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31AUGUST 2000

MEMORANDUM TO           CHRIS JENNINGS  
FROM                        JANICE ENRIGHT  
RE                            REVISED DRAFT GUIDELINES FOR  
                                  MEDICAID'S ADMINISTRATIVE  
                                  OUTREACH CLAIMING PROGRAM

Chris, as discussed, enclosed is a revised, "red lined", copy of the draft guidelines. These guidelines reflect changes as a result of the various school-based associations' comments.

Since today's meeting did not go forward, our hope is that you will be able to use this revised draft, as a vehicle to work from, combined with whatever work product HCFA and others are developing.

In addition, since there is a fair amount of discussion going on among government representatives, and others, perhaps you would be willing to set aside some time to have a conference call, prior to the rescheduling of today's meeting, to brief you on how this draft guide has worked through the process, and, for the most part, garnered the support of many, to, at least for the purposes of moving the process, be a reasonable document to work from.

Please let me know if that is a possibility, and we can discuss a possible time to arrange such a call.

Sent by hand

Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight (Letter Report, 04/05/2000, GAO/HEHS/OSI-00-69).

Pursuant to a congressional request, GAO provided information on states' practices regarding Medicaid reimbursement of school-based administrative activities, focusing on: (1) the extent to which school districts and states claim Medicaid reimbursement for school-based health services and administrative activities; (2) the appropriateness of methods states use to establish bundled rates for school-based health services and assess the costs of administrative activities that their schools may claim as reimbursable; (3) states' retention of federal Medicaid reimbursement for services provided by schools and schools' practice of paying contingency fees to private firms; and (4) the adequacy of the Health Care Financing Administration's (HCFA) oversight of state practices regarding school-based claims, including safeguards employed to ensure appropriate billing for health services and administrative activities.

GAO noted that: (1) nearly all states reported Medicaid expenditures for school-based activities, which totalled \$2.3 billion for the latest year of available state data; (2) the majority of payments--about \$1.6 billion--were for health services provided by schools in 45 states and the District of Columbia, and about \$712 million was for administrative activities billed by schools in 17 states; (3) three states--Illinois, Michigan, and New York--accounted for over 60 percent of total school-based claims; (4) New York accounted for 44 percent of all health services payments, while Illinois and Michigan together accounted for 74 percent of all administrative activity payments; (5) Medicaid payments to schools ranged from a high of nearly \$4820 per Medicaid-eligible child in Maryland to less than 5 cents per child in Mississippi, reflecting in part variation in the proportion of states' school districts that submitted claims for Medicaid services and activities; (6) some of the methods used by school districts and states to claim reimbursement for school-based services do not ensure that health services are provided, or that administrative activities are properly identified and reimbursed; (7) bundled rate methods used by school districts to claim Medicaid reimbursement for school-based health services have failed in some cases to take into account variations in service needs among children and have often lacked assurances that services paid for were provided; (8) in two states, monthly payments ranging from \$141 to \$636 per child were made to schools solely on the basis of at least 1 day's attendance in school, rather than on documentation of any actual service delivery; (9) with regard to administrative activities, poor controls have resulted in improper payments in at least two states, and there are indications that improprieties could be occurring in several other states; (10) Medicaid costs shared by the federal government and the states could fall under one of the two following categories: (a) medical assistance; and (b) administrative duties; (11) each state program's federal and state funding shares of health services payments are determined through a statutory matching formula; (12) this formula results in federal shares that range from 50 to 83 percent, depending on a state's per capita income in relationship to the national average; and (13) over 95 percent of Medicaid's \$177 billion in total expenditures in FY 1998 was spent on health services.

----- Indexing Terms -----

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SUBJECT: Children  
Allowable costs  
Program abuses

Health insurance  
 School health services  
 Administrative costs  
 State-administered programs  
 Cost sharing (finance)  
 School districts  
 Internal controls  
 IDENTIFIER: Medicaid Program  
 Illinois  
 Massachusetts  
 Michigan  
 Early and Periodic Screening, Diagnosis, and Treatment  
 Program  
 HHS Individuals With Disabilities Education Act Program  
 New York

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GAO/HEHS/OSI-00-69

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Dated May 21, 1999

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EPSDT Early and Periodic Screening, Diagnostic, and Treatment

HCFA Health Care Financing Administration

IDEA Individuals With Disabilities Education Act

OMB Office of Management and Budget

OSI Office of Special Investigations

SPMP skilled professional medical provider

Health, Education, and  
Human Services Division

B-283378

April 5, 2000

The Honorable William V. Roth, Jr.  
Chairman  
The Honorable Daniel Patrick Moynihan  
Ranking Minority Member  
Committee on Finance  
United States Senate

