DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

NOV 07 2001

CIN: A-04-00-02161

Carmen Hooker Buell, Secretary
North Carolina Department of Health
and Human Services
Adams Building, 101 Blair Drive
Raleigh, North Carolina 27603

Dear Secretary Buell:

Enclosed are two copies of a U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, ***Medicaid Monthly Payments for School-Based, Health-Related Services in North Carolina***. A copy of this report will be forwarded to the appropriate HHS action official (see page 2 of this letter) for his/her review and any action deemed necessary. Final determinations 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 (Public Law 90-23), OIG, OAS reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (see 45 Code of Federal Regulations Part 5).

To facilitate identification, please refer to Common Identification Number (CIN) A-04-00-02161 in all correspondence relating to this report.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures - as stated

**Direct Reply to HHS Action Official:**

Associate Regional Administrator for Medicaid
Centers for Medicare and Medicaid Services, Region IV
Sam Nunn Atlanta Federal Center
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303-8909

Department of Health and Human Services

# OFFICE OF INSPECTOR GENERAL

# MEDICAID MONTHLY PAYMENTS FOR SCHOOL-BASED, HEALTH-RELATED SERVICES IN NORTH CAROLINA

JANET REHNQUIST
Inspector General

NOVEMBER 2001
A-04-00-02161

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Carmen Hooker Buell, Secretary
North Carolina Department of Health
and Human Services
Adams Building, 101 Blair Drive
Raleigh, North Carolina 27603

Dear Secretary Buell:

Enclosed are two copies of a final report entitled, ***Medicaid Monthly Payments for School-Based, Health-Related Services in North Carolina.***

# EXECUTIVE SUMMARY

## OBJECTIVE

The objective of our review was to determine whether the Medicaid reimbursements for school-based, health-related services in North Carolina were allowable under the terms of the Medicaid State Plan and applicable Federal regulations. Our review included monthly payments[1] totaling $7.3 million[2] ($5.3 million Federal share) made to Local Education Agencies (LEAs) during State Fiscal Years (SFY) 1996 through 1998.

## FINDINGS

Our review showed that the North Carolina Division of Medical Assistance (DMA) made payments totaling $5.3 million (Federal share) for school-based, health-related services to LEAs using a methodology that was not included in its approved State Plan. These payments were made "at-risk" because the methodology DMA proposed in its State Plan amendment (SPA) 95-23 was

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[1]Medicaid monthly payments are defined as a monthly fee per service type for health-related services, such as audiology, speech and language therapy, physical therapy, occupational therapy, and psychological therapy provided in school settings. Throughout the course of our audit field work, DMA used the terms "monthly rates" and "bundled rates" interchangeably.

[2]The LEAs must certify the availability of the non-Federal share of the payments which would be approximately $2 million.

Our review showed that the North Carolina Division of Medical Assistance (DMA) made payments totaling $5.3 million (Federal share) for school-based, health-related services to LEAs using a methodology that was not included in its approved State Plan. These payments were made "at-risk" because the methodology DMA proposed in its State Plan amendment (SPA) 95-23 was not approved by the Centers for Medicare & Medicaid Services[3] (CMS). The payment methodology was not approved by CMS because DMA could not provide documentation to support the monthly payment rates. Moreover, in a June 14, 1999 letter to CMS, DMA agreed to recoup the monthly payments and resubmit the claims using an approved fee-for-service payment methodology. To date, DMA has not recouped the monthly payments and returned the Federal share.

These conditions occurred because DMA exercised minimal oversight of the activities of its revenue maximization subcontractor.

**RECOMMENDATIONS**

Subsequent to the issuance of our draft report, CMS approved SPA 95-23. Even though DMA approved the SPA, CMS did not approve the DMA's monthly payment methodology. By letter dated September 13, 2001, CMS notified DMA of its decision to approve the amendment. The letter also said that DMA had agreed it would: (1) recoup past monthly payments; (2) repay the past monthly payments based on fee-for-service rates; and (3) base repayments on services actually rendered. The findings contained in our report remain unchanged as CMS disapproved the State's monthly payment methodology. However, we have modified our recommendation relating to the DMA's repayment of the $5,344,160 Federal share.

Because the DMA will cost settle the monthly payments on a fee-for-service basis, the Federal share of any overpayments resulting from this cost settlement process may be less than the $5,344,160 we originally recommended the DMA repay. This cost settlement process is to be conducted by an independent contractor, beginning no later than March 1, 2002, and be completed by September 1, 2002.

Therefore, we recommend that the DMA:

- refund the Federal share of any overpayment resulting from this monthly payment cost settlement process; and

- exercise more oversight over the activities of its revenue maximization subcontractor.

In written comments to the draft report, DMA officials disagreed with our findings and recommendations. We have revised our final report based on their comments. The DMA's written comments and the Office of Inspector General's (OIG) response to the DMA's comments

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[3]During our review, the Health Care Financing Administration was renamed CMS.

