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Executive Summary

This audit report summarizes the results of the Office of Auditor General's (OAG) performance audit of Medicaid reimbursement program controls and processes in place to support reimbursement for special education health-related services provided to Medicaid eligible students, including compliance with laws, rules, and regulations. An area of potential concern is the under or over utilization of Medicaid reimbursements to cover eligible costs incurred by FCPS. The audit was performed in accordance with the Fiscal Year (FY) 2019 Audit Plan approved by the Fairfax County School Board.

The Individuals with Disabilities Education Act (IDEA) requires local education agencies, such as FCPS, to provide students with disabilities a free appropriate public education, including special education and related services according to each student’s Individualized Education Program (IEP). While FCPS is financially responsible for educational services provided to special education students, related services identified in a Medicaid eligible student’s IEP may be eligible for reimbursement from Virginia Department of Medical Assistance Service (DMAS), whom Centers for Medicare and Medicaid Services (CMS) has authorized to reimburse for services. As discussed in this report, the FCPS Medicaid reimbursement team has made considerable progress in increasing reimbursements for each year during the past four fiscal years and continues to explore new areas for growth.

The primary objectives of the audit were to perform the following:

- Assess whether FCPS Medicaid reimbursement program follows the relevant compliance requirements.
- Determine if FCPSMED (EasyTrac), the system established in 2015 to generate Medicaid claims for submission to the Virginia Department of Medical Assistance Services, serves its intended purpose.
- Evaluate effectiveness of the FCPS process for identifying Medicaid eligible students and obtaining Medicaid reimbursement.

While OAG did not note any instances of non-compliance with Medicaid program requirements during our testing of a sample of student service records, OAG observed that 3,356 services (3.6% of billable services), approximately $47,000 were not reimbursed in FY 2018 due to plan of care or diagnostic interview examination (plan of care1) documentation not being completed in a timely manner (Finding 1). However, after the conclusion of fieldwork, the Medicaid reimbursement team provided an updated rejected services report which identified a revised quantity. This new report noted a total of 1,459 services (1.6% of billable services) rejected for no plan of care at service date (a decrease of 1,897 services from original report), which, per the Medicaid reimbursement team, amounts to approximately $17,000 of unbilled services. The decrease in rejected services on the new report was mostly a result of the original report including services which were not billable due to students not being Medicaid eligible. While an IEP is the prerequisite for and legally obligates FCPS to provide special education services to a student, an active plan of care must exist prior to requesting reimbursement from Virginia Department of Medical Assistance Services (DMAS) for Audiology, Occupational Therapy (OT), Physical Therapy (PT), Psychological, and Speech Language Pathology services. As a result of this low risk finding, FCPS may not be able to obtain reimbursement for services which would otherwise be billable. Additionally, the existence of unbilled services for a student may decrease the

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1 For the purpose of this report, OAG refers to both the plan of care and diagnostic interview examination as a plan of care. While not synonymous, both the plan of care and diagnostic interview examination act as the document which identifies the services necessary to support the student’s health care and support needs.
cost report settlement claiming percentage calculated during the annual billing compliance review (BCR) process.

As a result of this finding, OAG had two recommendations:

1. Medicaid program team provide validation to OAG that 1,459 was the correct rejected services count for no plan of care and diagnostic interview examination at service date during FY 2018.

2. Medicaid program team consider reviewing existing FCPSMED Manual guidance and collaborate with service providers to enhance plan of care requirements by adding specific, measurable timeliness requirements.

Management concurs with OAG’s recommendations and will perform corrective actions, as detailed in the management response to Finding 1.

OAG also noted two observations, one related to the compensation agreement with FCPSMED (EasyTrac) vendor, Public Consulting Group (PCG), and one related to random moment time study participant training.

FCPS currently contracts with PCG for FCPSMED (an EasyTrac product), a web-based tool for documenting the delivery of health services to students. The FCPS contract with PCG provides that FCPS compensate PCG, in part, on a contingency fee basis; seven percent (7%) of net reimbursement, which is defined in the FCPS contract as "the total amount received by FCPS for direct service billing, cost settlement, and Medicaid administrative claiming." As Medicaid reimbursement increases each year, so does the contingency fee paid to PCG (Observation 1).

Additionally, FCPS staff who participate in the Medicaid program are not currently required to participate in random moment time study participant training provided by University of Massachusetts Medical School (UMASS), a third party who administers the time study and provides other Medicaid services for DMAS. According to UMASS, "well trained participants lead to higher reimbursement" (Observation 2).

