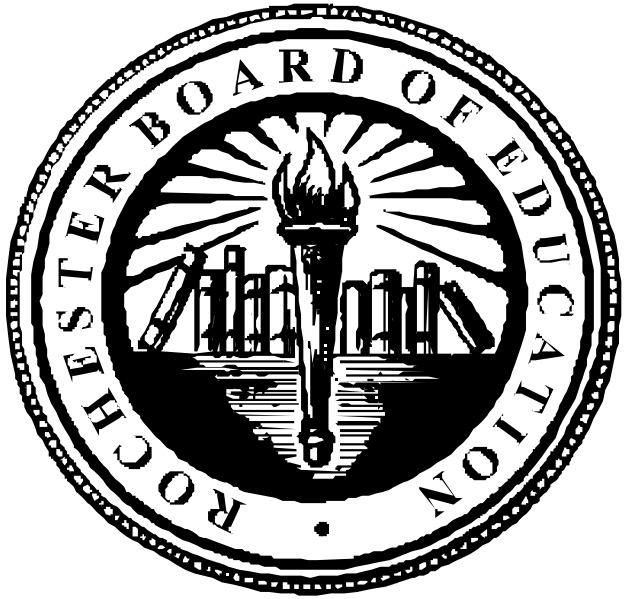
OFFICE OF AUDITOR GENERAL



Medicaid Reimbursement
FOLLOW UP

Medicaid Reimbursement
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Medicaid Reimbursement
Executive Summary

OBJECTIVE:

To evaluate the Medicaid Compliance program, as well as the reimbursement operating control environment to ensure that appropriate claims are processed for Medicaid billing.

BACKGROUND:

The District receives Medicaid reimbursement for support services to Medicaid eligible students with disabilities. The Office of the Medicaid Inspector General has increased the focus on School Supportive Health Service programs that submit Medicaid claims reimbursement. The District is required to have a mandatory Medicaid compliance program in place by December 1, 2009. Until the compliance program has been approved and accepted, RCSD is unable to submit claims for the current fiscal year. Gross receipts for 2008-09 were approximately $4 million. The District receives a portion of the total receipts as a revenue source.

SCOPE:

We will assess the adequacy of management's actions to complete improvements and resolve issues identified in our 2010 Audit. We will evaluate current compliance with respective laws, District policies, procedures, performance guidelines and best practices.

We will determine if adequate controls have been implemented to limit the District's exposure to unauthorized, non-compliant or inappropriate claims. We will evaluate the effectiveness of the internal controls, policies and procedures for Medicaid Reimbursements.

Medicaid Reimbursement
Executive Summary

CONCLUSION:

During the current economic climate, Medicaid should be closely evaluated for revenue leakage. We still believe, with effective operating processes and monitoring, additional revenues could be realized.

The Medicaid reimbursement for Special Education Related Services has experienced significant regulatory changes since our audit was performed. New York State prohibited all Districts from claiming Medicaid reimbursement for the period of July 1, 2009 – August 31, 2009. In April 2011, the State reinstated Medicaid claiming within the amended guidelines effective September 1, 2009. The Medicaid Department has made noteworthy efforts to develop processes that align with the new claims reimbursement requirements and train relevant staff. However, documented procedures still lacked detailed actions performed by the Medicaid Department to ensure the integrity of Medicaid claiming and reporting.

Management stated the Medicaid Direct system has not fully adapted to the increased demand for functionality. In lieu of this concern, management has a responsibility to develop alternate monitoring activities that will allow them to effectively manage and ensure integrity and maximization of claims reimbursement. The Medicaid Department recognizes that its operation is completely dependent upon actions of the Special Services Organization. The Medicaid Department believes that they are unable to control the activities in Specialized Services and this has hindered their progress. As a result, we believe that Senior Management should consider the efficiencies that may be gained by having the Medicaid Department report to Specialized Services instead of Finance.