Schools can be appropriate locations in which to identify low-income children who are eligible for Medicaid, assist them to enroll, and provide them Medicaid-covered services. Under Medicaid, a joint federal-state program that spent about \$177 billion in fiscal year 1998, the federal government pays a share of costs incurred by the states in providing health care to 41 million low-income beneficiaries, including 13 million school-aged children. States may use their Medicaid programs to pay for certain health services provided to eligible children by schools, including diagnostic screening and ongoing treatment, such as physical therapy. States may also obtain reimbursement from the federal government for the costs of administrative activities associated with providing Medicaid services in schools, such as conducting outreach activities to assist with enrolling children in Medicaid; providing eligibility determination assistance, program information, and referrals; and coordinating and monitoring Medicaid-covered health services.

In June 1999, we testified before your Committee about multimillion-dollar increases in Medicaid reimbursements for administrative activities in schools in 10 states and the need for more federal and state oversight of these growing expenditures.<sup>1</sup> In particular, we found that weak and inconsistent controls over the review and approval of claims for school-based administrative activities created an environment in which inappropriate claims could generate excessive Medicaid reimbursements. We also found that some school districts receive only \$4 of every \$10 that the federal government pays to reimburse them for Medicaid-allowable administrative costs, after the state takes a share of the federal payment and private firms are paid. Private firms are often engaged by school districts to design the methods used to claim Medicaid reimbursement, train school personnel to apply these methods, and submit the claims to state

Medicaid agencies to obtain federal reimbursement.

Since our initial review was limited to administrative cost claims, you requested that we expand our analysis of state practices regarding Medicaid reimbursement of school-based administrative activities and address as well the use of "bundled" rates for school-based services. Bundled rates are single payments for a package of various services that eligible special education children may need over a specified period of time; a fixed amount is paid per child on the basis of the services the child is expected to require, not on the basis of the services the child actually receives. This report addresses (1) the extent to which school districts and states claim Medicaid reimbursement for school-based health services and administrative activities; (2) the appropriateness of methods states use to establish bundled rates for school-based health services and to assess the costs of administrative activities that their schools may claim as reimbursable; (3) states' retention of federal Medicaid reimbursement for services provided by schools and schools' practice of paying contingency fees to private firms; and (4) the adequacy of the Health Care Financing Administration's (HCFA) oversight of state practices regarding school-based claims, including safeguards employed to ensure appropriate billing for health services and administrative activities.

To examine these issues, we surveyed the 50 states and the District of Columbia, focusing on their Medicaid policies and practices related to school-based health services and administrative activities. We visited six states in various regions of the country--Florida, Illinois, Massachusetts, Michigan, New Jersey, and Vermont--that allow schools to bill Medicaid for providing health services and carrying out administrative activities and that represent a mixture of methodologies for submitting claims for administrative activities, transportation to and from services, and bundled rate payments.<sup>2</sup> We also interviewed officials in 7 of HCFA's 10 regional offices, the 17 states that allow claims for Medicaid-related administrative activities, and the 8 states and the District of Columbia that HCFA identified as using bundled rate payments for health services. In addition, our Office of Special Investigations (OSI) began ongoing investigative work in July 1999 to determine whether fraudulent or abusive practices are occurring. OSI conducts its investigations in accordance with the standards of the President's Council on Integrity and Efficiency. We performed our work between July 1999 and March 2000 in accordance with generally accepted government auditing standards.

Nearly all states reported Medicaid expenditures for school-based activities, which totaled \$2.3 billion for the latest year of available state data.<sup>3</sup> The majority of payments--about \$1.6 billion--were for health services provided by schools in 45 states and the District of Columbia, and about \$712 million was for administrative activities billed by schools in 17 states. Three states--Illinois, Michigan, and New York--accounted for over 60 percent of total school-based claims. New York accounted for 44 percent of all health services payments, while Illinois and Michigan together accounted for 74 percent of all administrative activity payments. Medicaid payments to schools ranged from a high of nearly \$820 per Medicaid-eligible child in Maryland to less than 5 cents per child in Mississippi, reflecting in part variation in the proportion of states' school districts that submitted claims for Medicaid services and activities.