OAG is pleased to report that the audit team found a professional and organized group leading a complex Medicaid reimbursement program. The small team, who must coordinate with hundreds of service providers, including both FCPS employees and contractors, as well as other FCPS staff, provided OAG with notable consultation, cooperation, and courtesies throughout this audit.
Background, Scope and Objectives, and Methodology

Background

The Social Security Amendments of 1965 created Medicaid by adding Title XIX to the Social Security Act. Under the program, the federal government provides matching funds to states to enable them to provide medical assistance to residents who meet certain eligibility requirements. The objective is to help states provide medical assistance to residents whose incomes and resources are insufficient to meet the costs of necessary medical services.

The Centers for Medicare and Medicaid Services (CMS), part of U.S. Department of Health and Human Services, has authorized Virginia Department of Medical Assistance Services (DMAS) to reimburse services provided within a local education agency. DMAS reimburses local education agencies for two different categories of health care coverage plans for students, Medicaid and Medicaid Expansion or Family Access to Medical Insurance Security (FAMIS). Fairfax County Public Schools (FCPS) has been an authorized Medicaid provider since July 1, 1997.

The FCPS Medicaid reimbursement program receives reimbursement through three programmatic sources:

- **Direct Services** – Monthly reimbursement based on the delivery of health-related services by licensed therapists and clinicians. Claims must be submitted for reimbursement within one year of the date of service.

- **Administrative Activity Claiming (Administrative Claiming)** – Quarterly reimbursement to obtain partial federal reimbursement for activities in support of the Medicaid program or in support of the delivery of health-related services. Reimbursement amount based on salary and benefits of direct service providers and administrative staff, as well as other costs. Funding percentage is based on Medicaid eligibility percentage, total student membership, and a random moment time study.

- **Cost Report Settlement** – Annual reimbursement amount based on salary and benefits of direct service providers, direct service claim submissions, administrative costs, state-wide time study results, parental consent responses, Medicaid eligibility percentage, and special education membership. Funding percentage is based on a billing compliance review (BCR).

As shown below, during the past four fiscal years, total FCPS Medicaid reimbursement has increased year-over-year:

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Direct Service Reimbursement (a)</th>
<th>Administrative Claiming Reimbursement (b)</th>
<th>Cost Report Settlement Reimbursement (c)</th>
<th>Total Medicaid Reimbursement (a+b+c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2018</td>
<td>$1,196,339</td>
<td>$190,474</td>
<td>$4,472,281</td>
<td>$5,859,094</td>
</tr>
<tr>
<td>FY 2017</td>
<td>$1,251,437</td>
<td>$311,896</td>
<td>$2,842,351</td>
<td>$4,405,684</td>
</tr>
<tr>
<td>FY 2016</td>
<td>$897,864</td>
<td>$241,880</td>
<td>$1,850,193</td>
<td>$2,989,937</td>
</tr>
<tr>
<td>FY 2015</td>
<td>$928,159</td>
<td>$195,857</td>
<td>$1,203,382</td>
<td>$2,327,398</td>
</tr>
</tbody>
</table>

2 Amounts based on reimbursement posting date, except for annual cost report settlement which is shown in the year subsequent to submission as payment generally occurs close to fiscal year cut-off. For example, FY 2017 cost report was submitted in December 2017 and paid in June 2018 (FY 2018) while FY 2016 cost report was submitted in December 2016 and paid in July 2017 (also FY 2018).
Direct Services

The Individuals with Disabilities Education Act (IDEA) requires local education agencies, such as FCPS, to provide students with disabilities a free appropriate public education, including special education and related services according to each student’s Individualized Education Program (IEP). While FCPS is financially responsible for educational services provided to special education students, health-related services (related services) identified in a Medicaid eligible student’s IEP may be eligible for reimbursement from DMAS. FCPS coverage of DMAS health-related services include the following:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>FCPS Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical therapy, occupational therapy, and speech-language therapy</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychiatry, psychology and mental health</td>
<td>Yes</td>
</tr>
<tr>
<td>Audiology</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing</td>
<td>Partial ³</td>
</tr>
<tr>
<td>Personal care</td>
<td>No ⁴</td>
</tr>
<tr>
<td>Medical evaluation</td>
<td>No</td>
</tr>
<tr>
<td>Specialized transportation</td>
<td>Pilot Program⁵</td>
</tr>
</tbody>
</table>

In order for related services to qualify for reimbursement, a Medicaid eligible student must:

- Have an Individual Education Plan (IEP) for special education
- Receive a Medicaid covered service, pursuant to the IEP, provided by a Medicaid qualified practitioner
- Be granted parental consent for FCPS to release billing information to DMAS
- Have an active plan of care completed by a DMAS qualified provider

A special education student’s IEP acts as the authorization for services; however, prior to obtaining reimbursement for services from DMAS, a plan of care or diagnostic interview examination document must be created which identifies the services necessary to support the student’s health care and support needs. Per DMAS Local Education Agency Provider Manual – Chapter VI – Utilization Review and Control, the plan of care must include, at a minimum:

- The medical/treating diagnosis or identifying issue to be addressed by the service
- Type, amount, and frequency of service (depending on the service)
- Measurable long-term goals (up to one year duration maximum)
- Therapeutic interventions
- Goals that relate to the services in the IEP
- Signature, title, and date of DMAS qualified provider completing the plan of care

Students who receive ongoing psychiatry, psychology, and mental health services

³ FCPS began seeking reimbursement for nursing services provided to students during FY 2018. Nursing services are provided, funded, and managed by the Fairfax County Health Department (FCHD).
⁴ Personal care services will be re-evaluated following the full implementation of nursing and specialized transportation services.
⁵ FCPS began a specialized transportation services pilot during the summer 2018 extended school year (ESY). The pilot requires FCPS, for confidentiality purposes, to track all students who ride the bus each day, rather than just Medicaid eligible students who are claimed for reimbursement. In order for transportation services to be eligible for reimbursement, a student must have a billable service on the day transportation was provided. Bus drivers or attendants are required to sign program documentation daily.
(counseling services) require an initial diagnostic interview examination in order for services to be billed.

While not required by DMAS to seek reimbursement for direct services, parental consent is required by Virginia Department of Education (VDOE) for FCPS to release student information to DMAS. Consent is provided via the Medicaid parent consent process. Parental consent regulations were changed in 2012 to require parents to sign parent consent only once. Prior to the change, consent was required for every new IEP and addendum.

Reimbursement rates for direct services are based on the estimated costs for services furnished and are dependent on the type of services being provided and the group size of the session.

<table>
<thead>
<tr>
<th>Period</th>
<th>Medicaid Eligible Students with Billable Service⁶</th>
<th>Direct Service Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2018</td>
<td>3,643</td>
<td>$1,196,339</td>
</tr>
<tr>
<td>December 2017</td>
<td>3,649</td>
<td>$1,251,437</td>
</tr>
<tr>
<td>December 2016</td>
<td>3,380</td>
<td>$897,864</td>
</tr>
<tr>
<td>December 2015</td>
<td>2,194</td>
<td>$928,159</td>
</tr>
</tbody>
</table>

Administrative Claiming and Cost Report Settlement

Local education agency providers submit claims based on the estimated costs for services furnished. DMAS makes interim payments on these cost based claims. Final payment is based on each local education agency or school division’s costs reported and settled on an annual cost report. Personnel costs are determined by multiplying payroll costs of qualified practitioners times the percent of time qualified practitioners spend on medical services (determined by a statewide time study) times the percentage of IEP Special Education students that are Medicaid or FAMIS eligible. Non-personnel costs and indirect costs are also included in the cost basis. Local education agencies must submit interim claims to receive final payment through the cost based reimbursement process. All interim payments are subject to recovery if a provider fails to file a cost report for services.

Quarterly Administrative Claiming provides reimbursement for:

- Medicaid outreach
- Medicaid application assistance
- Specialized transportation scheduling/arranging
- Translation services related to health care service delivery
- Program planning and policy development related to the delivery of health services
- Referral, coordination, and monitoring of health services.

During the year, staff may be required to participate in a statewide random moment time study. This time study is a statistically valid means of measuring the amount of time that participants spend doing different types of activities. FCPS reports all participants in the Medicaid reimbursement process to DMAS quarterly. The time study is performed by sampling a sub-set of all possible working minutes in time for a group.

The three groups include:

- Direct Service – Nursing, Psychological, and Medical Services

⁶ Student count as of December 1, 2018; includes Medicaid eligible students with billable service, regardless of parental consent.
• Direct Service – Therapy Services
• Administrative Only

For the randomly selected moment (i.e. one minute of time), the participant who recorded that moment is required to report what task was being performed at that exact time. Time study results are used for calculating both administrative claiming and the cost report settlement reimbursement amounts.

Final cost settlement is designed to calculate the cost of Medicaid covered services provided to Medicaid eligible students by Medicaid qualified practitioners. The billing compliance review (BCR) process is used to determine the percentage of Medicaid services billed and paid over the total number of billable services delivered. The BCR consists of randomly selecting 50 students and determining the number of Medicaid qualified services provided to those students and the number of those services that were paid. Final reimbursement is reduced by the claiming percentage, which is applied to the entire cost report.

\[
\frac{\text{# of services paid (from interim billing)}}{\text{# of billable services delivered}} = \text{Claiming Percentage}
\]

As shown below, during the past four fiscal years, administrative claiming reimbursement has remained relatively consistent while cost report settlement reimbursement has increased each year:

<table>
<thead>
<tr>
<th>Period</th>
<th>Administrative Claiming Reimbursement</th>
<th>Cost Report Settlement Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2018</td>
<td>$190,474</td>
<td>$4,472,281</td>
</tr>
<tr>
<td>FY 2017</td>
<td>$311,896</td>
<td>$2,842,351</td>
</tr>
<tr>
<td>FY 2016</td>
<td>$241,880</td>
<td>$1,850,193</td>
</tr>
<tr>
<td>FY 2015</td>
<td>$195,857</td>
<td>$1,203,382</td>
</tr>
</tbody>
</table>

**FCPSMED**

FCPS currently contracts with Public Consulting Group (PCG) for FCPSMED (an EasyTrac product), which is a web-based tool for documenting the delivery of health services to students. FCPSMED is primarily used by FCPS service providers for documenting direct services provided to special education students, including Medicaid eligible students whose services qualify for reimbursement from DMAS.

IEPs are documented and maintained in Special Education Administrative System for Targeting and Reporting Success (SEA-STARS) and are uploaded into FCPSMED on a nightly basis. Service providers are responsible for reviewing any new or amended IEPs for students within their caseload for the purpose of creating a plan of care, which is a prerequisite for billing.

Data entered into FCPSMED is also utilized during the BCR process for determining the percentage of Medicaid reimbursable services billed and paid.

**FCPS Medicaid Eligibility Matching Process**

Medicaid eligibility matching is the process to identify Medicaid eligible students within FCPS. This process is essential to identify student’s whose services may be billed to DMAS as well as for calculating quarterly administrative claiming and annual cost report settlement Medicaid eligibility rates. School Divisions complete a minimum of five matchings per year.
The match for each quarter for administrative claiming only includes Medicaid and Medicaid Expansion students. An annual match performed on December 1 for the cost report includes all Medicaid, Medicaid Expansion and FAMIS students. The following processes are used to determine which FCPS students are eligible, may be eligible, or not eligible for Medicaid.

1. DMAS provides a ‘snapshot’ of Medicaid enrollees from Fairfax county, other surrounding counties, and cities effective as of the 1st day of the 3rd month of the quarter (3/1, 6/1, 9/1 and 12/1). The file includes students aged 3 – 22 and is used by FCPS Department of Information Technology (DIT) to identify Medicaid enrolled FCPS students.

2. FCPS provides the DMAS ‘snapshot’ of Medicaid enrollees to PCG. The file is used by PCG to identify Medicaid enrolled FCPS students who have been uploaded into the FCPSMED system.

3. DIT provides a quarterly ‘snapshot’ of the membership list of all students that are enrolled in FCPS schools based on the 1st day of the 3rd month of the quarter (3/1, 6/1, 9/1 and 12/1). It includes students aged 3 – 22 and is used to identify Medicaid enrolled FCPS students through a state-wide eligibility list the University of Massachusetts Medical School (UMASS) receives from DMAS.

FCPS Medicaid special education student eligibility rates for the past four fiscal years:

<table>
<thead>
<tr>
<th>Cost Report Settlement</th>
<th>Matching Period</th>
<th>Medicaid Special Education Students</th>
<th>Total Special Education Students</th>
<th>Medicaid Eligibility Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2018</td>
<td>December 2017</td>
<td>5,598</td>
<td>26,899</td>
<td>20.82%</td>
</tr>
<tr>
<td>FY 2017</td>
<td>December 2016</td>
<td>5,519</td>
<td>26,085</td>
<td>21.16%</td>
</tr>
<tr>
<td>FY 2016</td>
<td>December 2015</td>
<td>5,223</td>
<td>25,716</td>
<td>20.31%</td>
</tr>
<tr>
<td>FY 2015</td>
<td>December 2014</td>
<td>4,734</td>
<td>25,504</td>
<td>18.56%</td>
</tr>
</tbody>
</table>

Parental Consent Process

In accordance with the Family Educational Rights and Privacy Act (FERPA), FCPS is required to obtain parental consent before disclosing information about a student with a disability, which includes billing DMAS for Medicaid eligible students.

FCPS seeks to obtain parental consent to bill for Medicaid services for all students with an IEP, regardless of Medicaid eligibility at that time. This process ensures consistency in the information shared by FCPS staff during IEP meetings and equity in access to information for all parents/guardians. FCPS Medicaid reimbursement billing occurs at no cost to the student/their family as private insurance is not billed and out-of-school Medicaid benefits are not affected. Parental consent is only required one time.

While parental consent does not impact delivery of student’s services, denial of consent affects the district’s ability to access funds that benefit the education of students with disabilities.

During school year 2017-2018, there were 334 Medicaid eligible students in which FCPS did not have parental consent to bill for Medicaid services. Per discussion with the Medicaid reimbursement program team, as of April 30, 2019, FCPS has not received parental consent.

