Testimony of

SALLY RICHARDSON, DIRECTOR

CENTER FOR MEDICAID AND STATE OPERATIONS

HEALTH CARE FINANCING ADMINISTRATION

on

MEDICAID COVERAGE OF

SCHOOL-BASED SERVICES

before the

SENATE FINANCE COMMITTEE

JUNE 17, 1999

HCFA

MEDICARE • MEDICAID

Health Care Financing Administration

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Chairman Roth, Senator Moynihan, distinguished Committee members, thank you for inviting us to discuss Medicaid funding for school-based services. I want to emphasize the important role school-based services play in assuring that children receive needed health care. School-based programs can also play a powerful role in identifying and enrolling children who are eligible for Medicaid, as well as the new State Children's Health Insurance Programs. We strongly support Medicaid funding for school-based health services to children enrolled in Medicaid.

I have had the privilege of working closely with your Committee to understand the recent growth of Medicaid reimbursement in the schools. We recently sponsored a site visit for key Committee staff to see first hand the essential role school-based services play in ensuring that Medicaid-eligible children receive needed care while minimizing disruption to the education process.

However, your Committee, our staff, and now the General Accounting Office have identified serious concerns with Medicaid payments for school-based care in a handful of States. These include:

- "bundled" payment for groups of services to disabled children without documentation of the actual delivery of services or their costs;
- billing for transportation costs that Medicaid does not cover; and
- billing for administrative activities that Medicaid does not cover.

We believe we must act now to clarify issues, eliminate any inappropriate practices that exist, and protect the integrity of Medicaid funding for school-based services. We, therefore, sent State Medicaid Directors a letter May 21, 1999 that modifies and clarifies policy in these areas. Specifically:

- we will no longer approve federal Medicaid matching funds for bundled payments for school-based services;
- we will only pay transportation costs for children with special transportation needs; and
- we will issue guidance this Summer on Medicaid covered administrative costs.

We also will continue to work with Congress and the States to ensure that school-based services covered by Medicaid are billed appropriately and provided efficiently and effectively.

BACKGROUND

Many school-based health programs provide a broad range of services that are covered by Medicaid, affording access to care for children who otherwise might well go without needed services. And, as mentioned above, school-based programs also can play a powerful role in identifying and enrolling children who are eligible for Medicaid, as well as the new State Children's Health Insurance Programs. For Medicaid to cover school-based services, they must be primarily medical and not educational in nature. They must be provided by a qualified Medicaid provider to children in families that meet Medicaid income eligibility requirements. And they must be considered medically necessary for the child. The services can include:

- routine and preventive screenings and examinations;
- diagnosis and treatment of acute, uncomplicated problems;
- monitoring and treatment of chronic medical conditions; and
- provision of medical services to children with special needs under the Individuals with Disabilities Education Act.

Medicaid funding for school-based services was limited to coverage for routine screenings and treatment of acute, uncomplicated problems until 1988. Then Medicaid's role in supporting school-based health care was greatly expanded under the Medicare Catastrophic Coverage Act. It stipulates that Medicaid -- not the Department of Education -- pays for medical services provided to Medicaid-eligible children with special health care needs. Each child must have an Individualized Education Plan, in accordance with the Individuals with Disabilities Education Act, in order for Medicaid to pay for their school-based care.

There has been a surge of State interest in Medicaid reimbursement for school-based health services, mostly for Medicaid-eligible children with special needs under the Individuals with Disabilities Education Act. We have encouraged this because of the potential for school-based services to support "mainstreaming" children with disabilities into regular schools while continuing to ensure that they get the care they need.

As mentioned above, however, three major areas of concern have begun to emerge. We strongly believe we must address these issues now to make sure that taxpayer funds are spent appropriately, to protect the integrity of school-based health care programs, and to ensure that the potential of school-based services to maximize opportunities for children with disabilities is not compromised.

Bundling

Bundled payment for school-based services creates a real potential for Medicaid to pay too much or to pay for care which has not been provided. We have, therefore, told States in a May 21, 1999 letter that we will stop providing federal Medicaid matching funds for bundled payments.

Several Medicaid programs have been paying for school-based services with a bundled rate. This means that States make weekly or monthly payments to schools based on a package of services that are needed by children within various categories of disabilities, rather than paying separately for each individual service. Many services may be included in the bundled rate, such as physical therapy, speech therapy, and vision services. The cost for the bundled rate is based on the average historical cost of services for children in each disability category. The payment is the same regardless of the number of services actually furnished or the specific costs of services involved.

However, in most States that make bundled payments to schools, school-based providers are not maintaining adequate documentation for bundled payments. In fact, most do not have the administrative structure for maintaining such documentation. Also, State Medicaid agencies are

not conducting periodic reviews to reconcile claims to services delivered and plan approved costs. Without proper documentation of services included in bundled rates, there is no reliable basis for determining whether the needed service was delivered at a reasonable rate. This creates the potential for States to obtain Federal matching funds for care which has not been provided.

That is why our May 21, 1999 letter to State Medicaid Directors made clear that we will no longer recognize bundled rates for school-based health services. States that currently pay bundled rates for school-based services must develop and prospectively implement an alternative reimbursement methodology. We will meet with a workgroup of States, the Department of Education, and other interested parties to discuss ways to pay for school-based services that provide full accountability and administrative efficiency. In the meantime, our regional offices also will actively work with States to assist in the development and implementation of non-bundled rates.

We recognize that changing payment methods may require authorization or action by the legislature in some States, and that the work may have to compete with State efforts to make information systems Year 2000 compliant. We will not ask States that have been using bundled rates to give back federal matching funds for school-based payments made before our May 21 letter. However, we expect States to make necessary changes within a reasonable time frame. If they do not, we will take appropriate enforcement actions allowed under the law.

Transportation

Some school-based health care programs have inappropriately billed Medicaid for transportation costs that are not related to medical care. Medicaid covers the cost of transportation to and from school for children with specialized transportation needs identified in their Individualized Education Plan on days when they receive a medical service in school. In addition, if a child with special health care needs requires specialized transportation to and from school for a medical service but lives in an area that does not have routine school bus service, that transportation also may be billed to Medicaid.

In all situations, Medicaid funding is reserved for specialized transportation to school on a day when a child is receiving a medical service. However, several States have been claiming federal Medicaid matching funds for transportation costs not covered by this policy.

Therefore, our May 21 letter to State Medicaid Directors says explicitly that children who ride the regular school bus to school with other non-disabled children in the neighborhood should not have transportation listed in their Individualized Education Plan, and the cost of that bus ride should not be billed to Medicaid.

The letter also makes clear that:

- States must describe the methodology used to establish the transportation rate in the State's Medicaid plan;
- States must require documentation of each transportation service, usually in the form of a trip log maintained by the provider of the specialized transportation service, when claiming these costs as a direct service; and
- States must develop a cost allocation methodology to ensure that Medicaid only pays for transportation-related administrative costs attributable to Medicaid beneficiaries when claiming these costs as an administrative service.

Our regional offices also will provide technical assistance to help States in properly claiming Federal matching dollars for Medicaid-covered school-related transportation costs.

Administrative Claiming

Some school-based health programs may have billed Medicaid for administrative expenses that Medicaid does not cover. Medicaid covers administrative expenses incurred by schools in providing Medicaid services, such as outreach and case management. However, we again have identified important concerns about how these expenses are being accounted for and claimed. Specifically:

- some school-based providers are not adequately documenting Medicaid administrative claims;

- some school-based providers are including administrative activities related to services that Medicaid does not cover or for services to children who are not eligible for Medicaid; and
- some school-based providers may have claimed the same administrative costs twice by including activities that have already been paid for as part of the Medicaid service itself or by the State or local school district under the Individuals with Disabilities Education Act.

We are working diligently with States to foster a better understanding of when school-based administrative activities are eligible for Medicaid coverage. We plan to issue a written guide related to the requirements for school-based administrative activities this Summer.

CONCLUSION

We are committed to supporting school-based health care services and promoting their potential to afford access to children who otherwise might go without needed care. We must, however, make sure that Medicaid payments for school-based services are appropriate.

Thanks to the support and cooperation we have received from this Committee, we have identified and are addressing the concerns that have emerged. Our joint work on this issue is an example of how the Administration and Congress can work together to identify a potential problem, develop an understanding of the practice, and establish sound policy to protect the long-term interests of both taxpayers and beneficiaries.

We will, of course, continue to closely monitor the situation. However, the actions we are taking should halt inappropriate billing and protect the integrity of Medicaid funding for school-based health care. I thank you for holding this hearing, and I am happy to answer your questions.

# # #

UNITED STATES SENATE
COMMITTEE ON FINANCE

~~Hearing on~~ Medicaid and School-Based Services

Thursday, June 17, 1999, 2:00 p.m. in 215 Dirksen Senate Office Building

WITNESS LIST

I. A panel consisting of:

Sally Richardson, Director, Center for Medicaid and State Operations, Health Care Financing Administration; Washington, D.C.

William J. Scanlon, Ph.D., Director, Public Health and Financing Issues, Health, Education and Human Services Section, General Accounting Office; Washington, D.C.

Vernon K. Smith, Ph.D., Principal, Health Management Associates; Lansing, MI

Gregory A. Vadner, Director, Division of Medical Services, Missouri Department of Social Services; Jefferson City, MO

Sue Gamm, Chief Specialized Services Officer, Chicago Public Schools; Chicago, IL

UNITED STATES DEPARTMENT OF EDUCATION

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COMMENTS:

HCFA memo from Mike

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UNITED STATES DEPARTMENT OF EDUCATION

THE DEPUTY SECRETARY

MEMORANDUM

TO : Kevin Thurm
Deputy Secretary
Department of Health and Human Services

FROM : Marshall Smith
Acting

SUBJECT : Correspondence regarding School-based Medicaid Services

I am writing to express my concern about the lack of appropriate coordination between HHS and the Department of Education on HCFA's May 21st letter to State Medicaid Directors from Sally Richardson, Director of the Center for Medicaid and State Operations, concerning reimbursement for school-based services under Medicaid.

I know you share my belief that children would benefit substantially from improved interagency cooperation at all levels of government, particularly between education and health service agencies. I've been very supportive of the Department's participation on the interagency group that is charged with outreach on the new Children's Health Insurance Program because of the importance of providing all children with access to high quality health care. As part of that effort, we have been encouraging schools to join with health agencies to inform families about CHIP and help enroll the millions of uninsured children. One of the statutes we administer, the Individuals with Disabilities Education Act, as amended in 1997, now requires States to have mechanisms for coordination between State education agencies and non-education agencies to ensure that non-education agencies such as State Medicaid agencies pay for services for which they are responsible. This change, which the Administration endorsed, was intended to assist educational agencies in ensuring that children with disabilities receive the services to which they are entitled. We view cooperation at the Federal level to be critical to this effort.

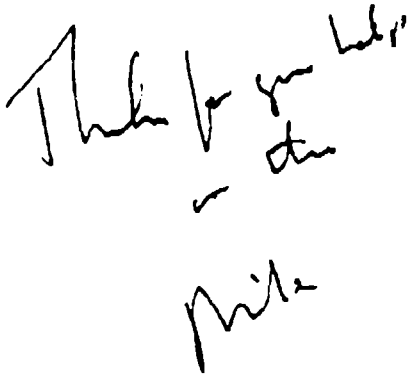
You, therefore, can understand my dismay to learn of the willful refusal of HCFA to coordinate with this Department on the issue of school-based medical services despite our manifest interests in this issue, a prior agreement to address the issue jointly, and an explicit request by Judy Heumann, our Assistant Secretary for the Office of Special Education and Rehabilitative Services, to Sally Richardson that we have an opportunity to discuss significant concerns with HCFA's proposal before a letter is sent to State Medicaid Directors.

We would like to partner with HCFA in helping to ensure appropriate use of Medicaid by the schools, but will have difficulty doing so unless we can participate in the development of policies affecting schools. We had questions regarding the policy that

has been put into place, but were not given an opportunity to discuss our issues before the letter was sent. We still believe a meeting between our departments is needed to discuss our outstanding policy concerns regarding HCFA's position on issues raised by the letter.

We also would request some reassurance that HCFA will provide appropriate technical assistance to the States on the issues addressed by the May 21st letter. The fact that none of the major education organizations that would be interested in this matter were copied on the letter raises a question about HCFA's resolve to work with the education community on these issues.

I hope we can work together to promote appropriate interagency cooperation between our two departments.



Hope this info on Medicaid/ school-based health services helps!

