Education, School District Business Officials
From: Ronald G. Calhoun, Coordinator of VR Services and Administration
Subject: Update to August 1995 Medicaid Memorandum

- May, 1996

To: District Superintendents, Superintendents of Public Schools, School Nurses, Directors of Special Education, County Preschool Administrators
From: Louis R. DeMeo, Management Specialist IV
Subject: Medicaid Reimbursable Nursing Services

- March, 1997

To: Selected School District Superintendents, Selected District Superintendents, Selected Directors of Special Education, Selected Business Officials
From: Lawrence C. Gloeckler, Deputy Commissioner for VESID and James A. Kadamus, Deputy Commissioner for Elementary, Middle, Secondary and Continuing Education
Subject: Development of a Medicaid fee for Targeted Case Management (TCM)

- May, 1997

To: District Superintendents, Superintendents of Schools, Directors of Special Education, Chairpersons on the Committee for Special Education, Committee on Preschool Special Education Chairpersons, Business Officials
From: Ann Clemency Kohler, Director, OMM, NYS DOH
Subject: Clarification of Medicaid Documentation Requirements for Speech and other Health Related Support Services

- June, 1997

To: District Superintendents, Superintendents of Schools, Directors of Special Education, Chairpersons on the Committee for Special Education, School District Business Officials, SETRC Project Directors and Training Specialists, ECDC Project Directors and Coordinators, Superintendents of State-Operated and State-Supported schools, Commissioner's Advisory Panel for Special Education, Preschool Advisory Committees
From: Robert J. Scalise Coordinator, Finance Unit, Office of VESID
Subject: Addendum to the May, 1997 Memorandum

- March, 1998

To: District Superintendents, Presidents of Boards of Education, Superintendents of Schools, School District Business Officials, Directors of Special Education, Chairpersons on the Committee for Special Education, Chairpersons of Preschool Committees on Special Education, Superintendents of 4201 Schools, Directors of Regional Information Centers and Regional Computer Centers, Chief Executive Officer of the County
From: Robert J. Scalise, Coordinator, Finance Unit, Office of VESID
Subject: New Medicaid Data System

- March, 1998

To: District Superintendents, Presidents of Boards of Education, Superintendents of Schools, School District Business Officials, Directors of Special Education, Chairpersons on the Committee for Special Education, Superintendents of 4201 Schools, Directors of Regional Information Centers and Regional Computer Centers
From: Robert J. Scalise, Coordinator, Finance Unit, Office of VESID
Subject: Targeted Case Management

- March, 1999

To: District Superintendents, Presidents of Boards of Education, Superintendents of Schools, School District Business Officials, Directors of Special Education, Chairpersons on the Committee for Special Education, Chairpersons of Preschool Committees on Special Education, SETRC Project Directors and Training Specialists, ECDC Project Directors and Coordinators, Superintendents of State-Supported Schools, Commissioner's Advisory Panel for Special Education, Regional Information Center Medicaid Contacts, CNYRIC, Department of Health, Office of Medicaid Management.
From: Robert J. Scalise, Coordinator, Finance Unit, Office of VESID
Subject: Medicaid Reimbursement for Targeted Case Management for Preschool Students and School Age Students placed in a New York State Supported Section 4201 School for the Deaf and/or Blind Appointed by the Commissioner of Education

- March, 1999

To: District Superintendents, Presidents of Boards of Education, Superintendents of Public Schools, School District Business Officials, Directors of Special Education, Chairpersons on the Committee for Special Education, School District Attorneys, Organizations, Parents & Individuals Concerned with Special Education, Nonpublic Schools, Impartial Hearing Officers, Commissioner's Advisory Panel, NYC Board of Education, Superintendents of State-Operated and State-Supported Schools, Executive Directors of Approved Private Schools, Directors of Pupil Personnel Services, Special Education Training & Resource Centers, Community Dispute Resolution Centers, Administrators Leadership Training Academies, Independent Living Centers
From: Kathy A. Ahearn, Council, Deputy Commissioner for Legal Affairs
Subject: March 3, 1999 Decision in Cedar Rapids Community School District v. Garret F., 119 S. Ct. 992

- August, 1999

To: District Superintendents, Presidents of Boards of Education, Superintendents of Public Schools, School District Business Officials, Directors of Special Education, Chairpersons on the Committee for Special Education, Chairpersons of Preschool Committees on Special Education, Superintendents of 4201 Schools, New York State Association of Counties, County Executives, County Preschool Administrators, Directors of Regional Information Centers and Regional Computer Centers
From: Robert J. Scalise Coordinator, Finance Unit, Office of VESID