## BACKGROUND

Under the Individuals with Disabilities Education Act, States may receive reimbursement for health-related services, such as audiology, speech and language therapy, physical therapy, occupational therapy, and psychological therapy, provided in school settings. The CMS provides Federal financial participation (FFP) in the cost of services rendered that are: (1) medically necessary; (2) delivered and claimed in accordance with all other Federal and State regulations; and (3) included in the State Plan or available under the Early and Periodic Screening, Diagnostic, and Treatment Services benefit.

In 1991, North Carolina requested approval from CMS to add these school-based, health-related services to its State Plan and receive FFP. In September 1995, North Carolina submitted an SPA requesting CMS' approval to allow schools to enroll in the Medicaid Program retroactively to 1993. This retroactive project was implemented by the State and allowed LEAs to receive FFP under a "monthly rate" payment methodology for these traditionally fee-for-service claims. The CMS had concerns with the content of the proposed SPA and was unable to reach an agreement with the State regarding the monthly payment methodology.

## SCOPE

To accomplish our objective, we held discussions with DMA officials, reviewed applicable laws and regulations, reviewed DMA manuals, examined correspondence, and performed such other auditing procedures as necessary.

Our review did not include a study and evaluation of DMA's internal accounting controls because the objective of our review did not require an understanding or an assessment of the internal control structure.

Field work was performed at the DMA office in Raleigh, North Carolina. Field work was conducted from November 1999 through December 2000. The DMA officials did not wish to have an exit conference to discuss the draft report's findings and recommendations. However, on May 9, 2001, the DMA officials did provide us with written comments.

Our review was made in accordance with generally accepted government auditing standards.

# FINDINGS AND RECOMMENDATIONS

## MONTHLY MEDICAID PAYMENTS

The DMA made monthly payments totaling $5,344,160 (Federal share) to LEAs during the period SFY 1996 to SFY 1998 for health-related services for which the State was "at-risk" because the payment methodology DMA used was not in accordance with North Carolina's approved Medicaid State Plan.

### At-Risk Payments

In September 1995, North Carolina submitted a proposed SPA requesting CMS approval for LEAs to retroactively enroll in the Medicaid Program. The LEA enrollment was to be retroactive to September 1993. The proposed SPA also sought to: (a) recognize Teachers of Speech/ Language Services in the Public School setting as eligible providers of Medicaid services, and (b) issue a supplemental payment to LEAs, for a retroactive period of 2 years, to reflect the actual cost of providing health-related services. In a letter dated December 18, 1995 to the Director, DMA, CMS communicated its concerns with the content of the proposed SPA. The CMS advised the State that the currently approved State Plan had no reimbursement methodology for these school-based, health-related services.

Even though CMS had not approved the proposed SPA, DMA implemented the proposed SPA's retroactive enrollment provisions for LEAs. In May 1996, DMA began making its monthly payments to LEAs.

The following chart summarizes total payments made during SFY 1996 through SFY 1998.

| Date Paid | Total Paid to LEAs Federal Share | Required Local Match (Certified Public Expenditures) | Total |
|---|---|---|---|
| May 1996 | $3,017,952 | $1,068,657 | $4,086,609 |
| June 1997 | 1,663,320 | 600,625 | 2,263,945 |
| July 1997 | 192,985 | 69,687 | 262,672 |
| February/March 1998 | 469,903 | 173,441 | 643,344 |
| Totals | $5,344,160 | $1,912,410 | $7,256,570 |

While there is no prohibition against a State implementing the provisions of an SPA while it is pending CMS' approval, the State is putting itself "at risk" should CMS ultimately deny the State's request for amending its State Plan. In these instances, the State is "at risk" because section 1903(a)(1) of the Social Security Act requires that costs be claimed under an approved State Plan in order to be reimbursable under Title XIX. The costs in question were claimed under the authority of a proposed SPA.

In addition, CMS notified State Medicaid Directors in May 1999 that "bundled rates" would no longer be permissible as they were inconsistent with the efficiency and economy requirements of Section 1902(a)(30)(A) of the Social Security Act. In response to CMS' May 1999 letter, an internal DMA memo dated November 21, 2000 stated: "HCFA has taken the position that the bundled rates are not permissible, and that the fee for service is the only payment means available. This would call into question the $5.3 million paid by bundled rates."

A bundled payment exists when a State pays a single rate for one or more of a group of *different services* furnished to an eligible individual during a fixed period of time; whereas, a monthly payment is a single rate for one or more of the *same type of services* furnished to an eligible individual during a fixed period of time[4]. Both the bundled payments and the monthly payments consist of a single rate for a group of services. The DMA used the terms "bundled payments" and "monthly payments" interchangeably throughout our review. The DMA recognized its monthly payments to LEAs did not meet Federal requirements for reimbursement as shown by their internal response to CMS' May 1999 letter.

The DMA accepted the risk associated with making the payments when it implemented the monthly rate methodology without CMS' approval. As such, we believe that the State is liable for the Federal share of payments made to LEAs because the DMA used a payment methodology that CMS had not approved.

On September 13, 2001, CMS ultimately approved DMA's State Plan Amendment 95-23; however, CMA did not approve the monthly payment methodology. Under this approved amendment, CMS agreed that DMA would: (1) recoup past monthly payments; (2) repay the past monthly payments based on fee-for-service rates; and (3) base repayments on services actually rendered. Thus, CMS disapproved the State's monthly payment methodology and the $5.3 million Federal share should be returned.