-Dave Rowe

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

MAY 2 1 1999

Dear State Medicaid Director:

This letter addresses reimbursement for school-based health services under Medicaid. School-based services play an important role in assuring that Medicaid-eligible adolescents and children receive needed health care. In particular, Medicaid is the payer of first resort for medical services provided to children with disabilities pursuant to the Individuals with Disabilities Education Act (IDEA). Although HCFA strongly supports the provision of school-based health services, it is important that these services meet applicable Federal Medicaid requirements. This letter clarifies HCFA policy in three areas: (1) use of a bundled rate to pay for medical services provided to Medicaid-eligible children in schools; (2) State claiming for school health-related transportation services for children with Individual Education Plans (IEPs) under the IDEA; and (3) State claiming for school health-related administrative activities.

Bundled Rates for School-Based Services

We and key Congressional Committees have identified a concern related to the "bundling" of school-based health services. We believe you share our interest in maintaining the fiscal integrity of the Medicaid program and, because of the risks discussed below, we are changing our policy in this regard.

A number of States have been paying for school-based services using a "bundled rate" methodology. This permits schools to minimize paperwork by billing for a package of medical services, rather than for each individual service provided to each child. A bundled payment rate exists when a State pays a single rate for one or more of a group of different services furnished to an eligible individual during a fixed period of time. The payment is the same regardless of the number of services furnished or the specific costs, or otherwise available rates, of those services. The bundle may include two or more components usually provided by different providers, each with their own unique provider qualifications, even if the components fall within the same 1905(a) service category. For example, bundling exists when two or more component services are provided under the rehabilitative services benefit even if all of the school-based services are identified in the State plan as being contained within that one 1905(a) service category.

Our concerns are related to the fact that bundled rates for school-based providers are not related to a specific type of procedure and are generally not available to all qualified providers in the community who might wish to be similarly reimbursed. Furthermore, schools do not maintain the types of medical documentation that establish the reasonableness or accuracy of a rate. Because of these factors, HCFA has concluded that these bundled rate methodologies do not produce sufficient documentation of accurate and reasonable payments, and may result in higher payments than would be reasonable on a fee-for-service basis for each individual service and thus do not meet the statutory intent of the law. Section 1902(a)(30)(A) of the Social Security Act requires that States have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care. We believe that a bundled rate for school-based services is inconsistent with economy, since the rate is not designed to accurately reflect true costs or reasonable fee-for-service rates, and with efficiency, since it requires substantially more Federal oversight resources to establish the accuracy and reasonableness of State expenditures. There is therefore no reliable basis for determining that the rate is related to the actual cost to the State and other public entities, absent documentation of the individual services provided.

Effective immediately, HCFA will no longer recognize bundled school-based health services rates as acceptable for purposes of claiming Federal financial participation (FFP). States that are currently paying bundled rates for school-based health services pursuant to an approved State plan amendment must develop and prospectively implement an alternative reimbursement methodology. We will be convening a meeting with a group from the States and the Department of Education to discuss options that are available. Also, States will be given time to work with the HCFA regional offices which will assist in the development and implementation of a non-bundled reimbursement methodology.

HCFA would like to work with states to implement a stratgey so that States can come into compliance prospectively. At this time, no retroactive disallowances of FFP are planned nor are prospective defferals. However, we expect states to work to come into compliance with this policy expeditiously. We recognize that some may require authorization or action by the State Legislature to implement a new reimbursement methodology. In the event that States do not come into compliance within a reasonable time, HCFA will consider taking a compliance action, including defferals and retrospective disallowances to the date of this letter.

HCFA will not approve any additional amendments to State plans that seek to reimburse for school-based health services using a bundled rate. States with pending bundling plan amendments may either withdraw those amendments or revise them to conform to the requirements described in this letter. If the State wishes to retain the effective date of the amendment, HCFA will assist the State to develop an approvable amendment. An approvable amendment must include requirements for maintaining documentation of the individual services provided to support claims for FFP. It should be noted that the IEP is not sufficient for purposes of documenting services provided since it identifies only those services that a child should receive, and not those services that the child actually receives.

Transportation

HCFA's policy concerning Medicaid payment for transporting Medicaid-eligible IDEA children to and from schools is described in the Medicaid and School Health Technical Assistance Guide. The Guide indicates that transportation to and from school may be claimed as a Medicaid service when the child receives a medical service in school on a particular day and when transportation is specifically listed in the IEP as a required service.

It is our understanding that an IEP should include only specialized services that a child would not otherwise receive in the course of attending school. Therefore, HCFA would like to clarify that a child with special education needs under IDEA who rides the regular school bus to school with the other non-disabled children in his/her neighborhood should not have transportation listed in his IEP and the cost of that bus ride should not be billed to Medicaid.

If a child requires transportation in a vehicle adapted to serve the needs of the disabled, including a specially adapted school bus, that transportation may be billed to Medicaid if the need for that specialized transportation is identified in the IEP. In addition, if a child resides in an area that does not have school bus transportation (such as those areas in close proximity to a school) but has a medical need for transportation that is noted in the IEP, that transportation may also be billed to Medicaid. As always, transportation from the school to a provider in the community also may be billed to Medicaid. These policies apply whether the State is claiming FFP for transportation under Medicaid as medical assistance or administration.

When a State claims FFP under the Medicaid program for transportation services as medical assistance under an approved reimbursement rate, the requirements for documentation of each service must be maintained for purposes of an audit trail. This usually takes the form of a trip log maintained by the provider of the specialized transportation service. The methodology used to establish the transportation rate should also be described in the State plan.

When FFP for the costs of transportation services is claimed as administration, the requirements of the Office of Management and Budget Circular A-87 for determining allowable costs, as well as any other applicable requirements for claiming administration under Medicaid, must be met. This includes the development of a cost allocation methodology to ensure that Medicaid only pays for that portion of the specialized mode of transportation allocable to Medicaid beneficiaries.

Effective July 1, 1999, FFP will only be available for Medicaid school-based transportation cost as administrative activities in accordance with the policies described above. Similarly, FFP for IEP related transportation services will only be available for services provided on or after July 1, 1999 as specified in this letter. HCFA's regional offices will provide technical assistance to States to assist them in properly claiming FFP for school-related transportation.

Administrative Claiming for School-Based Services

HCFA is currently reviewing practices related to State claiming for school-based administrative activities. A guide is expected to be published this Summer which clarifies the requirements for claims for Medicaid expenditures for administrative activities performed in schools.

HCFA regional and central office staff will provide every assistance to States in their efforts to conform to these policies.

Sincerely,

Sally K. Richardson
Director

cc:

All HCFA Regional Administrators
All HCFA Associate Regional Administrators
For Medicaid and State Operations
Lee Partridge - American Public Human Services Association
Joy Wilson - National Council of State Legislatures
Matt Salo - National Governors' Association

United States General Accounting Office

GAO

Testimony

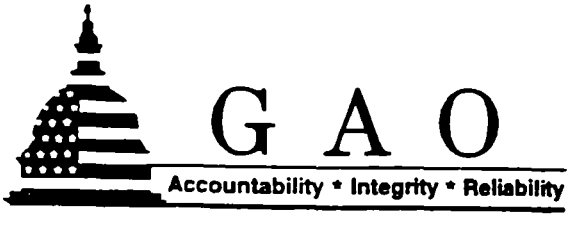
Before the Committee on Finance, U.S. Senate

For Release on Delivery
Expected at 2:00 p.m.
Thursday, June 17, 1999

MEDICAID

Questionable Practices Boost Federal Payments for School-Based Services

Statement of William J. Scanlon, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division



GAO/T-HEHS-99-148

Mr. Chairman and Members of the Committee:

We are pleased to be here today as you explore potential improprieties involving Medicaid claims for school-based health services. Because Medicaid is a federal-state program, the federal government is responsible for paying a share of costs incurred by the states to serve Medicaid's 40 million low-income beneficiaries, including 19.7 million children. For eligible children who receive certain health services through their schools, states can use their Medicaid programs to help pay for these services, which include diagnostic screening and ongoing treatment. Medicaid is also authorized to reimburse schools' costs for performing administrative activities associated with Medicaid's coverage of health services, such as conducting outreach activities to enroll children in Medicaid; providing eligibility determination assistance, program information, and referrals; and coordinating and monitoring the Medicaid-covered health services.

Recently, concerns have been raised about the appropriateness of states' efforts to claim Medicaid reimbursement for school-based services. Emerging practices appear to have some disturbing similarities to other "creative" financing mechanisms that began to be used in the mid-1980s. Some states used such mechanisms to increase the federal Medicaid contributions they received without increasing their own contribution. As the nature and magnitude of such mechanisms became apparent, the Congress acted on several occasions to halt them.[1]

Recent multimillion-dollar increases in Medicaid reimbursement for school-based health services have triggered questions about the state and federal procedures in approving and overseeing these growing expenditures. Specifically, your Committee asked that we examine the rise in claims for administrative costs associated with school-based health services.[2] Accordingly, my remarks will focus on (1) trends in Medicaid's spending for administrative costs, (2) the distribution of Medicaid payments for administrative claims to schools and other entities, and (3) the adequacy of federal oversight in approving school districts' claims for reimbursement. My comments are based on information collected over the past 2 months, at this Committee's request, when we interviewed the 18 states identified as currently claiming administrative costs. We also visited three of these states—Illinois, Massachusetts, and Michigan—where we contacted officials at federal and state agencies, school districts, and private firms; analyzed data; and reviewed relevant documents. We also contacted officials of the Health Care Financing

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[1]See Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government (GAO/HEHS-94-133, Aug. 1, 1994), Medicaid: Disproportionate Share Payments to State Psychiatric Hospitals (GAO/HEHS-98-52, Jan. 23, 1998), and Michigan Financing Arrangements (GAO/HEHS-94-146R, May 5, 1995). See also the list of related GAO products at the end of this statement.

[2]Concerns have also been raised about (1) using a bundled rate to pay for medical services provided to Medicaid-eligible children in schools and (2) claims for school health-related transportation services for children with disabilities. On May 21, 1999, the Health Care Financing Administration sent a letter to state Medicaid directors to clarify policy on these two issues. We do not address those issues in this testimony.

Administration (HCFA), the agency within the Department of Health and Human Services (HHS) responsible for administering Medicaid at the federal level.

In summary, over the past 4 years, school districts' claims for administrative costs associated with school-based health services have increased fivefold—from $82 million to $469 million—in 10 states for which we could readily obtain data. Two of these states—Michigan and Illinois—accounted for most of the increases in administrative cost claims over this time period. More school districts and additional states have expressed interest in seeking Medicaid reimbursement for health-related administrative activities in schools, suggesting that claims will continue to rise.

The share of Medicaid payments for school-based administrative activities received by the schools—as opposed to other entities—varies by state. At least four states retain a portion of the federal funds obtained, whereas other states return the entire federal share directly to the school districts. School districts often contract with private firms to perform the claims development and reporting activities, and they pay these firms fees ranging from 3 to 25 percent of the total amount of the federal Medicaid reimbursement. In one state we visited, some school districts, after the state takes its share and the private firm is paid, receive only $4 of every $10 that the federal government pays to reimburse schools' Medicaid-allowable administrative costs.

Federal oversight of school districts' claims for administrative expense reimbursements has been weak. HCFA guidance has been insufficient and its reviews of districts' claims activities uneven. As a result, what is submitted by states is approved by some HCFA regional offices as an allowable administrative claim and is denied by others as questionable or unallowable. These weak controls permit an environment for opportunism in which inappropriate claims could generate excessive Medicaid payments.

BACKGROUND

Under Medicaid's federal-state partnership, states operate their Medicaid programs within broad federal requirements and can elect to cover a range of optional populations and benefits. As a result, Medicaid is essentially 56 separate programs (including the 50 states, the District of Columbia, Puerto Rico, and the U.S. territories). Each program's respective federal and state funding shares are determined through a statutory matching formula.

As part of its responsibilities for Medicaid, HCFA reviews each state's program for conformity with federal requirements. HCFA's 10 regional offices are responsible for the direct oversight of the respective state Medicaid programs within their jurisdiction, whereas HCFA's central office sets federal Medicaid policy and works with the regional offices on issues regarding state Medicaid policy and administration.

States submit claims to HCFA for Medicaid reimbursement generally under two categories: medical assistance payments and administration. Most Medicaid expenditures are for medical assistance payments; the federal share of medical assistance payments varies by state and ranges from 50 percent to 83 percent based on each state's per capita income in relationship to the

national average. Nationally, the federal share of medical assistance expenditures averaged about 57 percent in fiscal year 1998. Of Medicaid's $177 billion in total expenditures in fiscal year 1998, administrative costs were approximately $8 billion, or 4.5 percent. For administrative activities, the federal share varies by the type of costs incurred. Most administrative expenditures are matched at a fixed rate of 50 percent, making the federal government's contribution equal to that of a state. However, certain administrative activities are matched above 50 percent; for example, the development of automated systems is federally matched at a 90-percent rate. In fiscal year 1998, the federal share of payments for Medicaid's administrative costs averaged about 55 percent nationwide.