\(^7\) Medicaid Expansion and FAMIS special education student eligibility percentages are calculated separately and are generally lower than Medicaid eligibility rates (between 2% and 7%).
to bill for Medicaid services for 221 of these students.

**Scope and Objectives**

We conducted this audit in accordance with generally accepted government auditing standards, with the exception of peer review. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our finding, observations and conclusions based on our audit objectives. This audit covered the period July 1, 2017 to June 30, 2018 (FY 2018) as well as data trends covering FY 2015 through 2018.

The primary objectives of the audit were to perform the following:

- Assess whether FCPS Medicaid reimbursement program follows the relevant compliance requirements.
- Determine if FCPSMED (EasyTrac), the system established in 2015 to generate Medicaid claims for submission to the Virginia Department of Medical Assistance Services, serves its intended purpose.
- Evaluate effectiveness of the FCPS process for identifying Medicaid eligible students and obtaining Medicaid reimbursement.

**Methodology**

To fulfill the audit objectives, the audit team performed the following:

- Reviewed applicable laws, rules, regulations, and FCPS policies and procedures
- Interviewed Medicaid reimbursement program personnel
- Obtained understanding of internal controls
- Analyzed reimbursement trend information
- Reviewed PCG contract and expenditure information
- Inspected sample of direct services and related documentation maintained within FCPSMED

OAG utilized the random sampling technique to select a sample of 29 records from a population of 93,393 service records associated with 3,586 Medicaid eligible students with a billable service in FY 2018. This statistical sampling method allows for each service record to have an equal chance of being selected. As this population includes both reimbursed and non-reimbursed services, OAG was able to evaluate whether the reimbursed services included in the sample were compliant with Medicaid requirements and non-reimbursed services were appropriately not reimbursed. A sample size of 29 was determined to be adequate to achieve at least a 95% confidence factor.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Sampled Records</th>
<th>Service Type Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech Language</td>
<td>16</td>
<td>68,464</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>5</td>
<td>15,253</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>4</td>
<td>5,908</td>
</tr>
<tr>
<td>Psychological</td>
<td>3</td>
<td>3,261</td>
</tr>
<tr>
<td>Audiology</td>
<td>1</td>
<td>507</td>
</tr>
<tr>
<td><strong>Total Sampled</strong></td>
<td><strong>29</strong></td>
<td><strong>93,393</strong></td>
</tr>
</tbody>
</table>
OAG is free from organizational impairments to independence in our reporting as defined by government auditing standards. OAG reports directly to the Fairfax County School Board through the Audit Committee. We report the results of our audits to the Audit Committee and the reports are made available to the public via the FCPS website.
Audit Findings, Recommendations, and Management’s Responses

The finding(s) within this report has been attributed a risk rating in accordance with established risk criteria as defined in Table 1.

Table 1 – Risk Criteria

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
</table>
| High  | One or more of the following exists:  
|       | • Controls are not in place or are inadequate.  
|       | • Compliance with legislation and regulations or contractual obligations is inadequate.  
|       | • Important issues are identified that could negatively impact the achievement of FCPS program/operational objectives. |
| Moderate | One or more of the following exists:  
|         | • Controls are in place but are not sufficiently complied with.  
|         | • Compliance with subject government regulations or FCPS policies and established procedures is inadequate, or FCPS policies and established procedures are inadequate.  
|         | • Issues are identified that could negatively impact the efficiency and effectiveness of FCPS operations. |
| Low   | One or more of the following exists:  
|       | • Controls are in place but the level of compliance varies.  
|       | • Compliance with government regulations or FCPS policies and established procedures varies.  
|       | • Issues identified are less significant but opportunities exist that could enhance FCPS operations. |

During this audit, OAG identified one low risk finding and two observations which are detailed below. The observations are classified as such due to no specific criteria or the lack of prescribed compliance requirements.
Finding 1 – Plan of Care Timeliness

**Risk Rating:** Low – Issues identified are less significant but opportunities exist that could enhance FCPS operations.

**Condition:**

While OAG did not note any instances of non-compliance with Medicaid program requirements during our detailed testing of a sample of student service records, OAG observed that 3,356 services (3.6% of billable services) were not reimbursed in FY 2018 due to plan of care or diagnostic interview examination documentation not being completed in a timely manner. While an IEP is the prerequisite for and legally obligates FCPS to provide special education services to a student, an active plan of care must exist to request reimbursement for Audiology, Occupational Therapy (OT), Physical Therapy (PT), Psychological\(^8\), and Speech Language Pathology services.

FCPSMED is configured to reject (i.e. not submit to DMAS for reimbursement) services provided prior to an active plan of care being created. FCPS Medicaid reimbursement program staff can review a report which itemizes rejected services.