Some of the methods used by school districts and states to claim reimbursement for school-based services do not ensure that health services are provided, or that administrative activities are properly identified and reimbursed. Bundled rate methods used by school districts to claim Medicaid reimbursement for school-based health services have failed in some cases to take into account variations in service needs among children and have often lacked assurances that services paid for were provided. In two states, monthly payments ranging from \$141 to \$636 per child were made to schools solely on the basis of at least 1 day's attendance in school, rather than on documentation of any actual service delivery. With regard to administrative

activities, poor controls have resulted in improper payments in at least two states, and there are indications that improprieties could be occurring in several other states. Examples follow.

- The HCFA Chicago regional office questioned \$30 million in administrative claims submitted by the state of Michigan for the quarter ending September 1998 for school activities that were not related to Medicaid. Among other issues, school staff interviewed by HCFA revealed that activities they performed that were related to general health screenings, family communications, or staff-related training had no Medicaid component or benefit, although a portion of their staff time was claimed and reimbursed as such. The HCFA regional office deferred Michigan's claim for \$33 million in federal payment for the quarter ending September 1999, asking again that the state better document that school-based claims for administrative activities were clearly linked to Medicaid.

- Our investigation and HCFA scrutiny of claims have also found that Michigan and Illinois claimed reimbursement for services such as health evaluations performed for the benefit of non-Medicaid-eligible children. The resulting improper payments for non-Medicaid-eligible children accounted for \$12.5 million of the \$56 million in federal reimbursement that was reviewed in Michigan for the quarter ending September 1998 and \$7.7 million in Illinois for the quarter ending March 1999. Our investigation in Michigan identified approximately \$28 million in improper federal reimbursement for 2 years.

In some states, funding arrangements among schools, states, and private firms can create adverse incentives for program oversight and cause schools to receive a small portion--as little as \$7.50 for every \$100 in Medicaid claims--of Medicaid reimbursement for school-based claims. We found that 18 states retained a total of \$324 million, or 34 percent, of federal funds intended to reimburse schools for their Medicaid-related costs; for 7 of these states, this amounted to 50 to 85 percent of federal Medicaid reimbursement for school-based claims. In addition, contingency fees, which some school districts pay to private firms for their assistance in preparing and submitting Medicaid claims, ranged from 3 to 25 percent of the federal Medicaid reimbursement, further reducing the net amount that schools receive. While school districts can--and do--pay private firms for assistance with Medicaid claims, these fees are not allowable for federal reimbursement. Yet, our investigation determined that in one state a school district inappropriately included contingency fees on a Medicaid administrative cost claim.

Finally, HCFA's overall weak direction and oversight have contributed to the problems we identified. Although at least one HCFA regional office has identified cases of improper payments, to date no consistent attempt has been made to determine how pervasive these practices may be in other regions and states or to halt them as quickly as possible. Moreover, problems we identified in last June's testimony--ambiguous policies and inconsistent oversight--continue and, in fact, have been exacerbated. For example, HCFA's attempt to clarify transportation policies for school-based services has been interpreted differently among regional offices, resulting in inequitable treatment of school district claims for special transportation needs. Recognizing that schools can be effective sites in which to identify low-income children eligible for Medicaid, assist them to enroll, and provide them Medicaid services, we are making recommendations to the Administrator of HCFA that are aimed at improving the development and consistent application of clear policies and appropriate oversight for school-based Medicaid services. Additionally, we are referring evidence of certain improprieties and other matters to the cognizant U.S. Attorney's Offices for appropriate action.

Medicaid is a joint federal-state program that in fiscal year 1998 spent about \$177 billion to finance health coverage for 41 million low-income individuals, 13 million of whom are school-aged children. States operate

their programs within broad federal requirements and can elect to cover a range of optional populations and benefits. As a result, Medicaid essentially operates as 56 separate programs: 1 in each of the 50 states, the District of Columbia, Puerto Rico, and the U.S. territories. Medicaid is an entitlement program under which the states and the federal government are obligated to pay for all covered services provided to an eligible individual.

Medicaid costs shared by the federal government and the states fall under one of the following two categories: medical assistance (called "health services" in this report) and administrative activities. Each state program's federal and state funding shares of health services payments are determined through a statutory matching formula. This formula results in federal shares that range from 50 to 83 percent, depending on a state's per capita income in relationship to the national average. For administrative activities claims, the federal share varies by the type of costs incurred. Most administrative expenditures are shared equally between the federal government and the individual state. However, certain administrative expenditures are eligible for higher federal matching funds.<sup>4</sup> Over 95 percent of Medicaid's \$177 billion in total expenditures in fiscal year 1998 was spent on health services.