Medicaid is authorized to reimburse schools as qualified providers for covered medical assistance services provided through (1) school personnel, (2) other qualified practitioners with whom the school contracts, or (3) a combination of these approaches. School-based Medicaid-covered services that qualify for federal funds include physical, occupational, and speech therapy, as well as diagnostic, preventive, and rehabilitative services. Some services are provided in conjunction with the Individuals With Disabilities Education Act (IDEA) program;[3] others are included through a state's Medicaid plan and are available through Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.[4]

Medicaid's Reimbursement of School-Based Administrative Services

Medicaid is also authorized to reimburse schools for certain administrative costs, even if the school has not provided any medical assistance services. Examples of such allowable administrative activities include conducting outreach for Medicaid, helping applicants complete Medicaid enrollment forms, and arranging appointments with various providers of medical and screening services. Both IDEA and EPSDT have requirements to conduct activities that would inform and encourage individuals to participate in their benefits and services, and schools are considered a good location for identifying Medicaid-eligible children, including those with special needs.

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[3]IDEA, 20 U.S.C. 1400, was first enacted in 1975. It covers children with disabilities in public schools and emphasizes special education; it also covers such related services as transportation, speech pathology and audiology, psychological services, physical and occupational therapy, and counseling. Medicaid has been authorized to cover health services provided to children under IDEA through a child's Individualized Education Plan or Individualized Family Services Plan, provided the services are covered in the state's Medicaid plan, or if medically necessary, through EPSDT. Medicaid funds have been available for IDEA services since the enactment of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360).

[4]EPSDT is Medicaid's set of comprehensive and preventive health care services to Medicaid-eligible children under age 21. The EPSDT program provides Medicaid coverage for any medically necessary service, regardless of whether the service is covered in a state's Medicaid plan.

HCFA guidance states that, to claim reimbursement for administrative costs, the schools must first identify the administrative activities associated with providing the Medicaid-covered health services and then determine their direct and indirect costs.[5] Different types of administrative activities can be totally, partially, or not eligible for Medicaid reimbursement. For some administrative activities related to Medicaid eligible and noneligible children, the share of Medicaid eligibles among all children is applied to the activities' costs, which are claimed as Medicaid administrative costs. In addition, time studies, which track staff activities during a set period, are often used to determine the allocation between Medicaid and non-Medicaid administrative activities.

For administrative costs to be claimed under Medicaid, they must be specified in an approved cost allocation plan.[6] According to HCFA guidance, a school district should develop its cost allocation plan in concert with the state Medicaid agency, which in turn forwards the plan to the responsible HCFA region for approval. Subsequently, the school district uses the approved plan as the basis for the cost report it forwards to the state, which then forwards claims to HCFA for Medicaid reimbursement.

Previous Financing Mechanisms
Used by States and Later Prohibited in Law

The creative financing mechanisms that states began using in the mid-1980s to maximize federal Medicaid contributions, without effectively committing their own share of matching funds, took various forms. One involved using provider-specific tax revenues or provider donations paid to the state being returned to the providers with federal matching funds added. Another mechanism involved states' generating federal matching funds by increasing payment rates for a particular group of public providers, such as nursing homes or public hospitals. However, these providers, through the use of intergovernmental transfers, returned all or the majority of federal and state funds to state treasuries. Those practices that involved hospitals contributed to an explosive increase in disproportionate share hospital (DSH) payments made to hospitals that serve larger proportions of low-income and Medicaid beneficiaries--from $1 billion in 1990 to $17 billion in 1992. Federal legislation in 1991 and 1993 banned certain of these practices and placed limits on allowable reimbursable expenditures. However, the legislation did not restrict states' use of intergovernmental transfers.

While these legislative actions significantly reduced the states' use of these financing mechanisms, states continued to find innovative ways to obtain additional federal funds. More recently, some state Medicaid programs were found to be making DSH payments to state psychiatric hospitals that were far larger on average than payments made to other types of local

[5]Direct costs are activities that can be identified with a specific final cost objective, such as Medicaid administrative functions. Indirect costs are those incurred for a common or joint purpose that cannot be readily assigned to a single cost objective.
[6]Cost allocation plans must abide by the cost allocation principles described in the Office of Management and Budget Circular A-87, which requires, among other things, that costs be "necessary and reasonable" and "allocable" to the Medicaid program.

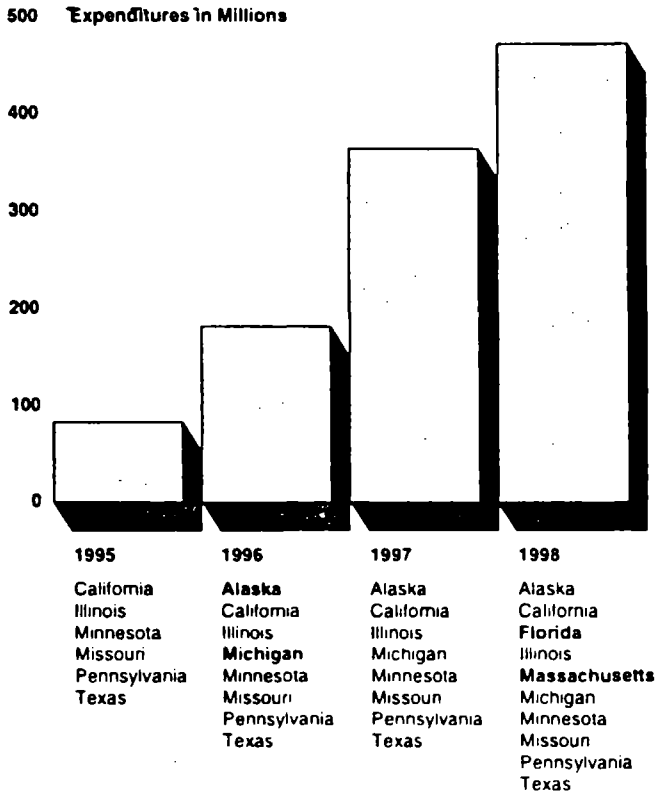
public and private hospitals. Overall, DSH payments to state psychiatric hospitals in six states we reviewed averaged about $29 million per hospital compared with $1.75 million for private hospitals. Such payments enabled the states to obtain federal matching funds to indirectly cover costs of services that federal law prohibits Medicaid programs from covering. In response to this practice, the Balanced Budget Act of 1997 limited the proportion of a state's DSH payments that can be paid to state psychiatric hospitals.

MEDICAID CLAIMS FOR ADMINISTRATIVE EXPENDITURES HAVE INCREASED DRAMATICALLY IN SOME STATES

A growing number of school districts are making claims for Medicaid's reimbursement of school-based administrative services. From 1995 to 1998, Medicaid expenditures claimed for administrative activities increased fivefold in the 10 states for which we could readily obtain data.[7] (See fig.1.) Two of these states—Michigan and Illinois—comprised the majority of the $387 million increase in administrative expenditures from 1995 through 1998.

[7]HCFA identified 18 states that make claims for the administrative costs associated with school-based services. Because Medicaid has no separate benefit category for school-based services, not all states were readily able to provide information on their administrative expenditures for schools or school districts.

Figure 1: Growth in Medicaid School-Based Administrative Claims for 10 States, FY 1995-98



Note: State names in bold are those that began claiming school-based administrative expenditures in the year listed.

Source: State-reported claims.

Increases in Medicaid administrative expenditures claimed reflect a growth in both the number of schools participating and the size of claims submitted by individual school districts.[8] For example, from 1996 to 1997, Michigan's Medicaid administrative claims for schools increased almost threefold, from $79 million to $227 million, which state and school officials indicated was due primarily to an increasing number of school districts submitting claims. In contrast, Illinois school districts, which have been claiming Medicaid reimbursement since 1992, continue

[8]Administrative activities vary considerably in their content and purpose, accounting, in part, for the differences in expenditures across states. For example, some states report that the administrative activities claimed in schools primarily reflect outreach efforts on behalf of EPSDT and other Medicaid benefits. Other states with school-based medical assistance services file administrative costs related to the provision of medical services, such as coordination and monitoring of health services and interagency coordination.

to identify additional activities that they believe are appropriate for Medicaid reimbursement.[9] Thus, increases in Illinois' expenditures between 1997 and 1998—from $89 million to $145 million—largely reflect increased cost claims from school districts.[10]

Barring any policy change, growth in Medicaid administrative cost claims from schools is likely to continue. Federal and state officials reported to us that other states and school districts not now making claims have expressed interest in obtaining Medicaid reimbursement for health-related administrative activities in schools. Some state officials noted that they expect to expand their claiming of costs in the near future and that they are now beginning to develop procedures and methodologies to support such an expansion. Additionally, HCFA officials commented that several states are interested in claiming Medicaid-related administrative costs but are "waiting in the wings" to ascertain whether HCFA will continue to approve certain practices for claiming administrative costs.

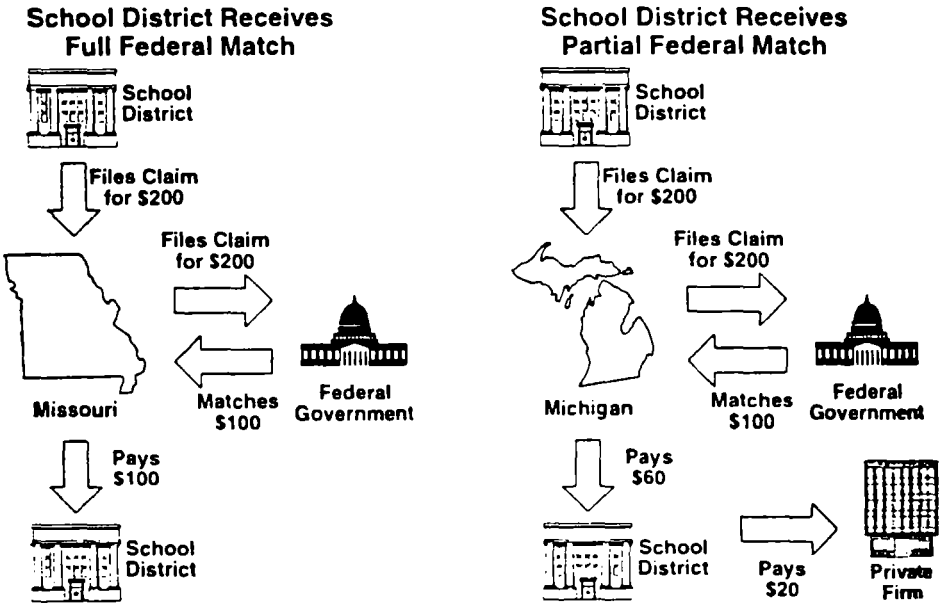
IN SOME STATES, MEDICAID FUNDS TO REIMBURSE SCHOOLS GO TO STATE TREASURIES AND PRIVATE FIRMS

Medicaid funds to reimburse schools for administrative activities are distributed differently, depending on the state. (See fig. 2.)

[9]Chicago public schools attributed increased Medicaid revenues to additional staff training and development, legal assistance, and claims reporting assistance.

[10]Among the 10 states, Pennsylvania was the only state to have steadily lowered its administrative claims expenditures; Missouri and Texas expenditures remained relatively stable.

Figure 2: Two Approaches to School-Based Administrative Claiming



Note: Examples assume a federal share of 50 percent.

For example, Arizona, Missouri, and Rhode Island provide all federal funds to the schools, whereas at least four other states allocate a portion of the federal reimbursement to their general revenue funds. Officials in two of these states said that, because state budgets fund a portion of school activities, a school district's share of federal reimbursement for administrative claims is, in principle, partially funded by the state. Under this reasoning, states believe they are entitled to some share of the federal reimbursements claimed by school districts. The three states we visited kept some portion of the federal share, ranging from 3 percent in Massachusetts to 40 percent in Michigan. Federal dollars contributed about $1.5 million, $8 million, and $47 million to the fiscal year 1998 revenues of Massachusetts, Illinois, and Michigan, respectively. Since Michigan schools began claiming for administrative reimbursement in fiscal year 1996, the state has retained close to $106 million of the federal share.