Medicaid Reimbursement
Summary of Recommendations

Rec#	Follow Up Status	Recommendations
1	***Open***	***Develop written protocols and procedures for the Medicaid function. Communicate and enforce compliance with the protocols and procedures.***
2	***OAG Closed***	***Establish procedures necessary to ensure district compliance with all OMIG requirements for the Medicaid Compliance Program.***
3	***Open***	***Establish a methodology for the Medicaid receivable based on actual claims information in IEP and Medicaid Direct and historical trends. Develop reporting, in IEP and Medicaid Direct that will identify submitted and unreceived, as well as unsubmitted Medicaid eligible claims. Reconcile claims submitted against claims paid to ensure the accuracy of accounts receivable amounts.***
4	***Completed***	***Develop defined timelines regarding the download and linking of the Medicaid Eligibility files. Reevaluate the ownership of these processes to assess the appropriateness of the parties performing these functions.***
5	***Open***	***Formalize a process for the timely resolution of students identified as a near match, multiple match, or match not found to facilitate the claiming process for eligible students.***
6	***Completed***	***Determine whether the capability exists or could be obtained to filter RS Log information for the Medicaid department to limit their review to only Medicaid eligible students.***
7	***Open***	***Develop processes to ensure e-signatures on RS Logs are obtained in a timely manner. Engage Service Provider Supervisors in obtaining RS Log signatures and hold them accountable for missing signatures.***
8	***Completed***	***Develop a process to ensure required UDO documentation exists on RS Logs. Ensure the required UDO contact occurs promptly at the beginning of the treatment period to eliminate the risk of lost revenue to the district.***

Medicaid Reimbursement
Summary of Recommendations

Rec#	Follow Up Status	Recommendations
9	***Open***	***Develop a formal process defining when a Medicaid parental consent form should be obtained. Identify responsibility for obtaining consent and an escalation process for when consent is not obtained. Enforce accountability for noncompliance.***
10	***Open***	***Conduct Related Service Reviews throughout each school year to ensure that services provided are supported and proper documentation is maintained.***
11	***OAG Closed***	***Develop procedures to ensure that all progress report requirements are fulfilled, including quarterly completion and submission. Establish a supervisor oversight requirement to ensure reporting is completed timely.***
12	***Open***	***Establish procedures for the ongoing review of Service Provider license and certification information, as well as the regular review of Service Providers on the Medicaid exclusion list.***
13	***Open***	***Establish reporting and operating procedures to ensure that all Medicaid eligible claims are submitted within the 24 month claiming period.***
14	***Open***	***Develop a process for the regular review and resolution of rejected claims. Trend rejected claims to determine common reasons for rejected claims and implement process improvements to minimize recurring issues.***
15	***Open***	***Establish and implement defined procedures and documentation standards to ensure proper supporting documentation exists to support Medicaid transportation claims. Start claiming Medicaid eligible special transportation costs.***
16	***Open***	***Develop a process to ensure the timely remediation for unbillable students. Identify responsibility for the resolution of unbillable students and enforce accountability.***

Medicaid Reimbursement
Summary of Recommendations

Rec#	Follow Up Status	Recommendations
17	***Open***	***Identify responsibility, designate responsibility, centrally locate and implement Medicaid documentation standards. Develop procedures to ensure that the location of the required documentation is consistently maintained. Consider the use of checklists to aid in ensuring that all appropriate documentation is present in all student files.***
18	***Completed***	***Evaluate if unbillable students can be identified in IEP Direct. Automate the unbillable process to help ensure unbillable students are not submitted for claims.***
19	***Completed***	***Develop and enforce procedures that require all Medicaid related documentation to be saved on the district's network in lieu of individual staff computers.***
20	***Open***	***Require access to all Third-Party Agencies related service information for district students.***

Medicaid Reimbursement
Observations, Recommendations and Action Plans

OBSERVATION #1

Policies and Procedures

Comprehensive Medicaid protocols and procedures do not exist to facilitate consistent operations. Significant efforts have recently occurred to establish some procedures within the Medicaid department to facilitate compliance with the required Medicaid Compliance Program. There is still a need for additional detailed desk procedures to communicate how daily responsibilities should be performed in compliance with established protocols. Specific attention is required to formalize protocols that outline specific processing timelines and expectations, formal escalation procedures for non-compliance, standard internal monitoring procedures and management reporting. Written and communicated protocols and procedures would enhance the consistency of the data maintained, consistency of the handling of documentation, and hold employees responsible and accountable for the services performed.

RECOMMENDATIONS and FOLLOW UP

Develop written protocols and procedures for the Medicaid function. Communicate and enforce compliance with the protocols and procedures.

FOLLOW UP STAUTS: OPEN

Documented procedures have been developed for the provisions of general guidance to Service Providers and relevant staff. However, we do not consider them to be robust enough to close this recommendation. Procedures lacked step by step actions performed by the Medicaid Department to ensure the integrity of Medicaid claiming and reporting. Examples of needed detailed procedures include but are not limited to reconciliation of claims submitted verses payments received, estimation of accrued receivables, compliance checklist reporting and issue resolution, provider credential monitoring and issue resolution, consent tracking and follow up, and operating procedures used to ensure that all eligible claims are submitted within the 24 month claiming period.

