Detroit Public Schools Community District

School Based Services Program
Student Claims Audit

For the Period July 1, 2016 through June 30, 2017

Final Report – Issued September 2022

State of Michigan
Department of Health and Human Services
Bureau of Audit
Audit Division

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

September 26, 2022

Mr. Jeremy Vidito, Chief Financial Officer
Detroit Public Schools Community District
3011 West Grand Boulevard
11th Floor, Fisher Building
Detroit, Michigan 48202

Dear Mr. Vidito:

Enclosed is our final report or the Michigan Department of Health and Human Services (MDHHS) audit of the Detroit Public Schools Community District (DPSCD) Medicaid School Based Services student claims for the period July 1, 2016 through June 30, 2017.

The final report contains the following: Executive Summary with objectives and conclusions; Exceptions, Recommendations and Corrective Actions; Funding Methodology; Scope and Methodology; and Glossary. The Corrective Actions contain the agency's response to the Preliminary Analysis.

Thank you for they courtesy and cooperation extended throughout this audit process.

Sincerely,

Tracie Bonner

Tracie Bonner, Manager
Child Care Fund and Medicaid School Services Program Audit Section
Bureau of Audit - Audit Division

c: Lohren Nzoma, DPSCD
Arthur Jackson, DPSCD
Renee Kidd, DPSCD
Fatima Malone, DPSCD
Pam Myers, MDHHS, Audit
Shannah Havens, MDHHS, Audit
Steve Ireland, MDHHS, Audit
Cheryl Miller, MDHHS, Audit
Kimberly Maharaj, MDHHS, Audit
Kevin Bauer, MDHHS, Medicaid Program Policy

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Below is a summary of our audit objectives, conclusions, and exceptions:

Audit Objective - Student Claims	Conclusion
To assess whether DPSCD effectively developed student claims in accordance with applicable Federal and State requirements.	Not Effective
We identified 2 exceptions related to student claims.	

Exception 1 Page 2	Insufficient Treatment Plans for Direct Medical Claims
Criteria	Medicaid Provider Manual, School Based Services, Section 1.7; and Section 2.9
Invalid Claims	12 (20%) of 60
Corrective Action	District will conduct internal Medicaid audits and conduct monthly signature audits.
Completion Date	September 15, 2022
Persons Responsible	Renee Kidd, Senior Director Bernadette Briggs, Medicaid Support Coordinator

Exception 2 Page 3	Insufficient Supporting Documentation for Direct Medical Claims
Criteria	Medicaid Provider Manual, School Based Services, Section 2.4.A; and Section 10.1; and Section 11.2
Invalid Claims	6 (10%) of 60
Corrective Action	District will conduct audit for attendance and provide training. District will also utilize EdPlan for signature verification and do weekly monitoring. Service time logging will be a system required field for Medicaid billing.
Completion Date	September 15, 2022
Persons Responsible	Renee Kidd, Senior Director Bernadette Briggs, Medicaid Support Coordinator

EXCEPTIONS, RECOMMENDATIONS, AND CORRECTIVE ACTIONS

Exception 1
Insufficient Treatment Plans for Direct Medical Claims

Condition
Detroit Public Schools Community District did not have sufficient IEP/Treatment Plans in place for Direct Medical Claims according to the Medicaid Provider Manual requirements.

Criteria
The Medicaid Provider Manual, School Based Services, Section 1.7 – Treatment Plan states:

> *The treatment plan must be signed, titled, and dated by the qualified staff prior to billing Medicaid for services and must be retained in the beneficiary's school clinical record…*

The Medicaid Provider Manual, School Based Services, Section 2.9 – Personal Care Services states:

> *Personal Care Services must be medically necessary and the need for the service must be documented in the student's IEP/IFSP.*

Exception
During our review, we identified 12 (20%) of the 60 claims reviewed where DPSCD did not have sufficient IEPs/IFSPs/Treatment Plans in place for direct medical claims.

- Ten claims did not have IEPs/Treatment Plans signed by qualified staff.
- Two claims for personal care services were not documented in the IEP/Treatment Plans.

Recommendation
We recommend that the DPSCD implement policies and procedures to ensure that all medically necessary services are documented in the IEP/Treatment plan and that the IEP/Treatment Plans are signed and dated by qualified staff before claims are submitted, in compliance with the Medicaid Provider Manual.