Some school districts employ private firms to facilitate their efforts to claim Medicaid reimbursement. These firms typically receive as compensation a share of the revenues generated by the claims. By receiving a percentage rather than a fixed fee, these firms have an incentive to maximize the amount of reimbursements claimed. Some school districts in the states we visited paid these firms fees ranging from 3 percent to 25 percent of the federal reimbursement amount, although most commonly, the fee paid was between 9 and 12 percent. One private firm is proposing to charge a flat fee that is based on the fees it has charged historically—which were originally set as a percentage of a school district's federal reimbursement received.

Marketing materials from two private firms suggest why concerns have been expressed that school districts' administrative claims may exceed reasonable or allowable costs. In these materials, the private firms note that their objectives are to maximize Medicaid revenues for schools and assert that they can maximize a school's claim potential by training school personnel to follow their methods for claiming costs. One firm emphasizes that, on average, its clients annually receive over 30 percent more per student than a competitor's.

INSUFFICIENT HCFA GUIDANCE, UNEVEN OVERSIGHT HAVE LED TO QUESTIONABLE PRACTICES FOR CLAIMING REIMBURSEMENT

Insufficient guidance, combined with uneven oversight across HCFA regions, has led to questionable billing practices by states and inconsistent federal review of states' administrative claims for school-based services. HCFA has not provided clear or consistent guidance to its regional offices regarding criteria for determining reasonable costs or appropriate methods for claiming administrative costs.

What are submitted by states and approved or denied by HCFA regions as allowable administrative costs vary widely. In the absence of specific direction from the HCFA central office, regional offices interpreted and applied the available guidance inconsistently. Practices that HCFA has allowed in one state it has not allowed in others, resulting in confusion for claimants and creating an environment in which claimants are not discouraged from testing questionable billing practices.

Broad HCFA Guidance Leaves Payment Determinations Largely to Regional Discretion

HCFA's guidance on how school districts should allocate costs to Medicaid is general to enable federal requirements to accommodate the features of 56 individual Medicaid programs. The burden of oversight necessary to ensure that administrative costs are reasonable and appropriately allocable to the Medicaid program falls to HCFA's 10 regional offices. However, guidance to the regional offices has been limited, leaving interpretation of policy and procedures up to each office. As a result, HCFA oversight of school-based administrative cost claims has been uneven, resulting in case-by-case determinations.

Generally, HCFA directs states to follow federal requirements for administrative cost allocation found in Office of Management and Budget (OMB) Circular A-87, which establishes the principles and standards for determining "reasonable" and "allocable" costs for federal awards such as Medicaid. In addition, the Medicaid statute says that Medicaid methods of administration should be "found to be necessary by the Secretary [of Health and Human Services] for proper and efficient administration" of a state's Medicaid program.[11]

[11]Section 1902(a)(4)(A) of the Social Security Act.

HCFA developed a technical assistance guide for states and school districts to provide more detailed guidance on Medicaid requirements associated with seeking payment for covered services (including administrative claims) in school-based settings.[12] Essentially, the guide echoes the requirements in OMB Circular A-87 and Medicaid regulations while providing a few illustrations. However, the guide does not specify criteria that would permit the systematic determination of what is reasonable and allocable to Medicaid.

The HCFA regional offices have been unsuccessful in obtaining decisive and consistent guidance from the agency's central office. For example, in 1997, a regional office requested assistance in determining what was allowable for one state's administrative claims. Multiple discussions between the two HCFA offices did not produce definitive answers. In another instance, a regional office consulted with the central office about deferring payment of a state's administrative claims until the state provided additional supporting documentation.[13] Instead, the regional office was told to pay the state but perform a postpayment review of the claims.[14] In a similar instance, another regional office deferred paying a state's questionable claims at its own initiative because it did not believe consultation was needed.

HCFA Oversight Fails to Discourage Suspect Billing Practices

Without specific guidance, federal determinations of the appropriateness of administrative claiming practices are inconsistent, permitting the approval of claims that in some cases may be suspect. Some regions have conducted very prescriptive approaches to administrative cost claiming; others have been more "hands-off." In those regions that have been "hands off," some states have tested the limits of reasonable and allowable standards, potentially maximizing Medicaid reimbursement inappropriately.

In our discussions with five regional offices, we found that their approval varied regarding states' approaches to allocating administrative costs to Medicaid. We found only one instance in which a HCFA region had been involved in the initial design of a state's cost allocation method. In other cases, state Medicaid agencies met with the regional offices for a "courtesy visit" to present their finalized cost allocation methods. In still other cases, the regional offices had no knowledge of a cost allocation plan in advance of a state's submission of administrative claims. In these cases, some regional offices deferred payments, others consulted with the central office about deferment, and still others paid the claims without further review.

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[12]See HCFA, Center for Medicaid and State Operations, Medicaid and School Health: A Technical Assistance Guide (Washington, D.C.: HCFA, Aug. 1997).

[13]According to federal Medicaid regulations at 42 C.F.R. 430.40 (b), HCFA may defer a claim when it is unable to determine, on the basis of available documentation, whether a claim should be allowed.

[14]In contrast to a deferral, a postpayment review retroactively reviews practices to ensure that the claims paid were allowable.

We found that regional offices varied in their response to the use of various cost allocation practices that some school districts employ to enhance the amounts of Medicaid reimbursement claimed. The following are examples:

- Two regional offices found instances in which school personnel charged to Medicaid 100 percent of their activities, only a portion of which were health-related. In response, one of the regional offices identified and deferred over $33 million in inappropriate claims, while the other has proposed a deferral to HCFA's central office. In contrast, another regional office found similar instances of inappropriately billed activities but reported to us taking no action that resulted in changes on the part of the claimants.

- In two instances within one region, private firms designed activity code definitions for outreach activities that claimed 100-percent reimbursement from Medicaid, even though the activities were performed for services associated with other programs, such as WIC[15] and Food Stamps. Other HCFA regions disapproved these same outreach activities when claimed by states in their jurisdiction.

- The HCFA regional offices vary in their treatment of administrative activities performed by skilled professional medical personnel, which under certain conditions, can be matched at a 75-percent rate.[16] Where an enhanced matching rate was allowed, claims may have been overstated because, counter to Medicaid regulations, no distinction was made between skilled and unskilled activities. Two HCFA regions disallowed an enhanced matching rate altogether, with one stating that "there was no way in the world" to document that certain activities required a skilled level of performance.

- In one instance, a consortium of school districts used a sampling methodology for identifying Medicaid-eligible children that did not include sampling data from all the school districts in the consortium. To the extent that lower-income school districts were overrepresented using this method, the inflated estimate of the proportion of Medicaid-eligible children increases the amount of Medicaid reimbursement for the consortium's administrative claims.

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[15]WIC, or the Special Supplemental Nutrition Program for Women, Infants, and Children is a federally funded nutrition assistance program that provides lower-income pregnant and postpartum women, infants, and children up to age 5 with supplemental foods, nutrition counseling, and access to heath care services.

[16]An enhanced matching rate of 75 percent is available for administrative activities performed by skilled professionals only if, among other things, they (1) have the appropriate credentials and (2) perform an activity that requires professional medical knowledge and skills. Hypothetically, a physical therapist would be eligible for the enhanced rate for time spent coordinating medical services but would be expected to claim at the 50 percent matching rate for time spent photocopying.

CONCLUDING OBSERVATIONS

Close to one-half of Medicaid-eligible individuals are children, making schools an important arena for Medicaid services. Even for schools that do not directly provide Medicaid services, administrative activities can help identify, refer, screen, and enroll eligible children for appropriate, covered services. Outreach and identification activities—in many and varied settings—help ensure that the nation's most vulnerable children receive routine preventive health care or ongoing primary care and treatment.

In stepping into this arena, however, some school district and state practices appear intent on maximizing their receipt of Medicaid funds through suspect financing mechanisms. Without additional guidance and consistent oversight by HCFA, many school districts with minimal knowledge of Medicaid and its billing requirements have chosen to contract with private firms. This places these firms "in the driver's seat," where they design the methods to claim administrative costs, train school personnel to apply these methods, and submit administrative claims to the state Medicaid agencies to obtain the federal reimbursement that provides the basis for their fees.

Embedded in this process are incentives for both the states and private firms to maximize Medicaid reimbursements. By being able to capture a share of the school district's federal payments, states and private firms are motivated to experiment with "creative" billing practices. At the same time, the treatment of these practices by some of HCFA's regional offices fails to adequately safeguard Medicaid dollars.

Striking a balance between the stewardship of Medicaid funds and the need for flexible approaches to ensure the coverage and treatment of eligible children is difficult. HCFA is in a position to explore policies and practices in partnership with states—and both have a fiduciary responsibility to administer Medicaid efficiently and effectively. Growing claims for school-based administrative services call for prompt attention by the federal government and the states.

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Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Committee may have.

GAO CONTACT AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call William J. Scanlon at (202) 512-7114. Key contributors to this testimony include Carolyn L. Yocom, Susan T. Anthony, Connie Peebles Barrow, and Victoria M. Smith.

RELATED GAO PRODUCTS

Medicaid: Disproportionate Share Payments to State Psychiatric Hospitals (GAO/HEHS-98-52, Jan. 23, 1998).

Medicaid: Disproportionate Share Hospital Payments to Institutions for Mental Diseases (GAO/HEHS-97-181R, July 15, 1997).

State Medicaid Financing Practices (GAO/HEHS-96-76R, Jan.23, 1996).

Michigan Financing Arrangements (GAO/HEHS-95-146R, May 5, 1995).

Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government (GAO/HEHS-94-133, Aug. 1, 1994).

(101833)

Testimony of

Vernon K. Smith, Ph.D.
Principal
Health Management Associates
Lansing, Michigan

Before the

Committee on Finance

U.S. Senate

Washington, D.C.
June 17, 1999

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss with you important issues that have emerged relating to Medicaid financing of services and activities in our nation's schools.

I appear before you with a somewhat unique perspective on these issues. Two years ago, I retired from the State of Michigan after nearly thirty years of service. During that time I was Medicaid director, Medicaid policy director and a budget official. From 1981 to 1994 I chaired the Maternal and Child Health Technical Advisory Group to the Health Care Financing Administration (HCFA), which in the early 1990's dealt with school-based health issues. For the past two years, I have been a Principal with Health Management Associates (HMA), a health care research and consulting firm with offices in Michigan, Florida and Washington, D.C. Over the course of the past two years, I have provided consulting services related to this issue to both school districts and a billing firm. At the present time, neither I nor HMA have any business relationships with school districts or billing firms, but these experiences have helped provide an understanding of these issues from several perspectives.

Context and Background

Over the past decade, Medicaid has undergone tremendous change and growth. Most of the focus has been on the growth in enrollment and costs, which has been significant. Less focus has been placed on an equally significant phenomenon: the increased use of

These numbers are certain to increase as states implement their Child Health Insurance Programs, because many who apply for CHIP are instead enrolled in Medicaid.

Current State Participation in Medicaid Supported School-Based Services

Early in 1999, the Institute for Human Services Research, which is affiliated with Health Management Associates, surveyed all states to determine the extent of state participation in Medicaid financed school-based health care services. Of the 51 Medicaid agencies surveyed (50 states and the District of Columbia), responses were received from all but one state. The report from this survey is still being finalized, but the following summary provides an indication of how states are using Medicaid funding for school services.

Summary of results for medical services:

- 45 states indicated that Medicaid is used to help fund school-based medical services.
- Responding states indicated the total amount of claims for direct medical services for their most recent fiscal year, usually FY1998, was $1.3 billion, of which $730 million was federal Medicaid funding.
- The $1.3 billion represents about $330 per year per special education student (using the most recent estimate of the special education population, by the U.S. Department of Education, for 1997.)
- Services commonly provided in schools include speech therapy, occupational therapy, rehabilitation, mental health services and case management services.

Summary of results relating to administrative outreach activities:

- 18 states indicated that Medicaid is used to help fund administrative outreach activities related to the Medicaid program.
- Responding states indicated a total claim of $603 million in administrative outreach activities for their most recent fiscal year. Of this total, the federal share was $339 million.
- Activities qualifying for Medicaid support include identification of children who may qualify for Medicaid, assisting in their enrollment, and arranging for medical appointments.

Overall, 47 states reported Medicaid funding for either direct services or administrative outreach. Fifteen states reported doing both. The total reported claim for both was just under $2 billion, of which the federal share was about $1.1 billion.

Issues in Medicaid Funding of School-Based Medical Services and Administrative Outreach

Issue #2: School Districts Often Pay Commissions based on the Amount of Revenue Generated

School districts typically pay billing companies a significant share of the federal reimbursement, often on the order of 10% to 20%. When payment to the billing agent is based on the amount of revenue generated, it creates an incentive for the billing company to maximize the billing. It is the provider who must bear the legal responsibility for the billing. In my view, inappropriate incentives are created when the billing agent earns more for claiming more.