Due Date: June 30, 2012

OBSERVATION #2

Medicaid Compliance Program

The district's gross Medicaid receipts for 2008-09 were approximately $4 million. The Office of the Medicaid Inspector General (OMIG) required all school districts with Medicaid claims greater than $500K annually to adopt, implement, and maintain an effective compliance program. The Medicaid Program was required to be certified by December 31, 2009. The program was lacking specific components of a required plan which was communicated by OAG to the Medicaid and Legal Departments on December 22, 2009. Although the district has adopted Superintendent's Regulation 8600-R as its Medicaid Compliance and Integrity Program and the December 31, 2009 certification deadline was met, the following deficiencies are still noted:

- The program was not fully implemented at the time of certification and is currently only partially implemented.
- The Medicaid Compliance Officer's (MCO) responsibilities are identified; however responsibilities and ownership for monitoring within the Special Education Organization have not been defined. The MCO will be unable to ensure than an effective program exists unless roles and responsibly are defined and monitored.
- The MCO shall report to the Superintendent or designee, and shall periodically report directly to the governing body. The Superintendent Regulation states that the Superintendent will provide periodic reports to the Board of Education on activity of the MCO.
- The Regulation states the MCO will review the risk assessment results and make recommendations or take appropriate corrective action. It remains unclear who is responsible for preparing a risk assessment.
- There is no responsibility designated for anyone other than the MCO to perform reviews and audits of the Medicaid process.

If the district does not have a satisfactory compliance program, the district may be subject to any sanctions or penalties permitted by Federal or State laws and regulations, including revocation of the district's agreement to participate in the medical assistance program. In conjunction with the compliance program requirement, the Office of the Medicaid Inspector General (OMIG) has announced that beginning January 2010; they will audit every school district that received more than $1 million or more from Medicaid annually. Any denied or unsupported claims will result in an overpayment which will require reimbursement to OMIG.

RECOMMENDATIONS and FOLLOW UP

Establish procedures necessary to ensure district compliance with all OMIG requirements for the Medicaid Compliance Program.

FOLLOW UP STATUS: OAG CLOSED The Medicaid Compliance Program is assessed in detail under separate cover. As a result, this item is being closed to another project for follow-up.

Medicaid Reimbursement
Observations, Recommendations and Action Plans

OBSERVATION #3

Eligibility Process

Accounts Receivable

The Medicaid accounts receivable valuation is created using estimated revenues, actual gross receipts per OMIG, and estimated collection percentages of parental consents. Understanding that the current Medicaid receivable value is an estimate, the receivable amount cannot be substantiated and little assurance regarding the accuracy of this value exists due to a lack of reporting for unsubmitted claims. For example, the estimated revenues used for 2008-09 were based on the 2007-08 estimates even though there has been a decline in Medicaid revenues. There is no component in the calculation of this Medicaid accounts receivable estimate that includes actual claims submitted but unpaid or unsubmitted claims. In addition, a reconciliation of claims submitted but unpaid are not prepared. The value of the Medicaid accounts receivable should be accurate and easily substantiated. Reporting should be available from IEP or Medicaid Direct which reflects services submitted and unpaid as well as unsubmitted claims. Unless additional supporting documentation is available, the Medicaid accounts receivable value can be incorrect on the annual financial statements.

RECOMMENDATIONS and FOLLOW UP

Establish a methodology for the Medicaid receivable based on actual claims information in IEP and Medicaid Direct and historical trends. Develop reporting, in IEP and Medicaid Direct that will identify submitted and unreceived, as well as unsubmitted Medicaid eligible claims. Reconcile claims submitted against claims paid to ensure the accuracy of accounts receivable amounts.

FOLLOW UP STATUS: OPEN

Medicaid has modified its methodology for determining Medicaid receivables, so that it is based upon actual services. OAG requested, but management did not provide, supporting documentation to validate actual services and eligible student values used in the 2010-2011 accrual. Therefore, OAG reconciled the accrued service revenues to the Medicaid Direct, Generated MS files (submitted claims) and found them to be somewhat comparable. Management stated that they could not identify submitted and unreceived claims as result of insufficient information received from Centris and the State. However, OAG was able to perform a detailed reconciliation of the MS files and NYS remittance report for cycle 1783 and determined that sufficient data is available to identify submitted and unreceived claims. Although a system report for determining unsubmitted and eligible claims has not been developed, we recommend that management develop an alternative method for identifying this information and maximizing Medicaid reimbursement revenue.