Corrective Action Plan
The District will implement the following procedures:

1) Conduct Internal Medicaid audits
   a) Randomly select TCM (Targeted Case Management), Direct Service Providers, Personal Care and Students at least once a month. Sample Population: TCM (5) Direct Service Provider (3) Personal Care Aides (2) Students (5)

b) Review the following:
   (i) Signed Documents
   (ii) Medical Service duration and frequency
   (iii) Goals and Objectives aligned with therapy provided
   (iv) Personal Care Services Aligned with therapy provided
   (v) Was Medicaid billed for medically related services
   (vi) Attendance records align with services dates

2) Conduct Monthly Signature Page Audits for FAPE (Free Appropriate Public Education) Signatures, Participants Signatures, and PCA (Personal Care Authorization Forms)
   a) Process
      (i) On the 5th of each month, we pull IEPs and Eligibility recommendations dated from the previous month to verify signature
      (ii) Manually enter PCA dates in the student's doctor authorization section in EdPlan. Only valid authorization dates are submitted for billing through ED Plans pre-authorization billing validation

Completion Date
September 15, 2022

Responsible Individuals
Renee Kidd, Senior Director
Bernadette Briggs, Medicaid Support Coordinator

Exception 2
Insufficient Supporting Documentation for Direct Medical Claims

Condition
Detroit Public Schools Community District did not maintain or provide sufficient documentation or the documentation to support some of its Direct Medical Service claims.

Criteria
The Medicaid Provider Manual, School Based Services, Section 11.2 – Audit and Recovery Procedures states:

> *Confirmation that services requiring the student to be in attendance have support documentation (i.e., attendance records) on file.*

The Medicaid Provider Manual, School Based Services, Section 2.4.A – Speech, Language and Hearing Therapy states:

> *Speech, language and hearing services may be reimbursed when provided by a limited licensed speech language pathologist, under the direction of a fully licensed SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed supervision SLP or licensed audiologist.*

The Medicaid Provider Manual, School Based Services, Section 10.1 – Direct Medical Services Documentation states:

> *For services that have time-specific procedure codes, the provider must indicate the actual begin and end times of the service in the school clinical record.*

Exception

During our review, we identified six (10%) of the 60 claims reviewed did not have sufficient supporting documentation as follows:

- Three claims were submitted where the attendance records stated the student was absent, or not scheduled for class on the date of the claim.
- One claim had personal care logs that stated the student was absent on the date of the claim.
- One claim did not have an authenticated signature for supervision of a limited licensed speech and language pathologist.
- One claim did not document the beginning and ending time for a time specific procedure code for psychiatrist services.

Recommendation

We recommend DPSCD implement policies and procedures to improve internal controls and ensure sufficient documentation, with all the necessary information, is maintained to comply with the requirements in the Medicaid Provider Manual.

Corrective Action Plan

The District will implement the following procedures:

1) Attendance
   a) Conduct random audits monthly
   b) Provide training

2) Supervisor signature
   a) Documentation review
      i) Supervisor will use the Service Log Approval Wizard in EdPlan to approve supervised services
      ii) EdPlan will verify signatures in their preauthorization billing check before submitting claims.
      iii) Weekly, the Medicaid Coordinator will send the Program Supervisors an email of claims that are pending Supervisor approval. Supervisors review and approve pending claims that are clear to be submitted for submission.

3) Duration of time
   a) Service Logging
      i) In EdPlan, for service logging, the time(s) and duration(s) of services are required fields for all providers except for Personal Care Aides (PCAs), and Audiologist (AUD).
      ii) If required fields are not entered, the provider will not be able save or submit the entry for Medicaid billing

Completion Date
September 15, 2022

Responsible Individuals
Renee Kidd, Senior Director
Bernadette Briggs, Medicaid Support Coordinator

FUNDING METHODOLOGY

The Administrative Outreach Program (AOP) and Direct Medical Services Program are companion programs. The AOP provides reimbursement for administrative activities required to identify, manage, refer, and develop programs for children at risk of academic failure due to an underlying health issue, including mental health. The Direct Medical Services Program reimburses schools for the cost of providing direct medical services to the special education Medicaid student population.

AOP

Staff salaries and related costs are reported directly to a hired contractor, the Public Consulting Group (PCG), on quarterly financial reports by each of the Local Education Agencies (LEAs). PCG combines the costs per Intermediate School District (ISD), applies various allocation percentages and submits the AOP claim directly to Michigan Department of Health and Human Services (MDHHS) for review, processing, and payment each fiscal quarter. Claim development is based on a "pool" of costs, primarily salaries, incurred by the school districts for individuals that engage in Medicaid-type activities on a regular basis. The percentage of effort spent on Medicaid-type activities is identified by a Random Moment Time Study (RMTS) that is also conducted by PCG. The final amount claimed for Medicaid reimbursement is equal to:

Cost Pools (salaries, overhead, etc.)	**X**	% Time Spent on Medicaid Outreach Administration from RMTS	**X**	Each ISD's Biannual Medicaid Eligibility % Rate	**X**	% Federal Financial Participation (FFP) Rate	**=**	The Claim Submitted for Medicaid Reimbursement

Direct Medical Services

School Based Services (SBS) providers are required to submit Direct Medical Services claims for all Medicaid covered allowable services. These claims do not generate a payment but are required by the Federal Centers for Medicare and Medicaid Services (CMS) in order to monitor the services provided, the eligibility of the recipient, and provide an audit trail. These claims are submitted and processed through the Community Health Automated Medicaid Processing System (CHAMPS); however, the procedure code fee screens are set to pay zero.