The current system creates a competition between billing companies to bill more. The company with the highest average billing amount per pupil markets itself as the one that can generate the most revenue for the school district. The incentive is to generate more reimbursement. Those billing agents with lower reimbursement per pupil are left to try to explain why, perhaps because they believe it is not appropriate to bill for certain services or activities.

In the case of public agencies, I believe it is reasonable that billing agents be paid for each claim prepared, rather than on basis of the amount of reimbursement received as a result of the claims.

Issue #3: Bundled billing

Recently the issue of bundled services and reimbursement has been addressed by HCFA in a letter to all Medicaid directors. The letter indicates HCFA will not recognize bundled services as acceptable for Medicaid reimbursement in the future.

It is my belief that the key issue is not bundled services and reimbursements. The issue is the definition of what is included in the package of services, and the actuarial soundness of the payment. From a technical standpoint, a bundled rate is no different than a capitation rate paid to an HMO, or a DRG payment to a hospital. It is a simplified system that minimizes administrative costs to those providing and billing for the services. Those involved with the administration of Medicaid, at the federal or state level, are committed to ensuring the financial integrity of Medicaid payments. However, it is my belief that the objective of financial integrity can be achieved without outlawing bundled service definitions and payments.

Issue #4: For Administrative Outreach, Cost Allocation Methodologies Are Developed and Maintained By Billing Companies

In some states, each billing company devises its own proprietary cost allocation methodology for determining the administrative outreach claim. In those states, a change from one billing agent to another would likely mean a new approach, with different time study methods and survey forms. Some billing companies market their approach as better, or more productive in terms of federal reimbursement.

TESTIMONY FOR THE SENATE FINANCE COMMITTEE HEARING ON MEDICAID FUNDING FOR SCHOOL BASED HEALTH SERVICES

GREGORY A. VADNER
DIRECTOR
DIVISION OF MEDICAL SERVICES
DEPARTMENT OF SOCIAL SERVICES
STATE OF MISSOURI

JUNE 17, 1999

Mr. Chairman, Members of the Committee:

Thank you for inviting me to appear before you today. I am the director of the Missouri Medicaid Program, and I am here in that capacity.

We believe school based services are an important asset to ensuring children's access to health care services. These services are a critical component of children's readiness to learn, especially in the case of children with special health care needs. The importance of this issue has recently been highlighted by four developments:

- Recent efforts by states to increase their ability to capture allowable Medicaid funding for school based health care services, particularly through bundling groups of services for the purpose of rate setting and the administrative efficiencies this brings; a bundled rate is merely the setting of an average per child cost of serving disabled children;
- Accompanying scrutiny by stakeholders such as yourself concerning these efforts to make sure program integrity is maintained;
- The Health Care Financing Administration's (HCFA) May 21, 1999 letter outlawing current and future bundled rate payment systems; and
- The March 3, 1999 U.S. Supreme Court case, *Cedar Rapids Community School District, v. Garret F.* This case will have the effect of increasing each school system's need to make sure Medicaid eligible children are on the program and to find ways to efficiently bill Medicaid for all eligible services.

Missouri is a state that is exploring the development of a bundling system, which HCFA has chosen to outlaw. Missouri Medicaid currently pays for school based administrative case management and direct services in a fee for service system. These are allowable Medicaid costs all schools have. Our program began in the early nineties with 6 districts out of 525 participating. We reached a peak in 1996 with less than 20% of all districts participating. Why this discrepancy? Simple, our schools tell us they are not in the business of billing for services. They got into this thinking that billing would be easy for them, and it is not. The results have been disappointing:

- Funding for services and service coordination through case management is not equitable. Sophisticated "wealthier" systems are

better able to participate, while poorer and smaller rural districts have not;

- Money is spent chasing paper, not coordinating access and services. This runs counter to the current trend of buying packages of services and coverage instead of piecemeal services;
- The resulting situation with most districts not able to participate puts pressure on all of us to look for efficiencies and increase participation.

If a good, sound bundling system is not allowed, I predict states will have to pursue other ways to streamline Medicaid payment for school based services. My fear is these ways will be less efficient and more open to error or abuse than a sound bundling program with good documentation. Regardless, the need for services and the accompanying Medicaid funding will not go away.

Every state looks for ways to deliver and fund school based services in the best way for them. Most of these models are similar in some respects and unique in others. That is the nature of states and why they are such vibrant examples of innovation, because they each approach problems with a focus on their own particular circumstances.

The federal government must play a critical role in this process. It is important that HCFA review each state's Medicaid plan, whether bundled or fee for service, to ensure:

- The integrity and efficiency of program designs so that money is not wasted and the chance of fraud or abuse is minimized;
- Where outside contractors are part of the design or operation of the program, the competitive bid process states use should be validated; and
- Most importantly, any approved plan must have a method to ensure that children receive the health care services to which they need. In most cases this could be built in as part of a student's Individual Education Plan (IEP).

I am concerned that the recent HCFA directive suddenly outlaws currently approved programs. Allowing states time to make the transition to some other, unknown system seems small consolation when suddenly faced with a complete reversal of policy. We are talking about throwing away fully approved and operational state plans with lengthy development and federal approval processes

behind them, a terrible precedent for this federal/state partnership. Wouldn't a better approach be to work with states to identify and correct any weaknesses in these plans. Where abuses are found, tough measures should be taken to stop them. In my opinion, current and developing bundled rate programs ought to be made to meet the federal tests I have outlined. They should not be invalidated overnight as a simple solution to tough policy issues. Close federal scrutiny and legitimate concerns ought to bring constructive improvements developed in full and ongoing partnership with the states.

I hope this debate does not cloud our view of the benefits of increased school based services through Medicaid. This would help states do a better job with the Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) program. It would help the schools achieve their federal mandate under the Individuals with Disabilities Education Act (IDEA), especially with the recent *Cedar Rapids* case. Most importantly, increasing participation in this program would directly benefit students with special health care needs and their non-disabled classmates who might otherwise see regular education budgets diverted for these costs.

Missouri, and I believe the other states join us, stands ready to work with Congress and HCFA so that we can show everyone the solutions to these concerns.

I have included additional background materials with my submission for the record.

I thank the committee for visiting these important issues.

Supporting Documentation to the
Testimony of Gregory A. Vadner, Director
Division of Medical Services
Missouri Department of Social Services
June 17, 1999

For many years, public schools and state Medicaid programs have struggled with the division of responsibility for providing school-based health services to poor children with disabilities who are enrolled in Medicaid. These school-based health services can range from scheduled sessions for occupational or speech therapy to the hour-by-hour personal care to children who have multiple physical impairments or who may be ventilator-dependent. Public schools are required to provide these services whenever they have been prescribed by a child's Individualized Education Program, or IEP -- which is required under the Individuals with Disabilities Education Act ("IDEA") to ensure that "all children with disabilities have access to a free appropriate public education which emphasizes special education and related services designed to meet their unique needs." 20 U.S.C. § 1400(c).

For a time after the IDEA was enacted, schools and state Medicaid agencies, and the federal Health Care Financing Administration, were unclear as to which entity was responsible for paying for school-based health services that were prescribed as part of an IEP for a child enrolled in Medicaid. On the one hand, schools were required to provide these services if they were part of an IEP; on the other, state Medicaid agencies are responsible for paying for medical assistance to Medicaid-enrolled children, no matter the particular location where that care may be provided.

In 1988, Congress amended title XIX to make clear that Medicaid could not refuse to pay for a covered service to a disabled child simply because that service was prescribed as part of an IEP. *See* 42 U.S.C. § 1903(c) (added as part of the Medicare Catastrophic Coverage Act of 1988). More recently, in 1997, Congress amended the IDEA to provide that the state education agency and the state Medicaid agency had to enter into cooperative agreements regarding the provisions of these school-based health services, and emphasizing that Medicaid's financial responsibility was to precede that of the school districts. *See* 20 U.S.C. § 1412(a)(12)(A)(i). School-based health services is thus an exception to the general rule that Medicaid is the payor of last resort.

The cost of providing these services to children with severe disabilities can become very high, as is illustrated by the U.S. Supreme Court's decision a few months ago in *Cedar Rapids Community School District v. Garrett F.*, 119 S. Ct. 992 (1999). In that case, the Supreme Court held that IDEA required the school district to provided one-on-one continual nursing care to a child who was in a wheelchair and ventilator dependent. The Court's decision describes quite vividly the array of health care services that may need to be provided throughout the school day in order for a disabled child to remain in school. The school district argued that IDEA did not require it to provide this type of continual care, which it estimated would cost $30,000 to $40,000 a year, but the Supreme Court disagreed and held that the school had to provide and pay for the care necessary to keep the child in school.

In light of the congressional mandates that Medicaid and not local school budgets could and should pay for these services where appropriate, a number of state Medicaid agencies have in recent years been looking at how to pay for these services. One way to pay for services is the so-called "bundled rate" under which schools are paid a set fee for each Medicaid-enrolled disabled child in that district, and the fee is intended to cover the range of services that would typically be accessed by a child with that disability. The "bundled rate" concept is very similar to the type of per diem rates that Medicaid typically pays hospitals and nursing homes, under which the facility is expected to provide a range of services for each inpatient day, even though on any particular day some patients may require very few services, and some may require a lot. In both cases, the rate is set according to the average costs of providing services.

Bundled rate systems for school-based health services allow participation rates by school districts. Schools have found it convenient and not inconsistent with their educational mission to seek Medicaid reimbursement based on a bundled system as opposed to the time-consuming, paper-driven fee-for-service billing.

JOINT STATEMENT ON SCHOOL HEALTH

by

The Secretaries of Education and Health and Human Services

Health and education are joined in fundamental ways with each other and with the destinies of the Nation's children. Because of our national leadership responsibilities for education and health, we have initiated unprecedented cooperative efforts between our Departments. In support of comprehensive school health programs, we affirm the following:

- *America's children face many compelling educational and health and developmental challenges that affect their lives and their futures.*

  These challenges include poor levels of achievement; unacceptably high drop-out rates; low literacy; violence, drug abuse, preventable injuries, physical and mental illness, developmental disabilities; and sexual activity resulting in sexually transmitted diseases, including HIV, and unintended pregnancy. These facts demand a reassessment of the contributions of education and health programs in safeguarding our children's present lives and preparing them for productive, responsible, and fulfilling futures.

- *To help children meet these challenges, education and health must be linked in partnership.*

  Schools are the only public institutions that touch nearly every young person in this country. Schools have a unique opportunity to affect the lives of children and their families, but they cannot address all of our children's needs alone. Health, education, and human service programs must be integrated, and schools must have the support of public and private health care providers, communities, and families.

- *School health programs support the education process, integrate services for disadvantaged and disabled children, and improve children's health prospects.*

  Through school health programs, children and their families can develop the knowledge, attitudes, beliefs, and behaviors necessary to remain healthy and perform well in school. These learning environments enhance safety; nutrition, and disease prevention; encourage exercise and fitness, support healthy physical, mental, and emotional development; promote abstinence and prevent sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended teenage pregnancy; discourage use of illegal drugs, alcohol, and tobacco; and help young people develop problem-solving and decision-making skills.

- *Reforms in health care and in education offer opportunities to forge the partnerships needed for our children in the 1990s.*

  The benefits of integrated health and education services can be achieved by working together to create a "seamless" network of services, both through the school setting and through linkages with other community resources.

- *GOALS 2000 and HEALTHY PEOPLE 2000 provide complementary visions that, together, can support our joint efforts in pursuit of a healthier, better educated Nation for the next century.*

  GOALS 2000 challenges us to ensure that all children arrive at school ready to learn; to increase the high school graduation rate, to achieve basic subject matter competencies, to achieve universal adult literacy; and to ensure that school environments are safe, disciplined, and drug free. HEALTHY PEOPLE 2000 challenges us to increase the span of healthy life for the American people, to reduce and finally to eliminate health disparities among population groups, and to ensure access to services for all Americans.

In support of GOALS 2000 and HEALTHY PEOPLE 2000, we have established the Interagency Committee on School Health co-chaired by the Assistant Secretary for Elementary and Secondary Education and the Assistant Secretary for Health, and we have convened the National Coordinating Committee on School Health to bring together representatives of major national education and health organizations to work with us.

We call upon professionals in the fields of education and health and concerned citizens across the Nation to join with us in a renewed effort and a reaffirmation of our mutual responsibility to our Nation's children.