Due Date: March 23, 2012

OBSERVATION #4

Eligibility Process

Eligibility

Defined timelines do not exist to identify when the Medicaid eligibility file is downloaded from the state. There is also no timeline identified for linking the Medicaid Eligibility file to IEP Direct. Although desk procedures exist for downloading the eligibility files and linking the file to IEP Direct, the Medicaid Department lacks formalized procedures regarding the Medicaid eligibility process. Responsibility for these processes is divided between the Medicaid Department and the Office of Accountability. Ownership of the processes should be reevaluated to assess whether the appropriate parties are performing these functions and that they are occurring timely. Formal timelines and delineated responsibilities will aid in ensuring all information is being processed timely and responsibility is clear for ensuring all Medicaid eligible students are identified in IEP Direct.

RECOMMENDATIONS and FOLLOW UP

Develop defined timelines regarding the download and linking of the Medicaid Eligibility files. Reevaluate the ownership of these processes to assess the appropriateness of the parties performing these functions.

FOLLOW UP STATUS: COMPLETED

A monthly process is in place for downloading Medicaid Eligibility files in alignment with the NYS 'Monthly Claiming Calendar - Submit billing data to CSE for processing' dates. Management elected to continue utilizing Accountability staff to upload and download its Medicaid files. It should be noted that these tasks take approximately two hours per month to perform and could easily be performed by Medicaid staff to maintain control of the entire process in the Medicaid Department.

Medicaid Reimbursement
Observations, Recommendations and Action Plans

OBSERVATION #5

Resolution of Non-Match Students

Eligibilty

The district receives a periodic Medicaid eligibility file from the state. At the time the eligibility file is provided, it identifies District students whose identifying information does not match directly with the information in their files. A non-Match Report is provided which includes students identified as either "near match", "multiple matches found", or "match not found". Near match students are identified as possible matches. Multiple match students are those whose biographical data is identified with more than one Client Identification Number (CIN). Match not found relates to student's whose biographical data was not matched against the Department of Health eligibility file. The Medicaid Department lacks a formal process for resolving students with near match, multiple match or match not found statuses. Timely identification of all Medicaid eligible students is necessary to ensure appropriate Medicaid eligible claims are submitted. The district is at risk of not claiming Medicaid reimbursement for related services for these students not properly identified as Medicaid eligible.

RECOMMENDATIONS and FOLLOW UP

Formalize a process for the timely resolution of students identified as a near match, multiple match, or match not found to facilitate the claiming process for eligible students.

FOLLOW UP STATUS: OPEN

Documented procedures reflect that management will only match students that have identical records with the exception of some name differences. Management stated that other criteria are considered for matching students, but they were not documented and could not be supported. OAG noted that 903 students were reflected as non-matched per the June 2011 Medicaid Billing Cycle 1765 - Match Report. We recommend that management define and document risk acceptable criteria for resolving each type of match exception. Additionally, documented procedures should state the times when match resolution will be performed, as well as how management will review and monitor the execution of these procedures for propriety.

Due Date: March 23, 2012

Medicaid Reimbursement
Observations, Recommendations and Action Plans

OBSERVATION #6

Related Service (RS) Log Review

Related Service (RS) Logs

RS Logs are used by Service Providers to attest to the services provided. The Medicaid Department relies on the e-signature in these RS Logs as an attestation that services were performed. The Medicaid department ensures that the RS Log is completed and electronically signed in order to claim reimbursement for related services. The RS Logs in IEP Direct includes all students receiving Special Education services, not just Medicaid eligible students. As a result, the Medicaid Department reviews all RS Logs for e-signatures, therefore spending time reviewing information for non-Medicaid eligible students. The Medicaid Department should only spend time reviewing RS Logs for Medicaid eligible students. A filter should be established to limit the review process for only Medicaid eligible students. This change in process will reduce the time spent reviewing RS Logs. This change could increase department efficiency and potentially increase the number of claims submitted.

RECOMMENDATIONS and FOLLOW UP

Determine whether the capability exists or could be obtained to filter RS Log information for the Medicaid department to limit their review to only Medicaid eligible students.

FOLLOW UP STATUS: COMPLETED

Medicaid Direct has been enhanced to filter claims reviewed by the Medicaid Department.

OBSERVATION #7

RS Log E-Signature Follow-Up

RS Logs

The Medicaid Department lacks a formalized process to ensure that missing e-signatures on RS Logs are being obtained. Error notifications are sent to the Service Providers and, in some cases, the area Director. Defined procedures are not in place to ensure that all e-signatures are properly being acquired in a timely manner. When an RS Logs does not have a signature, the District is unable to claim reimbursement from Medicaid for eligible services. This results in lost revenue for the District. E-signatures should be present on all qualifying RS Log entries and procedures should exist to ensure that all e-signatures are obtained. The Service Provider's supervisors should be actively involved in this process and both the Service Provider and their supervisor should be accountable for any missing e-signatures.