A FCPSMED system report of rejected services provided to OAG, which was generated by PCG, noted that 3,401 services were rejected during FY 2018 (3,356 for no plan of care at service date and 45 others for various reasons). The Medicaid reimbursement team provided an estimate generated by PCG which indicated a total of $47,227 of unbilled services associated with the 3,401 rejected services.

However, after the conclusion of fieldwork, the Medicaid reimbursement team provided an updated rejected services report which identified a revised quantity. This new report noted a total of 1,459 services (1.6% of billable services) rejected for no plan of care at service date (a decrease of 1,897 services from original report). The Medicaid reimbursement team provided an estimate generated by PCG which indicated a total of $17,044 of unbilled services associated with the 1,459 rejected services. According to the Medicaid reimbursement team, after consulting with PCG, the decrease in rejected services on the new report was mostly a result of the original report including services which were not billed due to students not being Medicaid eligible at the time of service\(^9\). As this new report was not provided until after the completion of fieldwork, OAG was unable to validate the new totals.

While the FCPSMED Manual states that once an IEP is signed by the parent, a new [plan of care] must be completed immediately following every annual IEP meeting, the manual does not address instances where a student becomes Medicaid eligible subsequent to the creation of an IEP.

Notwithstanding the quantity of FY 2018 services rejected for no plan of care, there are no compliance repercussions for not completing a plan of care in a timely manner; however, services provided prior to the plan of care or diagnostic interview examination being made active will not be reimbursed by DMAS. Therefore, without a plan of care, FCPS is not able to seek direct service reimbursement for these services. The plan of care and diagnostic interview examination documents are not allowed to be backdated. As a result, services provided prior to plan of care creation are not eligible for reimbursement even after a plan of care is created.

\(^8\) A diagnostic interview examination, which includes a plan of treatment, is required for ongoing psychological services.

\(^9\) Per the Medicaid reimbursement team, the decrease in rejected services can also be attributed to students who were erroneously included in the initial rejected services report but was removed from the revised report because a diagnostic interview examination was completed prior to service date(s).
In addition to not being able to obtain reimbursement for direct services provided prior to the creation of a plan of care, the existence of these non-billed services could negatively impact the cost report settlement billing compliance review (BCR). The cost report is used to report costs incurred by FCPS to provide DMAS covered health-related direct services provided to students pursuant to an IEP. The BCR is used to determine the percentage of Medicaid reimbursable services billed and paid. During the BCR process, 50 students are randomly sampled by DMAS for review. For these 50 students, the FCPS Medicaid team calculates a claiming percentage, as follows:

\[
\frac{\text{# of services paid (from interim billing)}}{\text{# of billable services delivered}} = \text{claiming percentage}
\]

This claiming percentage is then applied to the total costs reported on the cost report. While it is not possible to predict which students will be selected for the BCR, the existence of unbilled services for a selected student, including services not billed for lack of an active plan of care or diagnostic interview examination, could decrease the claiming percentage.

Criteria:

DMAS Local Education Agency Provider Manual – Chapter IV – Covered Services and Limitations, includes the following excerpts related to plan of care and diagnostic interview examination:

**Audiological Services**

Audiological services are services provided to a student that meet all of the following conditions:
- The services must be included in the IEP and must be directly and specifically related to an active written plan of care designed by a licensed Audiologist (18VAC30-21-10 et seq.);
- Audiological assessments included in the IEP are covered without needing a plan of care if this is the only service being provided;

**Occupational Therapy**

Occupational therapy services are services provided to a student who meets all of the following conditions:
- The services must be included in the student’s IEP and must be directly and specifically related to an active written plan of care developed by a licensed occupational therapist (18VAC85-80-100);

**Physical Therapy**

Physical therapy services may be reimbursed by DMAS when all of the following conditions are met:
- The services must be included in the student’s IEP and must be directly and specifically related to an active written plan of care developed by a licensed physical therapist.

---

10 Services could be unbilled for other reasons besides no active plan of care, including parental consent not being obtained, service provided by non-licensed person, student not Medicaid eligible at time of service, etc.
Psychological Services

Psychiatry, psychology and mental health services are those services provided to a student who meets all of the following conditions:

- Services must be directly and specifically related to an active written plan of care designed by a DMAS qualified provider, as defined in Chapter II of this manual, within the scope of his or her practice as defined under state law or regulations;
- Students must have an initial Diagnostic Interview Examination to establish the need for ongoing treatment, if needed. For on-going services, the ICD diagnosis should correspond with a psychiatric or substance abuse diagnosis from the current Diagnostic and Statistical Manual of Mental Disorders (DSM). If the student requires ongoing treatment, the behavioral health diagnosis needs to be current (within one year from date of service) and provided services must address the diagnosis;