**Payments Held in a Trust Fund**

One way a State may claim FFP is if a public agency certifies that expenditures claimed are eligible for FFP. In a letter dated September 28, 1995, the State Department of Public Instruction

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[4] The DMA's monthly payments were made for health-related services such as audiology, speech and language therapy, physical therapy, occupational therapy, and psychological therapy provided in school settings.

(DPI) certified to the Department of Environment, Health, and Natural Resources[5] (DEHNR) that LEAs had incurred over $31 million ($19.7 million Federal share) in expenses for health-related services to Medicaid eligible students. According to the certification, the services covered the period September 1, 1993 through September 30, 1995. The DPI requested that DMA transfer the $19.7 million Federal share to the DEHNR. In June 1996, DMA requested that DEHNR return $16.7 million to DMA because there were not enough LEA claims to justify FFP. The DMA, subsequently returned the $16.7 million to CMS. The remaining $3 million was held by DEHNR and never distributed to the LEAs. This $3 million is included in the $5.3 million we recommended be refunded to the Federal Government. The funds have been held in a State Division of Public Health trust account since May 1996 pending a decision from CMS relating to DMA's payment rate methodology.

**Subcontractor Oversight**

The DMA made Medicaid payments that did not meet Federal reimbursement criteria because DMA exercised minimal oversight of the activities of its subcontractor. The State contracted on a contingency basis with a prime contractor to maximize North Carolina's Medicaid revenue. The prime contractor in turn, subcontracted with another consulting group to develop the payment rate methodology. The subcontractor received a percentage of the gross cash revenues generated by the prime contractor. In addition to working on the State's revenue maximization project, the subcontractor also entered into contingency contracts with the LEAs to provide billing services.

The subcontractor's responsibilities were far-reaching. The subcontractor not only developed the proposed change in the rate process, but also calculated the revised rates for submission to the State. The State adopted the position that DMA, not the subcontractor, was responsible for establishing Medicaid rates. However, we determined that DMA's actual involvement in establishing the rates was minimal. The DMA officials verbally acknowledged the monthly payment rates that the subcontractor developed could not be substantiated.

**Quality Assurance**

Historically, States have used a Provider Manual to communicate Medicaid documentation requirements to providers. This manual, along with the providers' need to meet professional certification standards, have ensured general compliance.

In North Carolina, the subcontractor developed a monthly billing guide, i.e., Provider Manual, in coordination with its monthly rate methodology. This monthly billing guide had policies which were less stringent than those in DMA's official manual. One example of these less stringent requirements involved the issue of prior approval. The existing billing guide required LEAs to submit a written authorization request and obtain prior approval for treatment services. Although

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[5]The Health component of the former DEHNR is now the Division of Public Health within the State Department of Health and Human Services (HHS).

the LEA Program, the Independent Practitioner Program, and the Head Start Program were the only settings where physical therapy, occupational therapy, speech and language therapy, etc., required prior approval, there were concerns relating to the ease which these services could be abused from a cost perspective. The monthly billing guide developed by DMA's subcontractor eliminated the requirement for prior approval. In reference to the monthly billing guide, one State official wrote "...we received a revised Program Manual from the consultants which in our judgement eliminates the last vestiges of the original quality assurance mechanisms."

## RECOMMENDATIONS

Subsequent to the issuance of our draft report, CMS approved SPA 95-23. Even though CMS approved the SPA, CMS did not approve the DMA's monthly payment methodology. By letter dated September 13, 2001, CMS notified DMA of its decision to approve the amendment. The letter also said that DMA had agreed it would: (1) recoup past monthly payments; (2) repay the past monthly payments based on fee-for-service rates; and (3) base repayments on services actually rendered. The findings contained in our report remain unchanged as CMS disapproved the State's monthly payment methodology. However, we have modified our recommendation relating to the DMA's repayment of the $5,344,160 Federal share.

Because the DMA will cost settle the monthly payments on a fee-for-service basis, the Federal share of any overpayments resulting from this cost settlement process may be less than the $5,344,160 we originally recommended the DMA repay. This cost settlement process is to be conducted by an independent contractor, beginning no later than March 1, 2002, and be completed by September 1, 2002.

Therefore, we recommend that the DMA:

- refund the Federal share of any overpayment resulting from this monthly payment cost settlement process; and

- exercise more oversight over the activities of its revenue maximization subcontractor.

### DMA Comments - Medicaid Monthly Payments

In written comments to the draft report, the DMA said that North Carolina did not pay bundled rates; therefore, the CMS policy letter dated May 21, 1999 did not provide a basis for disallowing the State's claim. The DMA also said the OIG's approach was unfair, because it applied a policy retroactively; and it penalized the State for a practice that was an established, CMS-approved practice in other States. The DMA further asserted that the State had a reasonable expectation that its September 1995 plan amendment allowing the use of monthly rates would ultimately be

approved since CMS had approved similar amendments for other States. Finally, the DMA asserted that North Carolina's SPA complied with applicable practices, laws and regulations regarding the payment of actual cost incurred by efficiently and economically operated providers.