RECOMMENDATIONS and FOLLOW UP

Develop processes to ensure e-signatures on RS Logs are obtained in a timely manner. Engage Service Provider Supervisors in obtaining RS Log signatures and holding them accountable for missing signatures.

FOLLOW UP STATUS: OPEN

As of May 2011, the Medicaid Department provided a Medicaid Direct "Compliance Checklist Report" to the Specialized Services Directors monthly. Directors are expected to utilize this report to monitor and follow up on untimely and/or missing e-signatures. However, Management stated that the report utilized has known inaccuracies and does not reflect all current regulations. We noted that the Medicaid Department does not follow up with directors to ensure resolution of missing signatures and they do not analyze issues to determine patterns and trends limiting claims reimbursement. Management should work with the directors to establish and enforce consequences for non-compliant providers.

The Medicaid Department requires service providers to complete RS logs within two days after services are provided in order to comply with state rules for maintaining contemporaneous records. New York State does not specify how many days are required to comply with contemporaneous signatures. Management stated that another District is using five days. We recommend that management evaluate the financial impact of requiring a two day contemporaneous signature, in lieu of a longer timeframe.

Due Date: March 23, 2012

OBSERVATION #8

RS Logs and UDO Contact

RS Logs

A formal process does not exist to ensure that supervisory contact occurs as required. If a service provider is "Under the Direction Of" a supervisor (UDO), the UDO is required to provide face-to-face contact at the beginning of treatment and periodically thereafter. Services provided prior to student contact with the UDO are not claimable for Medicaid. During the audit, we noted missing e-signatures on RS Logs from required UDO's due to the lack of timely UDO contact with the student. Timely contact with the student by the UDO is crucial to reimbursement of Medicaid eligible expenses. Identification of the Service Providers that require a UDO should be maintained to support the UDO relationship. During our audit, we noted instances of missing documentation to support the UDO relationship. Unless this process is formalized to ensure prompt contact occurs, a loss of Medicaid revenue will occur.

RECOMMENDATIONS and FOLLOW UP

Develop a process to ensure required UDO documentation exists on RS Logs. Ensure the required UDO contact occurs promptly at the beginning of the treatment period to eliminate the risk of lost revenue to the district.

FOLLOW UP STATUS: COMPLETED

The Medicaid Department has developed and documented UDO/USO procedures to reasonably ensure District compliance with current NYS Medicaid requirements. The department heavily relies upon the Service Provider Directors to ensure UDO procedures are appropriate. However, the Medicaid Department should perform monitoring procedures to ensure directors are supervising appropriately. Additionally, the Medicaid Department stated that it does not maintain and did not obtain a list of Service Provider certifications that could be validated for compliance with established UDO/USO procedures. OAG obtained the current list of District staff provider licenses and provided it to the Medicaid department.

Medicaid Reimbursement
Observations, Recommendations and Action Plans

OBSERVATION #9

Parental Consents

The Federal Family Educational Rights and Privacy Act (FERPA, also known as the Buckley Amendment) and Medicaid regulations require that the identity of a student with a disability and their related services be kept confidential unless parent consent occurs. The parental consent gives the district permission to disclose information from the child's educational records to local, state and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for health related support services. Therefore, if consent does not exist, Medicaid reimbursement for services cannot be claimed. Although the Medicaid Department has made efforts to collect consent, they have been unable to obtain the required consents. A formal process does not exist to obtain all required Medicaid parental consents. Currently, the district has approximately a 40% parental consent collection rate. The district is at risk of losing Medicaid revenue on 60% of the Medicaid eligible related services due to the lack of parental consents.

RECOMMENDATIONS and FOLLOW UP

Develop a formal process defining when a Medicaid parental consent form should be obtained. Identify responsibility for obtaining consent and an escalation process for when consent is not obtained. Enforce accountability for noncompliance.

FOLLOW UP STATUS: OPEN

The District is still at risk of forgoing Medicaid reimbursements due to lack of control over the Parental Consent process. Formalized procedures for ensuring compliance with Medicaid Parental Consent Forms have not been developed. Operating procedures should be updated to reflect current consent processes, clearly identify the persons responsible for performing tasks, describe how missing consents will be identified and provide procedures of what to do when consent is not obtained.