SBS providers receive Direct Medical Services funding from interim monthly payments based on prior year actual costs. The interim payments are reconciled on an annual basis to the current year costs by the MDHHS Hospital and Clinic Reimbursement Division (HCRD). Cost reporting and reconciliation are based on the school fiscal year which is July 1 through June 30 of each year. Annually, ISDs and LEAs submit allowable costs to MDHHS in CHAMPS on the Facility Settlement (FS) system. The final amount claimed for Medicaid reimbursement is equal to:

Allowable Costs (FS & Financials for TCM & PCS)	+	Calculated Indirect Costs	X	Annual Average % Time Claimable to Medicaid from the RMTS	X	Each ISD's Medicaid Eligibility % Rate	X	Federal Medical Assistance Percentage (FMAP)	=	Medicaid Reimbursement

The cost settlement is accomplished by comparing the interim payments to the annual Medicaid allowable costs. Any over/under settlement payments are made.

Transportation

Specialized transportation costs are the costs associated with the special education buses used for the specific purpose of transporting special education students only. On an annual basis, the cost per trip is calculated by dividing the total reimbursable cost submitted on the Facility Settlement cost report by the total special education one-way transportation trips reported by the ISD in CHAMPS. The Medicaid reimbursable amount is obtained by multiplying the cost per trip by the number of "allowable" one-way trips from CHAMPS. An "allowable" one-way trip is provided to a Medicaid-eligible beneficiary and fulfills all the following requirements:

- Documentation of ridership is on file;
- The need for specialized transportation service is identified in the Individualized Education Program (IEP) or Individual Family Service Plan (IFSP); and
- A Medicaid-covered service is provided on the same date of the trip.

The cost settlement is accomplished by comparing the monthly interim payments to the annual Medicaid allowable specialized transportation costs. The cost settlement amount for the specialized transportation is combined with the cost settlement amounts for Direct Medical, Targeted Case Management (TCM), and Personal Care Services (PCS). Any over/under adjustments are processed as one transaction.

SCOPE AND METHODOLOGY

We examined the DPSCD's records and activities for the period July 1, 2016 through June 30, 2017.

Our audit procedures included the following:

- Performed remote fieldwork for Detroit Public Schools Community District.

- Reviewed the School district's Single Audits and Financial Statement Audits and relied upon the independent auditors' report on internal controls to identify potential weaknesses that might affect our review.

- Reviewed the Quality Assurance Plan and responses to the Audit Questionnaire.

- Reviewed a sample of Direct Medical Services claims and all required supporting documentation including:

    - Reviewed IEP/IFSP or treatment plan for details related to services provided:
        - To verify the diagnosis and treatment are medically necessary.
        - To verify that the IEP/IFSP or treatment plan was signed.
        - To verify that the service provided in the claim was identified in the IEP/IFSP or treatment plan.
        - To verify that the student was under the age of 21 years old.
        - To verify the IEP/IFSP or treatment plan contained appropriate short-term and long-term goals.

    - Reviewed Student Encounter Logs, Personal Care Service Logs, Provider Verification Logs, and Provider Encounter Logs as applicable for the sample of Direct Medical Services claims.

    - Reviewed provider Licenses to ensure that all providers had the appropriate credentials.

    - Reviewed Prescriptions, Referrals and Authorizations to ensure they were obtained for services provided and services were authorized by appropriate professionals.

    - Reviewed Attendance Records to verify student attendance on date of service.

GLOSSARY OF ABBREVIATIONS AND TERMS

AOP	Administrative Outreach Program
CHAMPS	Community Health Automated Medicaid Processing System
CMS	Centers for Medicare and Medicaid Services
DPSCD	Detroit Public Schools Community District
FFP	Federal Financial Participation
FMAP	Federal Medical Assistance Percentage
FS	Facility Settlement
HCRD	Hospital and Clinic Reimbursement Division
IEP	Individualized Education Program
IFSP	Individualized Family Service Plan
ISD	Intermediate School District
LEA	Local Education Agency
MDE	Michigan Department of Education
MDHHS	Michigan Department of Health and Human Services
OMB	Office of Management and Budget
PCG	Public Consulting Group
PCS	Personal Care Services
RMTS	Random Moment Time Study
SBS	School Based Services
TCM	Targeted Case Management