**OIG Response**

First, the $5.3 million in payments were based on a monthly fee for each service type as explained in Footnote 1, page 1 of the report. However, the LEA accounting systems did not capture the costs for services by individual service codes; instead, the costs were accumulated in groups (for example, speech/audiology; occupational therapy/physical therapy; and psychological services). As a result, the DMA was unable to identify the cost associated with each individual service code as the LEA accounting systems "bundled" the costs for one or more of a group of *different services*.

Throughout our review, the DMA used the terms "monthly rates" and "bundled rates" interchangeably. This is best illustrated in the internal DMA memo dated November 21, 2000 which is quoted on page 4 of the draft report. The memo states in part: "....This would call into question the $5.3 million paid by bundled rates." The DMA considered CMS' policy letter dated May 21, 1999 as applicable to its monthly payments.

Second, we do not agree that the OIG's approach was unfair nor do we concur that North Carolina was penalized for a practice that was an established, CMS-approved practice in other States. We recommended the monthly payments be disallowed on the grounds that the costs were not claimed pursuant to North Carolina's approved State Plan. Section 1903(a)(1) of the Social Security Act requires that costs be claimed under an approved State Plan in order to be eligible for reimbursement under Title XIX. The costs in question were claimed under the authority of a proposed SPA. Since the State made monthly payments outside of the approved State Plan, the State accepted the risk associated with these payments.

The DMA argued that even if the bundling methodology definition did apply, the May 21, 1999 policy letter "states clearly that there would be no retroactive application of this policy to past payments."

The DMA has inappropriately relied on that portion of CMS' policy letter which applies to States currently paying bundled rates for school-based health services pursuant to **an approved State Plan amendment** (emphasis added). In this particular instance, CMS indicated its willingness to work with the States to implement a strategy so these States could come into compliance prospectively. No retroactive disallowances of FFP were currently planned by CMS for those States paying bundled rates for school-based health services pursuant to **an approved State Plan amendment** (emphasis added).

North Carolina's plan **was not approved** (emphasis added); thus the State was required to meet the conditions discussed later in the May 21, 1999 policy letter for States **seeking approval**

(emphasis added) to reimburse school-based, health-related services using bundled rates. The policy letter states: "**HCFA will not approve any additional amendments to State plans that seek to reimburse for school-based health services using a bundled rate** (emphasis added). States with pending bundling plan amendments may either withdraw those amendments or revise them to conform to the requirements described in this letter." The CMS' policy announcement addresses **all States with pending bundling plan amendments** (emphasis added); and as such, we do not believe North Carolina was singled out or penalized for a practice that was an established, CMS-approved practice in other States. The DMA was aware that should its proposed State Plan amendment not be approved, or not be approved as originally submitted, the State would have to reimburse CMS for any Federal share claimed for its "at risk" monthly payments. Section 1903(a)(1) of the Social Security Act requires that costs must be claimed under an approved State Plan in order to be eligible for reimbursement under Title XIX. Accordingly, there is no authority for North Carolina's "at risk" monthly payments that were made outside of the approved State Plan.

Third, the approval process was delayed because of CMS' concerns with the proposed SPA. The CMS routinely communicated to the DMA these concerns, which included the proposed payment methodology, as well as, the State's attempts to lessen the qualifications for speech/language providers. The DMA never adequately addressed CMS' questions regarding how the State would determine actual costs.

Given the long and arduous amendment process, we believe the DMA was cognizant its monthly payments were at risk. The DMA acknowledged that the monthly rates developed by the subcontractor could not be justified. Moreover, the State asserts on page 8 of its response "As for the $3 million, it is still in a trust fund, **held in the event that the State does have to refund these monies**." (Emphasis added) Ultimately, the DMA informed CMS in a letter dated June 14, 1999 that, .... "Past payments based on the monthly interim rates will be recouped and repaid on the 15-minute increment." As of the date of our review, these monthly payments had not been recouped by the DMA.

## DMA Comments - State's Use of a Payment Methodology Not Described in an Approved State Plan

The DMA asserted that the State's approved Medicaid State Plan authorized payment to public entities based upon fees not to exceed reasonable costs. The DMA also asserted that the audit report ignores the requirement of the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. The DMA also interpreted 42 United States Code Section 1396d(a)(6); 42 Code of Federal Regulations (CFR) Section 440.60(a) as meaning "States must pay for necessary remedial services provided to children by individuals such as speech/language teachers who hold the equivalent State licenses that permit them to practice only in limited environments such as schools." The DMA further asserted that CMS advised that a State may not limit the settings in which it covers medically necessary services for EPSDT-eligible children.

**OIG Response**

North Carolina's approved Medicaid State Plan (Attachment 4.19-B, Section 6, Pages 1-2, Transmittal No. 92-01, approved October 21, 1992, effective date January 1, 1992) does not mention public entities. The proposed SPA 95-23 indicates public entities will be paid a fee not-to-exceed cost; however, this proposed SPA had not been approved by CMS.