Due Date: June 30, 2012

Medicaid Reimbursement
Observations, Recommendations and Action Plans

OBSERVATION #10

Verification of Services

There are no procedures in place to ensure that services were actually performed by the Service Providers. An e-signature by the Service Provider on the RS Logs is the only attestation that the Medicaid Department requires in order to submit claim for Medicaid reimbursement. Periodic review of the services should be performed on a test basis to ensure their validity. The district could potentially be claiming Medicaid reimbursement for services that were never actually performed. Related Service Reviews should be conducted throughout each school year to ensure that proper documentation is maintained and services provided are supported. Each Service Provider should be audited periodically. The Medicaid Department, operating management and the Medicaid Compliance Officer should work collaboratively to ensure proper coverage of the Service Providers.

RECOMMENDATIONS and FOLLOW UP

Conduct Related Service Reviews throughout each school year to ensure that services provided are supported and proper documentation is maintained.

FOLLOW UP STATUS: OPEN

Although the Related Services and External Education Directors perform periodic reviews of services provided, the Medicaid department should audit the results of their reviews to validate that service claims are properly supported.

Due Date: April 27, 2012

OBSERVATION #11

Progress Reports

Quarterly progress reports are required for all students receiving Special Education related services. Quarterly progress reports are prepared by Service Providers. Progress reports must address the objectives and goals indicated in the student's Individual Education Plan and be signed and dated. The Medicaid Department lacks effective procedures for ensuring the receipt of all required progress reports on a quarterly basis. There is a lack of assurance that all providers are submitting quarterly progress reports for all of their students, nor is there assurance regarding the timeliness of the submissions. Our testing noted that some progress reports were submitted late. We also noted missing progress reports for some or all of the required quarters. Our review included requests for specific student progress reports for specified quarters within the last year. We did not receive all the information requested for our testing. As a result, we were unable to validate the proper quarter's claims submission.

Also, through inquiry with Medicaid Department staff, their review consists of ensuring the progress reports are signed and dated, but they do not ensure the objectives and goals as indicated in the IEP were addressed. It was noted during our audit, the progress report's categories did not always align with established categories (i.e. "Other" category used instead of "Speech" or "Motor").

The district risks noncompliance with Medicaid requirements if all progress reports are not properly maintained and include all required information.

RECOMMENDATIONS and FOLLOW UP

Develop procedures to ensure that all progress report requirements are fulfilled, including quarterly completion and submission. Establish supervisor oversight requirements to ensure reporting is completed timely.

FOLLOW UP STATUS: OAG CLOSED

Progress notes are no longer a required component for Medicaid claims reimbursement. However, progress notes are still an IDEA Part 200 requirement for delivery of Specialized Education Services.

OBSERVATION #12

Service Providers

Service providers are required to maintain proper licensure and certifications. Defined processes should be in place to ensure that all of the Service Providers maintain the proper licenses and certifications, as required by Medicaid. All Service Providers should be evaluated to determine whether their licenses are current or if they have been included on the Medicaid exclusion list. This review should be performed on a regular basis to ensure that any changes are verified against district service providers. At the start of the Medicaid Audit, there were no defined processes in place to ensure the district maintains the proper licenses and certifications, nor were there processes in place to ensure that the Service Providers were not on the Medicaid exclusion list. It was communicated, prior to the completion of our audit, that verification of licenses, certifications and exclusions were performed. Procedures to periodically evaluate licenses, certifications and resolve providers on the exclusion list, has not yet been established. The district has a risk of employing Service Providers that are not allowed to be reimbursed for Medicaid eligible services.

RECOMMENDATIONS and FOLLOW UP

Establish procedures for the ongoing review of Service Provider license and certification information, as well as the regular review of Service Providers on the Medicaid exclusion list.

FOLLOW UP STATUS: OPEN

HCI has taken responsibility for ensuring that all District employed Service Provider's certifications and licenses are documented and current. At the time of our follow up, the Medicaid Department had not obtained a current list of Service Provider credentials from HCI and does not reconcile licensed providers to the claims submitted to ensure propriety. In addition, Medicaid does not validate the credentials of non-District Service Providers. Lastly, Medicaid does not actively check to ensure that providers are not excluded from Medicaid claiming. As result, the District is still at risk of submitting claims from unqualified or prohibited Service Providers.

Due Date: June 30, 2012

OBSERVATION #13

Claiming Process

The district lacks well defined processes and timelines for the Medicaid reimbursement process. The district has 24 months to submit a claim for a related service for a Medicaid eligible student. Standard cycle times or a schedule for claims submission does not exist. There is also no process in place to ensure that the 24 month claiming period for services does not expire before all eligible claims have been submitted. If this timeline is not closely managed, the district can lose eligible reimbursement dollars for related services. It is imperative that the district ensures that processes are in place to make certain that all potential Medicaid claims are being sought within the 24 month time period allotted. Reporting should be created and utilized to identify services that are eligible for Medicaid reimbursement, and indicate when the claim period is near expiration.