Speech Language Therapy

Speech-language therapy services are services provided to a student that meet all of the following conditions:

- The services must be included in the student’s IEP and must be directly and specifically related to an active written plan of care developed by a master’s level Speech-Language Pathologist (SLP) (18VAC30-21-10 et seq.) licensed by the Board of Audiology and Speech-Language Pathology (BASLP);

In addition to the DMAS Local Education Agency Provider Manual, the FCPS Medicaid reimbursement program has internal FCPSMED manuals for service providers. Within the FCPSMED manuals for Physical and Occupational Therapy providers, Speech Language providers, and Audiology providers, the following plan of care requirements are noted:

- The [plan of care] for every Medicaid/FAMIS eligible student must be prepared at least every 12 months.
- When an IEP is signed by the parent, a new [plan of care] must be completed immediately following every annual IEP meeting.
- If there is an IEP Addendum and any aspect of this service has changed, after the IEP Addendum has been signed by the parent, a new [plan of care] must be completed immediately.
- If there are no changes, the [plan of care] is completed every twelve months when the next annual IEP has been signed.

Cause:

In order to develop a plan of care, the IEP must first be completed, signed by the parent or guardian and then the IEP must be made current in the SEA-STARS system. When the IEP has been made current, it becomes the current IEP in SEA-STARS. Following this transaction, the IEP data is transmitted to the FCPSMED system on the following day at which point a plan of care can then be created. There are various reasons as to why a plan of care or diagnostic interview examination may not be completed in a timely manner.

- IEP is not made current in SEA-STARS after IEP has been signed by parent or guardian
- IEP team members are not notified when the IEP has been made current in SEA-STARS
- Prioritization of providing special education and related services to students over
performing administrative tasks such as documenting a plan of care

- Lack of specific, measurable guidance related to plan of care or diagnostic interview examination timeliness
- Students who are not eligible for Medicaid but are receiving services are not billable and would not require a plan of care or diagnostic interview examination

Effect:

FCPS is not eligible for reimbursement for direct services provided to Medicaid eligible students when no active plan of care or diagnostic interview examination exists. Additionally, the existence of unbilled services for a student could decrease the claiming percentage calculated during the annual BCR process.

Recommendation:

1. Medicaid program team provide validation to OAG that 1,459 was the correct rejected services count for no plan of care and diagnostic interview examination at service date during FY 2018.

2. Medicaid program team consider reviewing existing FCPSMED Manual guidance and collaborate with service providers to enhance plan of care requirements by adding specific, measurable timeliness requirements.

Management Response:

The FCPS Medicaid team and program offices involved, agree with OAG’s finding and recommendation.

Immediate Actions to be completed by May 31, 2019:

1. The Plan of Care (POC) caseload report and Diagnostic Interview evaluation (DIE) will be reviewed and all missing POCs and DIEs will be completed.

2. Medicaid program team will provide a validation report to OAG confirming that 1,459 records is the correct rejected services count for no plan of care and diagnostic interview examination at service date during FY 2018.

Additional Actions to be implemented in FY 2020:

3. FCPS Medicaid team and Program offices will work collaboratively to update guidance documents and Quick Reference Guides to reflect DMAS and FCPS Program office plan of care and diagnostic interview examination requirements by October 31, 2019.

4. FCPS Medicaid team will provide training resources to all providers regarding the completion of plans of care and diagnostic interview examinations by October 31, 2019.

Responsible: Medicaid Program Team

Due Date: See Management Response for specific due dates
Observation 1 – PCG Vendor Compensation Agreement

FCPS currently contracts with Public Consulting Group (PCG) for FCPSMED (an EasyTrac product), which, according to the vendor website, is a web-based tool for documenting the delivery of health services to students. FCPSMED is primarily used by FCPS service providers for documenting direct services provided to special education students, including Medicaid eligible students whose services qualify for reimbursement from DMAS. However, the FCPS contract with the vendor provides that PCG is compensated, in part, on a contingency fee basis; seven percent (7%) of net reimbursement, which is defined in FCPS Contract 4400003262 as “the total amount received by FCPS for direct service billing, cost settlement, and Medicaid administrative claiming.”

The following Pricing Schedule is included in FCPS Contract 4400003262 with PCG:

<table>
<thead>
<tr>
<th>Unit Description</th>
<th>Amount (per year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance Fees</td>
<td>$20,000</td>
</tr>
<tr>
<td>Hosting</td>
<td>$60,000</td>
</tr>
<tr>
<td><strong>Annual Fee Subtotal</strong></td>
<td>$80,000</td>
</tr>
<tr>
<td><strong>Plus:</strong> Annual Maintenance and support for data management system</td>
<td>7% of net reimbursement</td>
</tr>
</tbody>
</table>

While direct service and administrative claiming reimbursement has remained relatively consistent over the past four fiscal years, cost report settlement reimbursement has increased significantly over that period. As a result, FCPS has compensated PCG an increased amount for each of the past four fiscal years.