The State's argument regarding EPSDT, namely that Federal law requires provision of these school-based services to children, is flawed. Federal law mandates the provision of medically necessary services to Medicaid eligible children, but does not mandate the provider or the location of services. Further, the EPSDT statute does not waive the CMS' requirements for claiming FFP. The DMA is incorrectly equating the Agency's requirement to provide services with CMS' requirement to provide FFP for those services correctly claimed under Medicaid. At the State's option, services can be paid with all State funds or services can be federally matched. To receive the Federal match, a State must meet all applicable Federal requirements. In order to claim Federal funds to match the State share of these services, the State must have an approved payment methodology in its Title XIX State Plan.

The State makes the argument, again using the EPSDT requirements, that it must pay for speech/ language services provided by speech/language teachers certified by the Department of Public Instruction (DPI). However, in the June 14, 1999 official response to CMS' request for additional information, the State agreed not to pay for any claims for which the provider was a DPI-certified speech/language teacher. This decision was based on the fact that the DPI-certified individuals do not meet CMS regulatory requirements for speech/language therapists (42 CFR 440.110), and the approved State Plan specifically states that individual providers of speech/ language services must meet the provider requirements of 42 CFR 440.110. The CMS accepted the DMA's assurances that no FFP would be claimed for these individuals.

The DMA asserted that CMS advised that a State may not limit the settings in which it covers medically necessary services for EPSDT-eligible children; however, this is not accurate. In fact, CMS issued an EPSDT policy clarification which contradicts the DMA's argument. Specifically, CMS' policy clarification indicates States must provide all medically necessary services. However, "States are not required to provide every service through every possible setting or provider type" (CMS Program Issuance Transmittal Notice, MCD-78-92, October 7, 1992). The DMA reiterated it is required to pay for these services even though the methodology was not in the approved State Plan. However, to receive Federal matching funds, the services must be coverable under Section 1905(a) of the Social Security Act. The DMA did not demonstrate that everything included in its costs were coverable under that provision.

**DMA Comments - Subcontractor Oversight**

The DMA said that it is a common and accepted practice to utilize consultants and contractors in developing payment methodologies. The DMA also contended that North Carolina has been criticized for using contractors to maximize Federal revenues.

**OIG Response**

Regarding the use of consultants, we agree it is a common and accepted practice to utilize consultants and contractors in developing payment methodologies. The State should realize that CMS holds the State Medicaid agencies ultimately responsible for its contractors-and subcontractors- policies, procedures, and practices.

We believe the State needs to provide better oversight of its contractor's activities. The DMA was aware the revenue maximization subcontractor was also capturing a share of the LEAs' Federal payments through its contracts with the LEAs for billing services. The State contract for revenue maximization, as well as, the local LEA contracts for billing services were awarded on a contingency fee basis. The subcontractor was in the position of being able to create inappropriate or excessive claims while also generating increased Medicaid payments (at the local and State levels) through questionable reimbursement rates. As such, a potential conflict of interest existed. Under these circumstances, the State had the obligation to closely monitor the activities of its subcontractor.

**DMA Comments - Quality Assurance**

The DMA said the draft report suggests the recommended adjustment is warranted because the State utilized less stringent prior authorization and other quality assurance policies with respect to services provided by LEAs. The DMA asserted the Individualized Education Plan (IEP) is a sufficient basis for concluding that the services provided were necessary. The DMA also said that eliminating the original quality assurance mechanisms does not mean that there were no alternative quality assurance mechanisms.

The DMA disagreed with the unidentified State official's comment about the Arevised Program Manual eliminating the last vestiges of the original quality assurance mechanism@ The DMA also took exception to the OIG's withholding of the letter from the unnamed State official as privileged information.

**OIG Response**

The basis for our recommended adjustment was that the DMA made monthly payments using a methodology that was not in the approved State Plan. Therefore, the payments were ineligible for reimbursement in accordance with Section 1903(a)(1) of the Social Security Act.

In regards to the DMA's comment about the IEP, the IEP is a tool developed by the United States Department of Education to improve education results for children with disabilities. A child may require health-related services in order to benefit from special education. The health-related services which will be provided to the child must be listed in the IEP to demonstrate how these health-related services will improve the child's educational results. The IEP was not designed to serve as a quality assurance tool for Medicaid and does not demonstrate either that the services were actually provided or that the services were medically necessary.

Regarding the unidentified State official's comments, we believe the comments need no further explanation as they are clearly stated. Also, it should be noted that there are circumstances under which auditors may receive information from sources which should not be disclosed. Protection of this information-source is necessary to allow the free exchange of information and to further the audit process. We accept the DMA's right to disagree with the unnamed official; however, the official's comments remain as stated.

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In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to the exemptions in the Act which the Department chooses to exercise (see 45 CFR Part 5).