RECOMMENDATIONS and FOLLOW UP

Establish reporting and operating procedures to ensure that all Medicaid eligible claims are submitted within the 24 month claiming period.

FOLLOW UP STATUS: OPEN

Monthly, the Medicaid staff reviews all available claims in Medicaid Direct for the prior 23 months for submission. The staff logs the results of their review on a service claim worksheet. However, this review is not validated by the Medicaid Quality Assurance Coordinator prior to claims submission. It is recommended that management formally document this process. We also recommend that management validate/approve that reviews are performed and complete prior to claims submission.

Due Date: April 27, 2012

Medicaid Reimbursement
Observations, Recommendations and Action Plans

OBSERVATION #14

Resolution of Rejected Claims

Currently, there is no formal process for resolving or reviewing rejected claims. For the audit period tested, approximately $600K in claims were rejected. A process should exist for the regular review and resolution of rejected claims. Rejected claims should also be trended to determine the reason for the rejection. This will aid in assessing potential recurring issues that may be resolved through process improvements. If rejected claims are not monitored and resolved, Medicaid revenue could be lost.

RECOMMENDATIONS and FOLLOW UP

Develop a process for the regular review and resolution of rejected claims. Trend rejected claims to determine common reasons for rejected claims and implement process improvements to minimize recurring issues.

FOLLOW UP STATUS : OPEN

Management stated that monthly reviews of rejected claims are performed but did not provide sufficient documentation to validate that reviews occurred. Management also noted that trend analysis of rejected claims are performed and shared with Related Service Directors but did not provided support of these items either. As result, OAG was not able to evaluate this process to determine closure of this finding.

Due Date: March 23, 2012

Medicaid Reimbursement
Observations, Recommendations and Action Plans

OBSERVATION #15

Transportation Claims

The district lacks a formal process to claim Medicaid reimbursement for transportation services. All special transportation arrangements recommended by the Committee on Special Education (CSE) and the Committee on Preschool Special Education (CPSE) that are included in the student's Individualized Education Program (IEP) are eligible for Medicaid reimbursement. In order to claim Medicaid reimbursement for transportation services, the IEP must specify special transportation needs, the schedule/roster for the transportation must be available and daily attendance must be taken on the bus when the child is picked up and dropped off. The district should have a formalized process in place to ensure that the above criterion is met to support claims for special transportation services. For the audit period tested, approximately $400K in claims were for transportation services. Our audit testing revealed that attendance records were unavailable for all of the transportation claims tested. Currently, the Medicaid Department has ceased claiming eligible special transportation services for students receiving Medicaid related services. This is a lost revenue opportunity for the district.

RECOMMENDATIONS and FOLLOW UP

Establish and implement defined procedures and documentation standards to ensure proper supporting documentation exists to support Medicaid transportation claims. Start claiming Medicaid eligible special transportation costs.

FOLLOW UP STATUS: OPEN

Management has not developed a process to obtain student bus attendance support required for Medicaid transportation claiming. As result, the District still does not claim reimbursement for Medicaid eligible special transportation costs.

Due Date: June 30, 2012

Medicaid Reimbursement
Observations, Recommendations and Action Plans

OBSERVATION #16

Documentation

Unbillable Students

An unbillable student is one that is eligible for Medicaid reimbursement, but the district has not appropriately obtained the necessary documentation for reimbursement. The district lacks a formal process to ensure that all eligible students are billable and that the Service Providers are obtaining the appropriate documentation. A lack of ownership and follow up procedures exist to ensure that students that have been identified as unbillable, are promptly rectified to allow claims reimbursement. A process should be in place to ensure the timely remediation of unbillable students. Procedures and responsibility for resolving unbillable students should be clearly defined. If this issue is not addressed, it will result in lost revenue for the district.

RECOMMENDATIONS and FOLLOW UP

Develop a process to ensure the timely remediation for unbillable students. Identify responsibility for the resolution of unbillable students and enforce accountability.

FOLLOW UP STATUS: OPEN

OAG was not able to evaluate management's actions towards closure of this finding due to lack of supporting documentation.