Subject: Recent Memorandum from the Federal Health Care Administration

- July 11, 2001

To: Directors of Special Education and Regional Information Center Medicaid Coordinators
From: Robert J. Scalise, Coordinator Medicaid Unit
Subject: Release of New Special Transportation Rates

- July 23, 2001

To: District Superintendents, Superintendents of Public School Districts, Directors of Special Education, County Administrators, Other State Agency Education Programs, Executive Directors of Approved Private Schools
From: Robert J. Scalise, Coordinator Medicaid Unit
Subject: Use of Public Insurance Funds for Students with Disabilities

- January, 2002

To: Superintendents of Public Schools, Directors of Special Education, School District Business Officials, CNYRIC, Medicaid Contacts – RIC's
From: Robert J. Scalise, Coordinator Medicaid Unit
Subject: Students Transitioning from Preschool to School age

- January, 2002

To: Superintendents of Public School Districts, Directors of Special Education, School District Business Officials, County Executives, County Contacts for Preschool Services, CNYRIC, Medicaid Contacts – RIC's
From: Robert J. Scalise, Coordinator Medicaid Unit
Subject: Medicaid Reimbursement for Special Transportation

F

G

OIG AUDIT FINDINGS SUMMARY - SPEECH UPSTATE

ERROR FINDINGS CODE

(There were no errors for findings codes A and H so they are omitted from summary.)

Case Number	Number of Findings	B	C	D	E	F	G	I	J
									9
1									
2									
3									
4	1								7
5	3			5 6	5 6				7
6	7	0	8	8	0	6		8	9
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18	2			5 6 8	5 6 10 11				
19	1					6			
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21	2			4 5 6		3 5 6			
22	4			6 8	6 10	6			9
23	1					2 6 7			
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25	1					6			
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28	1					3 5 6			
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33	3			6 8	8	8			
34									
35	4			1 5 6 8	1 5 6	1 5 6			1 9

OIG AUDIT FINDINGS SUMMARY - SPEECH UPSTATE

Case Number	Number of Findings	ERROR FINDINGS CODE (There were no errors for findings codes A and H so they are omitted from summary.)																																		
		B		C				D						E										F								G	I		J			
		0	2	2	5	6	8	1	2	4	5	6	8	0	1	2	4	5	6	7	8	10	11	0	1	2	3	5	6	7	11	0	2	8	1	2	7	9
36																																						
37	2											6																	6									
38	1									4		6																										
39	1											6																										
40	1																											5	6									
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42																																						
43	1																										3	5	6									
44	3											6	8						6			10									11							
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49	1																											5	6									
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56																																						
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58	2										5	6	8					5	6																			
59	4										5	6	8					5	6					0								0						
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63																																						
64																																						
65																																						
66	1																								1			5	6									
67	3											6	8						6			10				2												
68	1																											5	6									
69	2																									2		5	6									9
70	7	0					8				5	6	8					5	6			10						5	6					8			7	

OIG AUDIT FINDINGS SUMMARY - SPEECH UPSTATE

Case Number	Number of Findings	ERROR FINDINGS CODE (There were no errors for findings codes A and H so they are omitted from summary.)																																			
		B		C				D						E										F								G	I		J			
		0	2	2	5	6	8	1	2	4	5	6	8	0	1	2	4	5	6	7	8	10	11	0	1	2	3	5	6	7	11	0	2	8	1	2	7	9
71	2										5	6	8					5	6																			
72	3										5	6	8					5	6								3	5	6									
73	4											6	8						6			10									11							9
74																																						
75																																						
76	1																										3	5	6									
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78	1																									2		5	6									
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80	3											6	8						6							2			6									
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85																																						
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87	3							1			5	6	8		1			5	6	7		10			1			5	6	7								
88	3										5	6	8					5	6									5	6	7								
89																																						
90	4				5	6					5	6	8					5	6			10						5	6									[illegible]
91	3											6	8						6										6									
92																																						
93	3									4		6	8				4		6			10				2			6	7								
94	2										5	6	8					5	6			10																
95	1																																					9
96																																						
97	7		2	2			8				5	6	8					5	6									5	6				2	8		2		
98																																						
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Totals		4	1	1	1	1	5	2	1	6	20	37	33	2	2	1	2	17	32	2	0	18	1	2	3	7	6	23	37	6	4	2	1	5	1	1	4	11

OIG AUDIT FINDINGS SUMMARY - SPEECH UPSTATE

Case Number	Number of Findings	ERROR FINDINGS CODE (There were no errors for findings codes A and H so they are omitted from summary.)																																					
		B		C				D						E										F								G			I		J			
		0	2	2	5	6	8	1	2	4	5	8	8	0	1	2	4	5	6	7	8	10	11	0	1	2	3	5	6	7	11	0	2	8	1	2	7	9