We request that you respond within 30 days from the date of this letter to the HHS action official shown below. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

To facilitate identification, please refer to the above Common identification Number (CIN) A-04-00-02161, in any correspondence related to this report. If you need any additional information, please contact John Drake of my staff at (404) 562-7755.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures

**Direct Reply to HHS Action Official:**
Associate Regional Administrator for Medicaid
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303-8909

North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor Carmen Hooker Buell, Secretary

May 9, 2001

CIN: A-04-00-02161
Transmit by Fax to (404) 562-7795 and
by Certified Mail

Mr. Charles J. Curtis
Regional Inspector General for Audit Services
Region IV, Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

Dear Mr. Curtis:

Thank you for the opportunity to respond to the draft audit report entitled, *Medicaid Monthly Payments for School-Based, Health Related Services in North Carolina.* We also appreciate the extension of time you granted in order for us to provide a more comprehensive response to the draft audit report. The draft report had several findings which are addressed in the following comments:

**MONTHLY MEDICAID PAYMENTS.** In this finding, $5.3 million in monthly medical payments made to Local Education Agencies (LEAs) beginning in May 1996 are questioned by the OIG auditors. The primary criteria utilized and referenced by the auditors is a May 1999 Notification letter by HCFA that bundled rates were no longer permissible. For several reasons, HCFA's May 1999 policy statement about bundled rates is not a valid basis for the auditor's recommendation.

First, under the definitions contained in the draft report, it should have been clear to the auditors that North Carolina's monthly rates in question were not "bundled rates." Bundled rates entail use of "a single rate for one or more of a group of <u>different</u> services." By contrast, North Carolina's $5.3 million claim was for payment to LEAs on the basis of "a monthly fee per service type," *i.e.*, a monthly fee for a <u>single</u> type of service. In

other words, North Carolina did not pay bundled rates. So the policy announced in the May 21, 1999 letter provides no basis whatsoever for disallowing North Carolina's claim.

Second, even if the bundling methodology definition did apply, the May 21, 1999 letter also states that:

> *"HCFA would like to work with states to implement a strategy so that States can come into compliance prospectively. At this time, no retroactive disallowances of FFP are planned nor are prospective deferrals. However, we expect states to work to come into compliance with this policy expeditiously...In the event that States do not come into compliance within a reasonable time, HCFA will consider taking a compliance action, including deferrals and retrospective disallowances to the date of this letter."* (Notification letter dated May 21, 1999) [emphasis supplied]

Thus, while the letter indicated that bundled payment methodologies were no longer acceptable, it states clearly that there would be no retroactive application of this policy to past payments. Despite that **assurance** from HCFA, the auditors purported to apply the policy set out in the May 21, 1999 letter to their review of the *"monthly payments made to Local Education Agencies (LEA) during State Fiscal Years (SFY) 1996 through 1998."* It is clear that the May 21, 1999 letter post-dates the period audited.

Not only was this retroactive application of a policy first announced in 1999 unfair, but this practice is without legal support. A State cannot knowingly accept the terms of the grant if it is unaware of the conditions being imposed. Davis v. Monroe County Board of Education, 526 U.S. 629, 119 S.Ct. 1661 (1999). Conditions in Federal grant programs must be clearly expressed so a State understands the bargain it has made when it signs up for federal programs. Maryland Psychiatric Society v. Shalala, 102 F.3d 717 (4th Cir. 1996).

The requirement of fair notice is not unique to grants. Due process likewise requires that parties receive fair notice of a regulatory interpretation before being deprived of property where the regulation is not sufficiently clear to warn a party of what is expected. Trinity Broadcasting of Florida v. FCC, 211 F.3d 618 (D.C. Cir. 2000). The DAB has similarly held that "the State cannot be fairly held to the Agency's interpretation if the State did not receive adequate, timely notice of that interpretation in

the context where there was another reasonable interpretation relied on by the State." Illinois Department of Children and Family Services, DAB No. 1335 (1992).

Compliance with grant requirements is determined on the basis of the law in effect at the time the grant was made. Bennett v. New Jersey, 470 U.S. 632, 105 S. Ct. 1555 (1985). States do not guarantee that their performance will satisfy whatever interpretation might later be adopted by the Agency. Bennett v. Kentucky Department of Education, 470 U.S. 656, 105 S.Ct. 1544, 1552 (1985). Accordingly, when determining if the State had adequate notice of the Agency's interpretation, the timing of that notice is crucial.

To apply a May 21, 1999 HCFA notification letter to events/activities occurring years before is both unreasonable and without legal authority. Therefore, we feel that it is totally inappropriate for the OIG to apply a May 1999 policy letter retroactive to May of 1996, even more so when the letter specifically stated there would be no retroactive application.

The auditors' approach was unfair not only because it applies a policy retroactively, but because it recommends penalizing North Carolina for a practice that was an established, HCFA-approved practice in other States. This is acknowledged by HCFA in its Notification letter, which states:

> *"A number of States have been paying for school-based services using a 'bundled rate' methodology."*

North Carolina had a reasonable expectation that its September 1995 plan amendment allowing for the use of monthly rates would ultimately be approved based on approvals for other States. In fact, North Carolina used the South Carolina Procedures Manual as a template. Other states that had similar approved State Plans and that apparently utilized a "bundled rate methodology" included Connecticut, Maryland, Massachusetts, New Jersey, New York and Ohio. At the time of the 1995 State Plan Amendment submission, there was no prohibition of bundled/monthly payments to participating LEAs. North Carolina's DMA State Plan Amendment complied with applicable practices, laws and regulations regarding the payment of actual cost incurred by efficiently and economically operated providers.