Due Date: April 27, 2012

OBSERVATION #17

Records

Unbillable Student

There is a lack of standards and consistency regarding the maintenance of required Medicaid documentation. We were able to locate many of the required documents when we searched in the mental health records and/or the school cumulative files; however there was a general lack of consistency in establishing the location of required information. We were unable to locate all of the required documentation required to support Medicaid claims. When documentation remained outstanding, it was communicated that the Service Providers may also have missing documentation. Responsibility for maintaining documentation does not exist. Consistency regarding how the files are maintained and where pertinent information is located should exist. Clear definition of responsibility for Medicaid documentation should be established to facilitate the Medicaid Audits by OMIG. Procedures should exist to ensure that the location of the required documentation is consistently maintained, whether it is with the Records Department, Medicaid Department, HCI or Service Providers. Significant time will be utilized looking for required documentation, due to the lack of uniformity of files. Checklists could aid in ensuring that all appropriate documentation is present in all student files. Record retention policies for Medicaid records should be clearly defined and align with Medicaid requirements. Lack of accountability for the required documentation can cause denied claims in the OMIG audit process.

RECOMMENDATIONS and FOLLOW UP

Identify responsibility, designate responsibility, centrally locate and implement Medicaid documentation standards. Develop procedures to ensure that the location of the required documentation is consistently maintained. Consider the use of checklists to aid in ensuring that all appropriate documentation is present in all student files.

FOLLOW UP STATUS: OPEN

The Medicaid Department relies upon the Specialized Services Department to obtain and maintain required documents within the student's cumulative folder. In December 2011, the Specialized Services and Medicaid Departments developed a quality assurance process to validate that required Medicaid claiming documentation is maintained. However, this process has not been implemented and could not be validated.

Due Date: June 30, 2012

OBSERVATION #18

Automation

Unbillable Student

Identification of eligible, but unbillable students is a manual process. IEP Direct does not produce reporting to make unbillable students easily identifiable. The Medicaid Department keeps an unbillable student log in MS Excel which identifies students that have been categorized as unbillable due to missing required documentation. This log is referred to when e-signatures are missing on RS Logs. If a provider signs the RS Log and the student is unbillable, reimbursement could be requested from Medicaid even though documentation does not exist to properly support the claim. If the process for identifying unbillable students on RS Logs was automated within IEP Direct, the Medicaid Department could ensure that unbillable students are not being submitted for claims. Automating the process could increase efficiencies and accuracies in the claiming process.

RECOMMENDATIONS and FOLLOW UP

Evaluate if unbillable students can be identified in IEP Direct. Automate the unbillable process to help ensure unbillable students are not submitted for claims.

FOLLOW UP STATUS: COMPLETED

Medicaid Direct was enhanced in April 2011, so that unbillable students can be viewed using a filter in the import claims screen. The system automatically reflects claims that do not meet District defined perquisites as 'un-claimable'. Although a system report of unbillable students has not been developed, management could copy and paste this information into excel for review and analysis.

OBSERVATION #19

Systems

The Medicaid Department's electronic files are primarily saved on individual Medicaid staff employees' computers rather than on the network. Medicaid assistance is also provided by the Office of Accountability whose files are created and saved on the Office of Accountability's network drive. Although the files are backed up on the network, they are not accessible to the Medicaid Department. The entire Medicaid Department should have access to all pertinent departmental documentation. Saving files on individual computers is problematic, since personal computers are not backed up and if an individual is out of the office, the information is inaccessible. All files should be saved to the district's network and accessible to the Medicaid Department to ensure proper backup of files and promote effective supervision of work performed.

RECOMMENDATIONS and FOLLOW UP

Develop and enforce procedures that require all Medicaid related documentation to be saved on the district's network in lieu of individual staff computers.

FOLLOW UP STATUS: COMPLETED

The Medicaid Department has established a dedicated network drive to house Medicaid Reimbursement related records.

Medicaid Reimbursement
Observations, Recommendations and Action Plans

OBSERVATION #20

Third-Party Agencies

There is a lack of visibility to the services performed by Third-Party agencies. Student special education service information performed by Third-Party Service Providers is not visible in the District's IEP Direct program, which includes information such as attendance and progress reports. The Medicaid Department should be able to view all students Medicaid related services performed regardless of the Service Provider performing the service. Inaccessibility to district student records creates a lack of visibility and proper supervision of Third-Party Service Providers.

RECOMMENDATIONS and FOLLOW UP

Require access to all Third-Party Agencies related service information for district students.

FOLLOW UP STATUS: OPEN

Due to revised External Education Agency agreements, the District now has the right to access District student records. In November 2011, the Medicaid Quality Assurance Coordinator and Director of Specialized Services performed site visits of the three external agencies for which the District claims Medicaid Reimbursements. Specific procedures and information have not yet been identified or obtained to validate the services that are billed.

Due Date: April 27, 2012