![Medicaid Reimbursement versus PCG Contingency Fees for FYs 2015-2018](chart.png)

11 After the conclusion of fieldwork, the Medicaid reimbursement team reviewed the contract and noted that the inclusion of administrative claiming in the compensation agreement was done in error, as PCG has never provided administrative claiming services nor has it invoiced FCPS for these services. In coordination with Office of Procurement Services (OPS), the contract with PCG will be amended to remove administrative claiming from “net reimbursement.”
As shown in the above chart, as Medicaid reimbursement increases each year, so does the contingency fee paid to PCG. FCPS has paid PCG the following contingency fees during fiscal years 2015-2018, which are in addition to annual maintenance and hosting fees:

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>PCG Contingency Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2018</td>
<td>$256,027</td>
</tr>
<tr>
<td>FY 2017</td>
<td>$230,663</td>
</tr>
<tr>
<td>FY 2016</td>
<td>$144,830</td>
</tr>
<tr>
<td>FY 2015</td>
<td>$141,499</td>
</tr>
</tbody>
</table>

OAG would also like to note that, per DMAS rules, contingency fees paid to a vendor are not reimbursable in cost report settlement as only non-contingency based fees paid to vendors are allowable.

The FCPS contract with PCG is currently being renewed on an annual basis; the current contract term is through June 30, 2019.

OAG encourages the Medicaid reimbursement team to consider reviewing the current compensation agreement with PCG and conduct a cost-benefit analysis to evaluate alternative fee structures. Additionally, as this contract was initially executed in FY 2013 as a rider to Prince William County Public Schools contract # MA 041 RBH-10030-R1, the Medicaid reimbursement team should consider issuing a request for proposal (RFP) for the data management system used to record direct services provided to special education students.
Observation 2 – Random Moment Time Study Training

Department of Special Services (DSS) staff who have reimbursable health related job duties participate in a random moment time study; however, they are not currently required to participate in random moment time study participant training provided by University of Massachusetts Medical School (UMASS), a third party who administers the time study and provides other Medicaid services for DMAS. According to an October 2018 UMASS random moment time study PowerPoint presentation for the Commonwealth of Virginia Medicaid and Schools Program, online training modules are available for time study participants, and “well trained participants lead to higher reimbursement.”

As part of the administrative claiming and cost report settlement reimbursement process, designated participants may be required to respond to a random moment time study. The random moment time study is a statistically valid means of measuring the amount of time that participants spend doing different types of activities. The time study is performed by sampling a sub-set of all possible working minutes in time for a group. Program participants are divided into three pools based on their job description and whether they are a qualified service provider. Participants included in each quarterly sample are required to complete is randomly sub-sampled moment. A moment is defined by UMASS as “one minute of scheduled work time for a participant.”

When selected for the time study, participants are required to complete a randomly sub-sampled moment by typing in a response which documents the issues, ideas, or services that were being conveyed during that moment, as well as indicating whether the topic was focused on academic, behavioral, administrative, or medical concerns. Drop-down responses are also acceptable in some circumstances.

The training appears to be particularly beneficial due to the activities UMASS considers to be related to the Medicaid program, which may not always be apparent. For example, reimbursable administrative activities may include:

- Providing information about the benefits and availability of services provided by the Medicaid and FAMIS program
- Providing information about Medicaid managed care program and how to access those benefits
- Planning or coordinating training for outreach staff
- Facilitating Medicaid applications
- Translation related to Medicaid covered students
- Program planning, policy development, or interagency coordination related to health services

In its presentation, UMASS provides some examples of problematic time study responses submitted by Virginia participants. Examples of these responses include:

- I wasn’t doing anything related to Medicaid (because the student I was working with isn’t on Medicaid)
- I wasn’t with a student at the time of my moment (I was alone, documenting services) so it’s not Medicaid related
- I don’t work with Medicaid, remove me from this survey
- I don’t provide health services, I work in a school so I only provide educational services
- My student was absent so this does not apply to me

The UMASS random moment time study training video, ‘Get to the P.O.I.N.T.,” emphasizes
quality time study answers and responses, which address the following:

- **Primary Focus** – what is the main topic or subject during your moment
- **Objective** – what were you working on or trying to accomplish
- **Insight** – provide context for what was taking place
- **Necessary Detail** – only provide relevant details, but enough to understand what is happening
- **Timely** – answer the moment as well as follow-up questions within one to two days

While the Medicaid reimbursement team has indicated that this training is an emerging area, OAG encourages the team to develop a written policy which requires random moment time study participants view the training and routinely monitor participation rates.