**THE STATE'S USE OF A PAYMENT METHODOLOGY ALLEGEDLY NOT DESCRIBED IN AN APPROVED STATE PLAN.** The draft audit report states repeatedly that the $5.3 million in issue was paid using a methodology that was not in accordance with North Carolina's approved Medicaid State plan. This is incorrect; North Carolina's approved plan authorized payment to public entities based upon fees not to exceed reasonable costs. The report also ignores the fact that because of the requirements of the Medicaid Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") program, the State was obligated to pay for the LEA services in question even if the services were not covered under the State plan and even if the State plan did not describe an approved payment methodology.

The EPSDT provisions of the Social Security Act require States to provide or arrange for the provision of corrective treatment for a child for any condition disclosed by any "screen." 42 U.S.C. §§ 1396a(a)(43)(A)-(C). States are required to provide any "necessary health care, diagnostic services, treatment, and other measures described in [section 1905(a) of the Act] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, *whether or not such services are covered under the State plan.*" Social Security Act, § 1905(r)(5), 42 U.S.C. § 1396d(r)(5) (emphasis added). HCFA has said that "any encounter with a health professional practicing within the scope of his or her practice would be considered to be a screen." 58 Fed. Reg. 51291 (1993). HCFA has also explained that under EPSDT, "a State no longer has the discretion to decide which optional services it [will] furnish to EPSDT participants." 58 Fed. Reg. 51290 (1993).

One broad category of services that States may cover under their Medicaid plans, *and that therefore must be covered under EPSDT,* is "any medical or remedial care or services . . . provided by licensed practitioners within the scope of practice as defined under State law." 42 U.S.C. § 1396d(a) (6); 42 C.F.R. § 440.60(a). This means that States must pay for necessary remedial services provided to children by individuals such as speech language teachers who hold the equivalent State licenses that permit them to practice only in limited environments such as schools.

Congress recognized the important role that school-based providers play in providing adequate access to medically necessary services for Medicaid-eligible children, and specifically intended that school-based providers of services would furnish services mandated under the EPSDT program. In reporting the bill (H.R. 3299) that was adopted as section 6403 of the Omnibus Budget Reconciliation Act of 1989 ("OBRA '89"), the House Budget Committee stated that the bill:

> *"clarifies that States are without authority to restrict the classes of qualified providers that may participate in the EPSDT program. Providers that meet the professional qualifications required under State law to provide an EPSDT screening, diagnostic, or treatment service must be permitted to participate in the program even if they deliver services in school settings, and even if they are qualified to deliver only one of the items or services in the EPSDT benefit."* H.Rep. No. 247, 101st Cong., 1st Sess. 400 (1989) (emphasis added).

In addition, HCFA has advised that a State may *not* limit the settings in which it covers medically necessary services for EPSDT-eligible children. See 62 Fed. Reg. 47896, 47898 (1997) ("personal care services outside the home is not optional with respect to those individuals who are eligible" under EPSDT). These authorities also show that North Carolina was required under its Medicaid program to pay for school-based medical and remedial services for Medicaid-eligible children, whether or not the services were covered under an approved State plan payment methodology.

In summary, under EPSDT, North Carolina's Medicaid program was required to pay for IEP-related medical or remedial services provided to Medicaid-eligible children by licensed practitioners, even if the services (and the payment methodology) were not described in North Carolina's Medicaid State plan, and even if no payment methodology had been established before services were provided. Moreover, States are not required to describe their payment methods for school-based services in their State plans, so the fact that the $5.3 million was paid under a methodology not described in the State plan does not provide a basis for disallowing the State's claim for FFP. A recommended adjustment of $5.3 million is entirely inequitable given the fact that no question has been raised about the fact that services were provided to eligible children.

There are court decisions that offer guidance about how a State may pay for medical or remedial services that it is required to cover under EPSDT, but for which there

is no State reimbursement methodology. The cases are *Pereira v. Kozlowski*, 805 F. Supp. 361 (E.D. Va. 1992), and *McLaughlin v. Williams*, 801 F. Supp. 633 (S.D. Fla. 1992), both of which pertain to States' coverage of organ transplant operations for Medicaid eligible children even though the States' Medicaid plans purported did not cover transplants. In *Pereira*, the court ordered the State of Virginia to pay the hospital's charges for the necessary procedure. In *McLaughlin*, the court ordered the State to provide the financial guarantee that the hospital required. These cases establish that, in complying with the EPSDT mandate to pay for necessary medical or remedial services for children even if the services are not covered under the State plan, a State may pay what the provider charges for a service.

North Carolina's consultants assisted LEAs to develop cost-based charge structures for IEP-related services provided to school children. The State did more than was necessary in setting out to establish monthly rates that were cost-based. Since the audit report does not suggest that the LEA's charges were in any way unreasonable, the State was entitled to pay the monthly rates charged. For this reason too, there is no basis for the recommended audit adjustment.