Richard W. Riley
Secretary of Education

Donna E. Shalala
Secretary of Health and Human Services

CHICAGO PUBLIC SCHOOLS

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Sue Gamm
Chief Specialized Services Officer

TESTIMONY BEFORE THE FINANCE COMMITTEE UNITED STATES SENATE

Sue Gamm
Chief Specialized Services Officer
Chicago Public Schools
June 17, 1999

Mr. Chairman, Senator Moynihan, and members of the Senate Finance Committee:

I am here today to speak with you on behalf of Mayor Daley, Gery Chico, President of the Chicago School Reform Board of Trustees, and Paul Vallas, Chief Executive Officer of the Chicago Public Schools (CPS), and the Council of Great City Schools, a coalition of the 55 largest city and urban school systems in the nation. We appreciate the opportunity to share with you today our experiences and thoughts about a subject we care deeply about - health services for our students, and the related contribution of Medicaid reimbursement to the overall success of our program.

As the Chief Specialized Services Officer, I am responsible for activities that include: special education and related services for 53,000 students with disabilities; health services for CPS' 430,000 students; violence prevention program, including alternative safe schools and Saturday morning alternative to expulsion program; and crisis intervention services. Present with me today is our Chief Finance Officer, Ken Gotsch, who, as one of the most hands-on and supportive school finance officers you will find, is a key player in this program.

As the third largest school system in the country, CPS has participated in the Medicaid reimbursement program for seven years. During that time, we have greatly expanded our health services and Medicaid outreach activities for children. We view these initiatives as key to the continued improvement of educational performance. Through this experience, we believe that the continuation of this program requires the communication of consistent, reasonable, and understandable rules so that schools do not have to rely on expensive vendors to access the system. As school systems are required to provide more extensive mental and physical health services to meet the needs of children and youth, we must be able to appropriately utilize existing Federal and State financial resources.

BACKGROUND

Schools are no longer simply responsible for education. To ensure that all students have an opportunity to learn, schools must address their nutrition, health, safety, and social needs. The U.S.

Supreme Court affirmed in *Garret v Cedar Rapids School District* that federal law requires schools to ensure physical and mental health services are provided to disabled students in order to guarantee an appropriate education. To provide such services, schools need the assistance and financial aid of other governmental agencies.

As you may remember, Chicago was labeled "worst school system in the nation" by Secretary of Education William Bennett in the mid-1980's. In 1995, the Illinois legislature gave Mayor Richard Daley what he asked for: the authority to effectively manage the city's schools. Now, Chicago is recognized as a national model for school reform.

We certainly have our challenges: 85% of our 430,000 students are enrolled in the National School Breakfast/Lunch Program; and 53% are enrolled in Medicaid. Of special note, 12% of our students have disabilities and 20% of our $3 billion budget is designated for their education.

CPS HEALTH CARE SERVICES

CPS currently spends $209 million annually to deliver a wide range of health services to our 430,000 students. Through a primary infrastructure of approximately 2,500 audiologists, nurses, occupational and physical therapists, psychologists, social workers, counselors/case managers, speech pathologists, and hearing and vision screeners, we provide:

- Medicaid outreach: *CHIP enrollment, public awareness and family notification, referral and follow-up, training*
- Crisis intervention: *Support for students and adults following tragedies and health emergencies, i.e., deaths, suicidal or homicidal threats, hepatitis outbreaks, etc.*
- Mental health services and counseling: *Direct services for aggressive and violent student behavior, substance abuse counseling*
- Physical health services: *Tracheotomy assistance, respirator support, occupational and physical therapy, asthma management*
- Assessment of health needs: *Case planning and coordination, quality assurance*
- EPSDT services: *primary health care, hearing and vision, mental health, asthma, scoliosis, etc., screenings, immunizations*
- Transportation: *Children transported to school to receive health services*

HISTORY

Infancy (1991- 94)

CPS began its involvement in the Medicaid program in 1991, when we signed our first agreement with state agencies. We billed for vision and hearing screenings and were thrilled when we received $1.5 million for our efforts. This activity was accomplished as a result of CPS' implementation of a special education data system in the mid-1980's.

Reimbursement Program (1994-97)

In 1994, CPS realized that to meaningfully access the Medicaid program, we would have to turn to a vendor with significant expertise and experience in this area. We had no experience with the complexities of reimbursement and enhanced reimbursement rules approved for other school districts; we lacked access to the state's decision making and power structure to change the then-current billing structure; and we received no assistance from Federal or State agencies to facilitate our involvement.

To address this situation, we retained an outside consulting firm (at a 20% revenue commission rate) to:

- Expand fee-for-service billing program;
- Develop an administrative outreach claim (AOC); and
- Act as CPS' agent with Federal and State agencies to increase rates and enhance our reimbursement.

While the reimbursement program was extremely successful, one of the priorities of the Chicago School Reform Board of Trustees and Paul Vallas was to directly manage our Medicaid reimbursement program and to lower costs. We were concerned that:

- Service documentation was being collected for Medicaid-enrolled students only and provided no usefulness for service management;
- There was no coordination between the reimbursement initiative and service delivery requirements for students;
- There was insufficient accountability for service delivery by clinicians, principals, and regional and central office administrators;
- Service information was neither analyzed nor used for management of health service delivery; and
- Revenue that could have been used for health services was diverted to an administrative vendor.

Health Services Management (1997 - current)

To address these issues, CPS in 1997 redesigned its Medicaid reimbursement program to focus on health services management. We hired a new outside vendor through a Request for Proposal process, at a greatly reduced cost, to collect health services data for services provided to all students, produce management reports, and process Medicaid claims as appropriate. In addition, we directly partnered with Federal and State agencies responsible for administering school-based health services programs to streamline administrative components of the program and to identify approaches to enhance health care services in the school setting.

Universal access to preventative and primary health services is an essential element for improved educational performance. To achieve this outcome, CPS implemented the following activities:

- Health services expansion through the *Healthy Kids... Healthy Minds* program, which includes: eye examinations, eye glasses and hearing aids for underinsured and uninsured children; expansion of school based and linked physical and mental health services; health education; dental screening; and a database to track referrals for care, follow-up and services received;
- Enhanced public health insurance enrollment through Children's Health Insurance Program (CHIP) outreach efforts by partnering with Governor George Ryan, the Illinois Department of Public Aid, and community health agencies to communicate the program to parents and support enrollment activities; provide intensive training to school staff on enrollment procedures;
- Health service data information system;
- Service documentation for all students; and
- Accountability structure for clinicians, principals, and central and regional administrators.

CRITICAL COMPONENTS OF HEALTH SERVICES MANAGEMENT SYSTEM

Financial Management

To maximize support for expanded health care services, we learned the rules of administrative outreach (AOC) and fee-for-service (FFS) and designed our processes according to these rules and consistent with the operation of schools. To this end, CPS:

- Addressed the complexity and time consuming activities related to FFS documentation by school health clinicians;
- Managed AOC to include allowable activities related to the early identification of mental and physical health services;
- Established data exchange procedures with the Illinois Department of Public Aid to identify more fully the actual population of Medicaid enrolled children;
- Delineated actual cost of student health services and found that Illinois' Medicaid reimbursement rates were significantly below CPS' actual costs;
- Established internal controls over claim submission through electronic documentation edits that decreased the number of errors; and
- Developed management reports that compare services to IEP standards and benchmark clinician productivity.

Information Technology

To enhance student health services, we leveraged the most current technology available to streamline and improve health services management and the Medicaid reimbursement process. To this end, we:

- Provided laptops to 1,500 clinicians. This activity enabled us to eliminate "bubble" sheets that had been used to scan service information, and to share information in "real" time, not month-old time;
- Designed custom software that provides clinicians control over downloading student information and uploading health service information;
- Eliminated errors, including: incorrect/missing student ID numbers and birth dates, misspelled names, lost paper case logs, etc.;
- Provided a view of complete child service needs across all disciplines;
- Established visible accountability by creating electronic reports for clinicians, principals, and administrators that compare required health services to service documentation information.

As a result of these initiatives, CPS cut administrative costs and increased reimbursement with compliance controls to address the escalating costs of health services:

	Health Services Costs	**Administrative Costs** *Vendors*	**Medicaid Reimbursement**
FY '94	$103,000,000	$ 308,000 (straight rate)	$ 1,500,000
FY '97	$157,000,000	$6,168,000 (20% commission)	$34,300,000
FY '99	$209,000,000	$2,500,000 (4.5% & straight rate)	$48,000,000

As the above chart shows, CPS is keeping administrative costs down but is spending a larger portion of its budget on health care services.

FUTURE CPS INITIATIVES

We continue to identify technological enhancements that will enable our health services clinicians to spend optimum time providing health services rather than filling out forms. Future activities include establishing:

- CPS intranet e-mail account;
- On-line Individual Education Plans (IEPs) and other required forms;
- Instructional testing materials and research through internet; and
- Staff development through computer-based distance learning.

RECOMMENDATIONS

To enable school districts to implement the Medicaid reimbursement program correctly and independently, we offer the following recommendations:

1. Rules should be fair and consistently interpreted across the country;
2. Federal officials should actively study and understand the uniqueness of school health services delivery models, utilize this information as rules are interpreted for the school setting, and consult with school officials prior to the finalization of rule interpretations;
3. Rules should be understandable, and State and Federal agencies should take an active role in communicating with and assisting school officials so they are not unreasonably dependent on private vendors;
4. Promote reimbursement models whereby school districts may receive sufficient financial resources to support the provision of health care services to all Medicaid/CHIP eligible children; and
5. Establish CHIP enrollment processes consistent with the successful model of the *National School Breakfast/Lunch Program*. Eliminate barriers to successful data exchanges between school districts and State Medicaid agencies consistent with the Memorandum of Understanding between the U.S. Departments of Education and Agriculture. ***Children who are fed and who have their physical and mental needs addressed will achieve greater academic success.***

In closing, thank you again for the opportunity to share some of the things the Chicago Public Schools have been doing to improve the health, and consequently, the academic performance of its children. We have and will continue to share this information with other school districts so we may collectively enhance our knowledge and expertise.

HCFA To Rein In Medicaid Billing For Disabled Students

In the coming months, the Health Care Finance Administration (HCFA) will issue new policy guidelines and introduce new training programs to prevent schools from overcharging the Medicaid program for special services to disabled students.

The new reforms are an effort to get schools to bill the Medicaid program on a fee-for-service basis—as opposed to the more costly "bundling" process, in which schools estimate the cost of Medicaid services based on the number of disabled students enrolled.

The reforms stem from a damning General Accounting Office analysis that found school-related Medicaid costs for 10 states increased from $82 million to $469 million between 1994 and 1998 (SER, Oct. 30, 1996).

Speaking last month before the Senate Finance Committee, William Scanlon, the GAO director of health financing and public health issues, said, "Federal oversight of school districts claims for administrative expense reimbursements has been weak."

HCFA officials stress that they have been working with states to rein in the billing process for schools since May, prior to Scanlon's remarks.

In its study of 10 states, GAO found three factors that have led to rising Medicaid costs in schools. For starters, many states have adopted "creative billing techniques," according to GAO's analysis, that increase the contribution of Medicaid payments to schools without matching the increases from state funds. Medicaid funding requires states to match funds with the federal government.

Many schools also are billing the Medicaid system for improper administrative costs not directly related to the cost of administering health services to students—the costs Medicaid is intended to defray. This problem is made worse because many states do not keep adequate records of administrative costs. GAO found only two of 10 states had kept such records.

Finally, HCFA has provided little effective guidance to schools on how to properly bill the Medicaid program for services. This problem is made worse by what the report says is uneven oversight. "HCFA has not provided clear or consistent guidance to its regional offices regarding criteria for determining reasonable costs or appropriate methods for claiming administrative costs," Scanlon said.

In an effort to address that problem in particular, HCFA officials have convened meetings with state health officials to clear up the complex procedures and will be drafting a manual on appropriate costs and billing techniques in the coming months. —Eli J. Lake

Attachment 3

SCHOOL BASED HEALTH SERVICES SURVEY

I.A. States that Enroll and Reimburse Schools as Providers of Medicaid School-Based Services

Region I

Connecticut - reimburses using a **bundled rate** with an annual reconciliation process.
Maine reimburses using a **bundled rate.** The State does not reconcile.
Massachusetts reimburses using a **bundled rate**. The State does not reconcile.
New Hampshire reimburses on a **regular fee-for-service** basis.
Rhode Island reimburses on a **regular fee-for-service** basis.
Vermont reimburses for select services on a **regular fee-for-service** basis and reimburses for others using a **bundled rate.** The State does not reconcile.

Region II

New Jersey reimburses using a **bundled rate** which is adjusted annually based on the MCPI. The State does not reconcile.
New York reimburses on a **regular fee-for-service** basis.