OIG Findings	
A	No Documentation
B	No Service Report
C	No Assurance that Services were Rendered
D	No ASHA Certification
E	Service not by or "Under the Direction of"
F	No Referral
G	No IEP or IFSP
H	No Speech on IEP or IFSP
I	No Assurance of Minimum of 2 Services Rendere
J	No Progress Notes

Reasons/Defense	
0	No argument on OIG findings
1	Date exceeds State requirements for document retention
2	Documentation meeting OIG specifications was found
3	Referral requirements allowed medical professional after April 1995 - documentation exists
4	Service provider has NYS license for speech pathology
5	EPA 94-42 was in force - allowed service provision by state qualified individual (pre June 4 1997 letter of clarification)
6	Rehabilitation argument (42 CFR 440.130d) - who provides & who refers (CSE, IEP)
7	Alternative Documentation (IEP)
8	Duplicate findings argument
9	Problem with progress notes no longer an issue after 1998
10	Meets NYS "under the direction of" requirements
11	Documentation not acceptable by OIG

H

Berbach, John (OIG/OAS)

From: Berbach, John (OIG/OAS)
Sent: Tuesday, July 30, 2002 10:42 AM
To: 'jpotter@asha.org'
Cc: Peltz, Linda ; Tavener, Linda ; Lasowski, William S; Rhodes, Rhonda ; Zelinger, Jerry ; Strauss, Richard ; Reisman, Peter ; Kelly, Sue ; Bonnie, Edmond A; Provost, William G; Horgan, Timothy (OIG/OAS); Jackson, Ben (OIG/OAS); Hagg, John (OIG/OAS); Wellins, Gregory (OIG/OCIG); Smith, Kevin (OIG/OAS); Inzerillo, Victoria (OIG/OAS); Halko, Nicholas (OIG/OAS); Sharkey, Terence (OIG/OAS); Fratangelo, Michael (OIG/OAS); Cavallaro, Tyeese (OIG/OAS)
Subject: Question For ASHA Related To NYS's Licensed Speech-Language Pathologists

Mr. James Potter
Director of Government Relations and Public Policy
American Speech-Language Hearing Association (ASHA)

We have a follow-up question to our April 8, 2002 meeting/phone conference related to our audit of New York State's (NYS) school health claims to Medicaid for speech services. Our question is this: For compliance with 42 CFR Part 440.110 (c) would NYS's licensed speech-language pathologists be equivalent to and meet the requirements of a speech-language pathologist who possesses a Certificate of Clinical Competence (CCC) from ASHA? If they are not equivalent or meet the requirements, please provide a detailed explanation as to why.

As background to our question, during our April 8, 2002 meeting/conference call with DOJ Attorney Carol Wallack, AUSA Rob Sadowski, and the Office of Audit Services (OAS), we indicated that the Federal Government was performing an audit of NYS's speech school health claims to Medicaid. During the meeting, we explained that within NYS, speech services to school and preschool students are delivered by three types of individuals as follows: (1) a Teacher of the Speech and Hearing Handicapped (TSHH) who possesses a Teaching Certificate from NYS, (2) a NYS licensed speech-language pathologist, or (3) an ASHA certified speech pathologist. Some individuals possess all three, some just the first two, and others are just a TSHH.

Federal regulations governing Medicaid reimbursement, found at 42 CFR Part 440.110 (c), state that speech services must be provided by or under the direction of a speech pathologist or audiologist. The regulations define a speech pathologist or audiologist as an individual who: "(i) Has a certificate of clinical competence from the American Speech and Hearing Association; (ii) Has completed the equivalent requirements and work experience necessary for the certificate; or (iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate."

NYS has provided written guidance to its school health providers. The guidance states that in order to claim Medicaid reimbursement, speech services must be provided by or under the direction of an ASHA certified speech pathologist "or" a NYS licensed speech pathologist.

It is our understanding that NYS officials believe that their licensed speech pathologists are equivalent to and meet the requirements of a speech pathologist with a CCC from ASHA. Although we do not agree, OAS felt it necessary to consult with ASHA officials on this question. Please provide us with a written response.

On a final note, DOJ has "stepped aside" with respect to its investigation of NYS's school health claims to Medicaid. However, CMS officials have requested that OAS continue with its audits of this area.

If you have any questions or would like to meet, please let me know. Thank you in advance for your consideration.

John W. Berbach
Audit Manager
HHS OIG Office of Audit Services
(518) 437-9390 Ext. 228