THE STATE'S USE OF MORE THAN ONE PAYMENT METHODOLOGY FOR SCHOOL-BASED SERVICES. There is nothing improper about the fact that the State has paid some LEAs using its fee-for-service rates established for various types of therapists and has paid other LEAs using monthly rates. HCFA has specifically recognized that a State may choose to pay for a service under one or more options. For example, a State may pay for nursing services as clinic services that require physician supervision, or instead pay for them -- perhaps at a different rate -- as nurse practitioner services that do not require physician supervision. *See* 60 Fed. Reg. 19856, 19858, 19859 (1995). There was nothing improper about North Carolina's paying for some school-based services (such as speech pathology or audiology services) as therapy services, at established fee-for-service rates; and paying for other services (such as services by speech-language teachers, whose State certification, according to an opinion of the Attorney General of North Carolina, is the equivalent of licensure under State law)

as services by other licensed practitioners of the healing arts, on the basis of charges billed by the LEAs.

In addition, there is no requirement under Medicaid that all providers of a type of service be paid at the same rate or under the same billing arrangement. Just as under the Medicare program, a State is free to utilize different rate structures on the basis of whether a provider has agreed to a particular billing arrangement, whether a provider has the capability to bill in a particular format, whether a provider is a safety-net provider or instead can be selective about its patients, etc.

The State's approach does not mean that there was not a single, Statewide Medicaid program in operation for school-based services. The statutory requirement of "statewideness" means that Medicaid benefits for beneficiaries must be available in all areas of the State, without regard to the ability of local jurisdictions to fund the program. At all times, North Carolina's Medicaid program has operated as a statewide program. The use of different payment methodologies does not affect statewideness, and the facts do not support an audit finding about lack of State-wide operation.

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As for the $ 3 million, it is still in a trust fund, held in the event that the State does have to refund these monies. However, we implore HCFA to allow the State to retain and pass these funds along to the rightful LEA benefactors who are currently in a financial crisis due to natural disasters and the most serious economic downturn the State has incurred in over a decade. These funds have been earned multiple times over the past years with local/State dollars expended for these eligible services to eligible students. To recommend a payback of these funds under these circumstances is unconscionable.

SUBCONTRACTOR OVERSIGHT. The audit report is critical of the "far reaching" duties of the State's subcontractor in assisting in identifying and developing payment methodologies. Yet, it is a common and accepted practice for States (and for HCFA, under the Medicare program) to utilize consultants and contractors to assist in developing payment methodologies. If the State had the necessary resources to perform some of these activities, there would have been no need to employ a subcontractor. It is a demonstrated fact that the State has not availed itself of all of the resources available

from the Federal level. Yet in this and other audits, North Carolina and other States have been severely criticized for using contractors to maximize Federal revenues.

QUALITY ASSURANCE. The draft audit report suggests that the recommended adjustment is warranted because the State utilized less stringent prior authorization and other quality assurance policies with respect to services provided by LEAs than were utilized under with respect to other State plan services. This comment ignores the fact that States may regard specification of the need for services in a State's IEP as a sufficient basis for concluding that the services provided were necessary. The auditors do not suggest that there is any more basis for concern about fraudulent claims, *i.e.*claims for services not provided, by LEAs than there is about fraudulent claims by other types of health care providers.

The draft audit report also cites an unidentified "State official" as writing that "*...we received a revised Program Manual from the consultants which in our judgement eliminates the last vestiges of the original quality assurance mechanisms.*" Eliminating the original quality assurance mechanisms does not mean that there were no alternative quality assurance mechanisms. Also, what is not stated is that the subcontractor was assisting LEAs through a simpler, more efficient billing process. Efficiency and economy as well as quality assurance are valid considerations in establishing a payment methodology.

In regard to the unnamed State official referenced in the draft report, we have two comments.

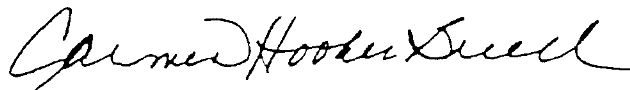
- First, it is extremely difficult for the Department to respond to something to which we have not been privy. We do not have a copy of the cited letter. When we requested a copy of this referenced correspondence from the OIG audit working papers, we were informed that the letter from the unnamed State official was "Privileged Information." If the purpose of this audit report is to cite a selective unofficial opinion from one of the Department's 17,000+ employees, then there is not much purpose in this response. If the OIG wants an official response from Department management, then the official statements need to be solicited from

the Division Director or the Department Secretary—not from some undisclosed "confidential" source. Using and yet withholding this unidentified writing does not lend credibility to the audit process.

- Secondly, Division management disagreed with the position of this unknown "State official." As noted in the audit report, the Division of Medical Assistance removed the requirement of prior approvals for "all providers retroactive to November 1, 1999," an action that DMA would not have taken if it believed that prior authorization is always necessary for quality assurance or program integrity.

**In conclusion**, we respectfully disagree with a number of points made in the audit report for the reasons stated. The audit report does not represent an equitable position for North Carolina in relation to other States. Anyone can look at the number of eligible students and the medical services provided through the State's LEAs and easily determine that the funds in question have been expended many times over during the last decade. During the past decade, North Carolina state government has used limited financial resources to provide these services which are eligible for Medicaid funding. We respectfully request that the OIG reconsider its position and that HCFA allow the State to retain these funds for the benefit of North Carolina's needy children.

Sincerely yours,



Carmen Hooker Buell

CHB:dcs

cc: Lanier M. Cansler
Satana Deberry
Dick Perruzzi