Region III

Delaware reimburses on a **regular fee-for-service** basis.
District of Columbia reimburses most schools on a **regular fee-for-service** basis. However, 2 schools are reimbursed using a **bundled per diem rate,** which has never been reconciled.
Maryland reimburses on a **regular fee-for-service** basis.
Pennsylvania reimburses on a **regular fee-for-service** basis.
Virginia reimburses on a **regular fee-for-service** basis.
West Virginia reimburses on a **regular fee-for-service** basis.

Region IV

Florida reimburses on a **regular fee-for-service** basis.
Georgia reimburses on a **regular fee-for-service** basis.
Kentucky reimburses on a **regular fee-for-service** basis.
North Carolina has a pending plan amendment to reimburse for services using a **bundled rate.** They are currently paying that rate to schools which have contracted with Public Consulting Group. The State proposes reconciling the rate annually. Other schools are being paid on a **regular fee-for-service** basis.
South Carolina reimburses on a **regular fee-for-service** basis.

Region V

Illinois reimburses on a **regular fee-for-service** basis.
Indiana reimburses on a **regular fee-for-service** basis.
Michigan reimburses on a **regular fee-for-service** basis.
Minnesota reimburses on a **regular fee-for-service** basis.

Ohio reimburses on a cost-based **fee-for-service** basis.
Wisconsin reimburses on a **regular fee-for-service** basis.

Region VI
Arkansas currently reimburses on a **regular fee-for-service** basis. However, the State has a plan amendment pending to pay using a bundled rate. The issue of reconciliation has not been resolved.
Louisiana reimburses on a **regular fee-for-service** basis.
New Mexico reimburses on a **regular fee-for-service** basis.
Oklahoma reimburses on a **regular fee-for-service** basis.
Texas reimburses on a **regular fee-for-service** basis.

Region VII
Iowa reimburses on a **regular fee-for-service** basis.
Nebraska reimburses on a **regular fee-for-service** basis.
Kansas reimburses using a **bundled rate.** The State does not reconcile.
Missouri reimburses on a **regular fee-for-service** basis.

Region VIII
Colorado reimburses on a **regular fee-for-service** basis.
South Dakota reimburses on a **regular fee-for-service** basis.
Utah uses a **daily bundled rate.** The State does not reconcile.

Region IX
California reimburses on a **regular fee-for-service** basis.
Nevada reimburses on a **regular fee-for-service** basis. The State has a plan amendment pending to bundle services.

Region X
Idaho (no reimbursement information available).
Oregon (no reimbursement information available).
Washington (no reimbursement information available).

Total of States reimbursing fee-for-service: 30
Total of States reimbursing using a bundled rate: 6
Total of States using fee-for service and bundling: 3
Total of States which reconcile the bundled rate: 1
Total of States reimbursing using a capitated rate: 0

I. B. States That Do Not Enroll Schools as Providers of Services

Alabama - Therapy services for special needs children are provided by Medicaid-enrolled therapists employed by the Department of Education. The therapists bill Medicaid directly on a fee-for-service basis and reassign the claims to the Department of Education. EPSDT services are provided in schools by Department of Health personnel. The Department of Health bills Medicaid for those services on a fee-for-service basis.

Alaska
Arizona
Hawaii
Mississippi
Montana
North Dakota
Tennessee
Wyoming

II. States Which Claim Administrative Costs for School-Based Activities

Region I — ***Massachusetts***
Rhode Island
New Hampshire do not claim for administrative costs. Connecticut, Maine and Vermont do not claim for administrative costs at the administrative rate; some administrative costs are included in the bundled rate.

Region II — ***New Jersey*** has made a claim which has been deferred and will be disallowed for lack of documentation.
New York has made a claim which has been deferred for lack of documentation.

Region III — ***Delaware***
Pennsylvania
West Virginia
Maryland, Virginia and the District do not claim for administrative costs.

Region IV — ***Florida***
Alabama, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee do not currently claim for administrative costs.

Region V — ***Illinois***
Michigan
Minnesota
Indiana, Ohio and Wisconsin do not currently claim for administrative costs but are all in discussions with the RO to do so.

Region VI — ***Texas***
Arkansas, Louisiana, New Mexico and Oklahoma do not currently claim for administrative costs. (Oklahoma is working towards claiming).

Region VII ***Missouri***
Iowa, Kansas and Nebraska do not currently claim for administrative costs.

Region VIII Colorado (although it is preparing to do so), Montana, North Dakota, South Dakota, Utah and Wyoming do not currently claim for administrative activities.

Region IX **Arizona**
California
Hawaii and Nevada do not currently claim for administrative activities.

Region X ***Alaska***
Oregon
Washington
Idaho does not currently claim for administrative activities.

Total number of States claiming for school-based related administrative activities: 18

III. States Claiming Transportation Costs to and From the School for Children Who Receive an IEP Medical Service on that Day and Ride to School on the Regular Yellow School Bus

Region I *Maine* and *Massachusetts*
Region II *New Jersey* and *New York*
Region III *Maryland* and *Delaware*
Region IV *Florida*
Region V *Ohio* and *Wisconsin* claim as a service cost. *Illinois*, *Michigan* and *Minnesota* claim as an administrative cost.
Region VI *New Mexico* and *Texas*
Region VII *Missouri*
Region VIII None.
Region IX *Nevada*
Region X None.

Total Number of States claiming regular school bus transportation as an administrative or service cost: 16

OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503
Education Branch
Education, Income Maintenance, and Labor Division

FAX COVER

DATE: 10/20/99 **TIME:** _____

TO: Aust Rotherham / Bethany Little

FAX NUMBER: 6-5581

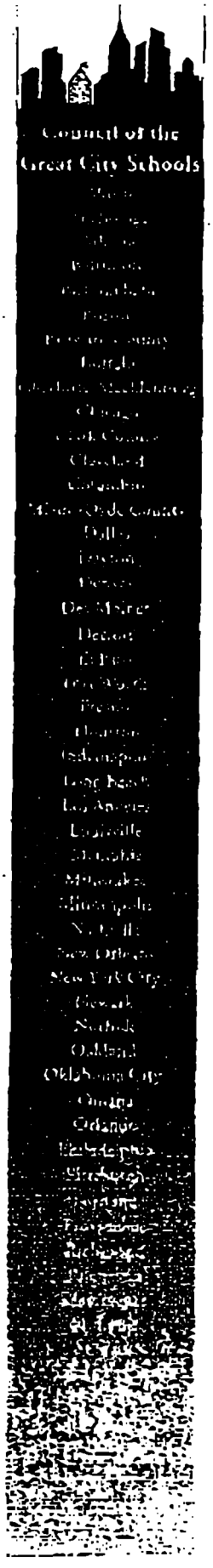
FROM:

___ Wayne Upshaw	___ Lorenzo Rasetti
___ Leslie Mustain	___ Wei-Min Wang
___ Jonathan Travers	___ Kathy Stack
✓ David Rowe	___ Mary Cassell

NUMBER OF PAGES: Cover + 15

Notes: See my email on Medicaid school-based health services.

Education Branch Fax Number: 202/395-4875
Voice Confirmation: 202/395-5880



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MEMORANDUM – 10/18/99

TO: Amy Driskowski
House Commerce Committee

FROM: Jeff Simering
Council of the Great City Schools

SUB: School-Based Medicaid Provisions in H.R. 3070 & H.R. 1180 Implications

The Council of the Great City Schools, the coalition of the nation's largest central city school districts, is very concerned with the implications of the school-based Medicaid provisions attached to H.R. 3070. The 58 member school districts of the Council represent approximately 30% of the nation's poor school children and 13% of the nation's disabled school children.

Federal statutes mandate that public school districts provide health-related services to disabled school children in order to ensure their access to an equal educational opportunity. These health services can be quite costly for some severely impaired children and in any event represent a significant financial burden on the primary educational mission of the public school districts.

For the last decade, there has been an express authorization for eligible Medicaid services to disabled children identified under the Individuals with Disabilities Education Act (IDEA). Yet school district participation in the Medicaid program has been very limited until recent years. In effect, school districts have been absorbing Medicaid eligible health services costs within their own strained local school budgets for many years due to the complexities of undertaken this new frontier of health services accounting. The fact that school-based Medicaid claims have increased in recent years reflects significant local efforts to overcome Medicaid access barriers, rather than reflecting any substantial gimmickry or abuse. Even HCFA after consultation over the past several months with State Medicaid directors and education representatives appears to be retrenching from its May 21st letter that absolutely prohibited certain services and methodologies. It has become clear during these consultations, in which the Council has participated, that misunderstanding of school operations by HCFA and vice versa have contributed to the perception of wide spread problems. The Council does not suggest that this relatively new arena of Medicaid participation is problem-free, but we do not believe it to be problem-plagued either.

The school-based provisions attached to H.R. 3070 similarly reflect many of the misunderstandings of the May 21st HCFA letter. HCFA is taking six months of inquiry and consultation before completing their action on just the "bundling" issue. The Council believes that the Commerce Committee should not adopt the school-based provisions of H.R. 3070 without a similar in-depth inquiry, since apparently no hearings on this matter have been held. The discussion on these issues, from our understanding, have been mainly with Senate finance staff and were still in the process of revision based on such input. The Council fears that an attempt to fix

some limited problems could result unintentionally in creating wide spread access problems for schools and school children.

The Council would prefer to work with the Committee to crafted a fully informed measure that addressed both access barriers and problem areas.

A few specific concerns with the provisions may underscore the Council's hesitation on such language:

A HCFA-Mandated Uniform Methodology May Limit Access for Eligible School Children to Medicaid Services

Many of the Council school districts believe that HCFA has been part of the problem, rather than part of the solution to access barriers for school-based Medicaid services. History suggests that a HCFA-developed uniform methodology may be overly restrictive and excessively burdensome. Though consultation with states and local schools is commendable, HCFA just began consultation with school representative last July after a decade of inaction on the IDEA disabled child services provision. There is, therefore, no substantial record to suggest that such consultation will be effective. Finally, the narrow 90 day timeframe for methodology development almost ensures a less than optimal and informed outcome in this complex area. The Council is also concerned that formal notice and comment rulemaking is apparently waived or delay by this provision.

Recommendation: The Council recommends in the alternative crafting a provision that would require HCFA to issue a technical assistance manual and conduct regional technical assistance workshops for states, schools and applicable managed care organizations.

The Managed Care Provision Could Abrogate Managed Care Responsibilities and Shift Further Responsibilities and Costs to School Districts

The managed care provisions of section 408 of H.R. 3070 apparently seek to avoid duplication of services or billings. However, section 408(b) may unintentionally relieve managed care providers of service responsibilities for disabled school children and place the full responsibility for such services on the schools without any assurance of access to Medicaid reimbursements. If duplication is the problem, than the language need be no more complex than requiring State Medicaid agencies to establish procedures to facilitate coordination and prevent duplication.

New Unspecified Procedures, Methods and Standards Established in Section 408 Are Likely to Cause Confusion, Added Burdens, Delays and Potential Access Limitations.

- The requirement for "itemization" in the bundling provision seems inconsistent with the concept of bundling of groups of services and expenses. (Note: Though less than a handful of the Great City Schools use a bundling methodology at present, the prospect of a more efficient methodological option like bundling or capitation, rather than more elaborate encounter billing, is very attractive to school organizations whose primary mission in not health services.

- Schools find little in the health services system to be reasonable, particularly the costs and the low reimbursement rates. Therefore, the interjection of unspecified tests of reasonableness by HCFA is of concern.
- No school officials working in Medicaid services can understand how a proportionate allocation of costs for transportation will work and not be exceptionally administrative burdensome and costly. For example, if a child who would otherwise walk to the neighborhood school is so severely disabled to require enrollment in a specialized school with specialized facilities in another neighborhood or across town within the school district, how would the district determine proportionate impact of the health impairments and the needed services on the costs of transporting this child to this specialized facility. Without the impairment, no costs would be incurred.

<u>The Requirement for Reimbursing Only Transportation on Specially Equipped Vehicles Misunderstands the Nature of Eligible School-based Health Services and is Inconsistent with other Federal Statutory and Civil Rights Law Prohibiting the Segregation of Disabled Children</u>

There is no reason to send many disabled children to receive health services on a specially equipped bus. A child with a speech impairment clearly does not need a bus equipped for physically disabled children. The costs of specially equipped vehicles obviously are more expensive as well. Moreover, federal law prohibits nonessential segregation of disabled children in environments without non-disabled children. This provision is substantially flawed, as was the original May 21st HCFA directive from which the provision has likely been drawn.

<u>While Supporting the Concept of Full Reimbursement to Schools from the State, There May Be a Potential for Gaming the Provision by the States</u>

Under section 408(c) of H.R. 3070 a State may prospective establish a dedicated line item for such expenditures purely to capture the Medicaid reimbursements. This second option should only be available for States which have such a dedicated line item in current law as of the beginning of this federal fiscal year.

In the short period available for review, these are the most immediate areas of concern. (Note that there is no argument regarding contingency and noncompetitive fees for vendors, although this might overreach and inhibit contracts with merely "paper billing" agents as opposed to solely large scale consulting operations.)

The multiple nuances of this complex interaction between health systems and school systems deserved more study and targeted language. The Council hopes that the Committee can hold off taking this action at this late date. A policy of paying for additional services for disabled near-poor adults by limiting access to services for disabled children and schools is questionable at best. The Council is happy to be of whatever assistance is appropriate.

American Association of School Administrators

Leadership for Learning

October 18, 1999

Dear Congressman:

We are extremely concerned that the Rules Committee may—today—act precipitously over a piece of legislation, H.R. 3070 (specifically Section 408), which would have a severe and profoundly negative impact on local school districts serving poor and disabled children.

This bill, scheduled for Rules action today, would, despite its title, limit a school district's recovery of Medicaid-related services, for poor/disabled children, under the assumption that there is widespread "Fraud and Abuse" in this recovery process. We firmly believe this is an erroneous assumption and urge a more comprehensive, open, public discussion before any action is taken on Sec. 408 of H.R. 3070.

We, as the professional association of 14,000 local school superintendents and school executives, were never consulted about this section of H.R. 3070, and we further understand that no group representing local educators had been consulted or asked to participate in any hearing on this matter. In fact, to our knowledge, the bill was not the subject of hearings, but was introduced and immediately marked-up and reported to the full House last week.

We ask that Section 408 be removed and referred back for more thorough consideration, because it would have direct and extremely negative impact on the manner and recovery of costs in a number of areas. Of particular concern is how HMO's, it appears, would be allowed to stop assisting disabled students. Because the Supreme Court has acted in this area, we are keenly aware that new medical costs are already being shifted to schools. Other issues of concern deal with transportation, bundling of claims, and excessive amounts to state-level agencies.

Thank you for your consideration of our views on this highly controversial proposal.

Sincerely,

Bruce Hunter
Director of Public Affairs

1801 North Moore Street ▲ Arlington, Virginia 22209-1813 ▲ 703.528.0700 ▲ Fax 703.841.1543 ▲ http://www.aasa.org

CONSORTIUM for CITIZENS with DISABILITIES

October 15, 1999

The Honorable J. Dennis Hastert
Speaker
U.S. House of Representatives
Washington, DC 20515

Dear Speaker Hastert:

The undersigned member organizations of the Consortium for Citizens with Disabilities Task Forces on Social Security and Employment and Training are pleased to see work incentives legislation on the verge of passage on the House floor.

We appreciate all of the work that you and the Members of the Ways and Means and Commerce Committees have put into resolving numerous issues that have arisen in the legislation. However, as the legislation is addressed by the Rules Committee and prepared for a floor vote, we believe that it is imperative that several issues be resolved. Specifically, we urge you to ensure:

- Inclusion of the Medicaid provisions as marked-up by the Commerce Committee, particularly inclusion of funding for the demonstration and state grant programs as mandatory funding, rather than discretionary funding. The discretionary funding approach for Medicaid programs is unacceptable because it will make the provisions ineffective.

- Inclusion of pay-fors for the entire bill that are acceptable to people with disabilities. Currently, the attorneys' fees provision and the current draft of the Medicaid/education services provisions are unacceptable because they will harm people with disabilities.

All parties to this effort – the President, the House of Representatives, and the Senate – must come together to enact legislation that fulfills the promise of the Work Incentives Improvement Act and does not harm those people with disabilities whom the bill is designed to assist. We can only support a final bill that resolves the above issues.

We pledge to continue to work with you to resolve these important issues so that people with disabilities will have barriers to work removed. We hope to be able to

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join with you, the Senate, and the President in celebrating enactment of a bill that truly works for people with disabilities.

Sincerely,

Marty Ford
The Arc of the US

Tony Young
UCPA

Paul Seifert
IAPSRS

Co-Chairs, CCD Task Force on Social Security

cc: Chairman David Dreier
Chairman Bill Archer
Chairman Tom Bliley
Ranking Member Joe Moakley
Ranking Member Charles Rangel
Ranking Member John Dingell

On behalf of:

AIDS Action
Alliance for Rehabilitation Counseling (NRCA/ARCA)
American Network of Community Options and Resources
Easter Seals
International Association of Psychosocial Rehabilitation Services
National Association of Developmental Disabilities Councils
National Association of Protection and Advocacy Systems
National Parent Network on Disabilities
NISH
Paralyzed Veterans of America
The Arc of the United States
United Cerebral Palsy Associations

TOTAL P.05

(c) EFFECTIVE DATE.—The amendments made by this section shall apply in the case of any attorney with respect to whom a fee for services is required to be certified for payment from a claimant's past-due benefits pursuant to subsection (a)(4)(A) or (b)(4)(A) of section 206 of the Social Security Act after—

(1) December 31, 1999, or

(2) the last day of the first month beginning after the month in which this Act is enacted.

SEC. 407. PREVENTION OF FRAUD AND ABUSE ASSOCIATED WITH CERTAIN PAYMENTS UNDER THE MEDICAID PROGRAM.

(a) REQUIREMENTS FOR PAYMENTS.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) (as amended by section 201(a)(3)(B)) is amended further—

(1) in paragraph (20), by striking the period at the end and inserting "; or"; and

(2) by inserting immediately after paragraph (20) the following:

"(21) with respect to any amount expended for an item or service provided under the plan, or for any administrative expense incurred to carry out the plan, which is provided or incurred by, or on behalf of, a State or local educational agency or school dis-

trict, unless payment for the item, service, or administrative expense is made in accordance with a methodology approved in advance by the Secretary under which—

"(A) in the case of payment for—

"(i) a group of individual items, services, and administrative expenses, the methodology—

"(I) provides for an itemization to the Secretary that assures accountability of the cost of the grouped items, services, and administrative expenses and includes payment rates and the methodologies underlying the establishment of such rates;

"(II) has an actuarially sound basis for determining the payment rates and the methodologies; and

"(III) reconciles payments for the grouped items, services, and administrative expenses with items and services provided and administrative expenses incurred under this title; or

"(ii) an individual item, service, or administrative expense, the amount of pay-

ment for the item, service, or administrative expense does not exceed the amount that would be paid for the item, service, or administrative expense if the item, service, or administrative expense were incurred by an entity other than a State or local educational agency or school district, unless the State can demonstrate to the satisfaction of the Secretary a higher amount for such item, service, or administrative expense; and

"(B) in the case of a transportation service for an individual under age 21 who is eligible for medical assistance under this title (whether or not the child has an individualized education program established pursuant to part B of the Individuals with Disabilities Education Act)—

"(i) a medical need for transportation is noted in such an individualized education program (if any) for the individual, including such an individual residing in a geographic area within which school bus transportation is otherwise not provided;

"(ii) in the case of a child with special medical needs, the vehicle used to furnish

such transportation service is specially equipped or staffed to accommodate individuals with special medical needs; and

"(iii) payment for such service only—

"(I) is made with respect to costs directly attributable to the costs associated with transporting such individuals whose medical needs require transport in such a vehicle; and

"(II) reflects the proportion of transportation costs equal to the proportion of the school day spent by such individuals in activities relating to the receipt of covered services under this title or such other proportion based on an allocation method that the Secretary finds reasonable in light of the benefit to the program under this title and consistent with the cost principles contained in OMB Circular A–87; or

"(22) with respect to any amount expended for an item or service under the plan or for any administrative expense to carry out the plan provided by or on behalf of a State or local agency (including a

State or local educational agency or school district) that enters into a contract or other arrangement with a person or entity for, or in connection with, the collection or submission of claims for such expenditures, unless, notwithstanding section 1902(a)(32), the agency—

"(A) uses a competitive bidding process or otherwise to contract with such person or entity at a reasonable rate commensurate with the services performed by the person or entity; and

"(B) requires that any fees (including any administrative fees) to be paid to the person or entity for the collection or submission of such claims are identified as a non-contingent, specified dollar amount in the contract."; and

(3) in the third sentence, by striking "(17), and (18)" and inserting "(17), (18), (19), and (21)".

(b) PROVISION OF ITEMS AND SERVICES THROUGH MEDICAID MANAGED CARE ORGANIZATIONS.—

(1) CONTRACTUAL REQUIREMENT.—Section 1903(m)(2)(A) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)) is amended by redesignating clause (xi) (as added by section 4701(c)(3) of the Balanced Budget Act of 1997) as clause (xiii), by striking

"and" at the end of clause (xi), and by inserting after clause (xi) the following:

"(xii) such contract provides that with respect to payment for, and coverage of, such services, the contract requires coordination between the State or local educational agency or school district and the medicaid managed care organization to prevent duplication of services and duplication of payments under this title for such services."

(2) PROHIBITION ON DUPLICATIVE PAYMENTS.—

(A) IN GENERAL.—Section 1903(i) of the Social Security Act (42 U.S.C 1396b(i)), as amended by subsection (a), is amended—

(i) in paragraph (22), by striking the period and inserting "; or"; and

(ii) by adding at the end the following:

"(23) with respect to any amount expended under the plan for an item, service, or administrative expense for which payment is or may be made directly to a person or entity (including a State or local educational agency or school district) under the State plan if payment for such item, service, or administrative expense

was included in the determination of a prepaid capitation or other risk-based rate of payment to an entity under a contract pursuant to section 1903(m).".

(B) CONFORMING AMENDMENT.—The third sentence of section 1903(i) of such Act (42 U.S.C. 1396b(i)), as amended by subsection (a)(3), is amended by striking "and (21)" and inserting "(21), and (23)".

(c) ALLOWABLE SHARE OF FFP WITH RESPECT TO PAYMENT FOR SERVICES FURNISHED IN SCHOOL SETTING.—Section 1903(w)(6) of the Social Security Act (42 U.S.C. 1396b(w)(6)) is amended—

(1) in subparagraph (A), by inserting "subject to subparagraph (C)," after "subsection."; and

(2) by adding at the end the following:

"(C) In the case of any Federal financial participation amount determined under subsection (a) with respect to any expenditure for an item or service under the plan, or for any administrative expense to carry out the plan, that is furnished by a State or local educational agency or school district, the State shall provide that there is paid to the agency or district a percent of such amount that is not less than the percentage of such expenditure or expense that is paid by such agency or district.".

(d) UNIFORM METHODOLOGY FOR SCHOOL-BASED ADMINISTRATIVE CLAIMS.—Not later than 90 days after the date of enactment of this Act, the Administrator of the Health Care Financing Administration, in consultation with State medicaid and State educational agencies and local school systems, shall develop and implement a uniform methodology for claims for payment of administrative expenses furnished under title XIX of the Social Security Act by State or local educational agencies or school districts. Such methodology shall be based on standards related to time studies and population estimates and a national standard for determining payment for such administrative expenses.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section (other than by subsection (b)) shall apply to items and services provided on and after the date of enactment of this Act, without regard to whether implementing regulations are in effect.

(2) MANAGED CARE AMENDMENTS.—The amendments made by subsection (b) shall apply to contracts entered into or renewed on or after the date of the enactment of this Act.

(3) REGULATIONS.—The Secretary of Health and Human Services shall promulgate such final

regulations as are necessary to carry out the amendments made by this section not later than 1 year after the date of the enactment of this Act.

SEC. 408. EXTENSION OF AUTHORITY OF STATE MEDICAID FRAUD CONTROL UNITS.

(a) EXTENSION OF AUTHORITY TO INVESTIGATE AND PROSECUTE FRAUD IN OTHER FEDERAL HEALTH CARE PROGRAMS.—Section 1903(q)(3) of the Social Security Act (42 U.S.C. 1396b(q)(3)) is amended—

(1) by inserting "(A)" after "in connection with"; and

(2) by striking "title." and inserting "title; and (B) upon the approval of the Inspector General of the relevant Federal agency, any aspect of the provision of health care services and activities of providers of such services under any Federal health care program (as defined in section 1128B(f)(1)), if the suspected fraud or violation of law in such case or investigation is primarily related to the State plan under this title.".

(b) RECOUPMENT OF FUNDS.—Section 1903(q)(5) of such Act (42 U.S.C. 1396b(q)(5)) is amended—

(1) by inserting "or under any Federal health care program (as so defined)" after "plan"; and