Schools can help identify eligible low-income children, assist them to enroll, and provide them Medicaid-covered services, and states are authorized to use their Medicaid programs to help pay for certain health care services delivered to these children in schools. In addition, Medicaid is authorized to cover health services provided to children under the Individuals With Disabilities Education Act (IDEA).<sup>5</sup>

Children who qualify for IDEA have access to a wide array of services, and Medicaid may cover the costs of health-related services provided to eligible children. In particular, IDEA obligates schools to provide the "related services" that are required to help a child with a disability benefit from special education, including transportation, speech-language pathology, and physical and occupational therapy. Because many services required by the individualized plan developed to address the specific needs of a child with a disability are health-related, Medicaid is an attractive option for funding many IDEA services. Children who qualify for IDEA are frequently eligible for Medicaid services, and although Medicaid is generally the payer of last resort for health care services, it is required to pay for IDEA-related medically necessary services for Medicaid-eligible children before IDEA funds are used.

IDEA requires that states have in effect policies and procedures to ensure the identification, location, and evaluation of all children with disabilities who are in need of special education and related services, a concept termed "child find." Some activities under Medicaid, such as outreach in support of Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, can be coordinated with IDEA activities.<sup>6</sup> While related, these two programs still have distinguishing goals: IDEA's child-find activities are focused on identifying and meeting the educational needs of children with disabilities, while EPSDT outreach is directed at informing children who are potentially eligible for Medicaid about benefits available under the EPSDT program and facilitating the Medicaid application process.

#### School-Based Health Services

Commonly provided school-based health services that qualify for Medicaid reimbursement include physical, occupational, and speech therapy as well as diagnostic, preventive, and rehabilitative services. Schools that submit claims to their state Medicaid agency for reimbursement for health services must meet Medicaid provider qualifications established by their state and must have a provider agreement with the state Medicaid agency.<sup>7</sup>

In addition, states must develop a methodology for determining payment rates for school-based health services. Payment rates are established by the state Medicaid agency, described in a state plan, and approved by HCFA. Although states have broad discretion in establishing payment rates, they must be reasonable and sufficient to ensure the provision of quality services and access to care. Within these general payment principles, however, considerable variation can exist. For example, states may set a payment rate for each individual service provided or base Medicaid reimbursement on the actual costs providers incur in supplying services.

Until recently, states have been allowed to develop methods to bundle payments for a specified group of services. However, in a May 21, 1999, letter to state Medicaid directors, HCFA prohibited states' use of this approach because HCFA had concluded that bundled rate methodologies do not produce sufficient documentation of accurate and reasonable payments. HCFA informed states that it would not be considering further proposals by states to use a bundled rate payment system. HCFA directed states with bundled rates to develop and prospectively implement an alternate reimbursement methodology. HCFA expected states to come into compliance with its May 21, 1999, letter within a reasonable time frame and stated it would consider taking action if this did not occur. While HCFA expects to issue further clarification on bundled rates some time this year, states with previously approved bundled rates continue to use them.

#### School-Based Administrative Activities

Schools may also receive reimbursement for the costs of performing administrative activities related to Medicaid. Administrative activities performed by school districts and schools may include Medicaid outreach, application assistance, and coordination and monitoring of health services. Unlike the requirements for health services claims, a school does not need to become a qualified Medicaid provider to submit administrative activity claims. However, there must be (1) either an interagency agreement or a contract that defines the relationship between the state Medicaid agency and other parties and (2) an acceptable reimbursement methodology for calculating payments for administrative activities.

Cost allocation plans are expected to be supported by a system that has the capability to properly identify and isolate the costs that are directly related to the support of the Medicaid program. States must also abide by the cost allocation principles described in Office of Management and Budget (OMB) Circular A-87, which requires, among other things, that costs be "necessary and reasonable" and "allocable" to the Medicaid program.<sup>8</sup>

#### Services

In August 1997, HCFA issued a technical assistance guide for Medicaid claims for school-based services.<sup>9</sup> This guide provides general information and guidelines regarding the specific Medicaid requirements associated with federal reimbursement for the costs of school health services and administrative activities. HCFA requires states to provide and maintain appropriate documentation and assurances that claims for administrative activities do not duplicate other claims or payments.

HCFA's May 21, 1999, letter to state Medicaid directors, in addition to prohibiting bundling payments, attempted to clarify HCFA's policy on transportation and stated that HCFA was in the process of updating its guiding principles related to claims for school-based administrative activities costs. (See app. I for the full text of the May 21, 1999, letter.) In February 2000, HCFA released for public comment a draft of its revised technical assistance guide on submitting school-based administrative activity claims.<sup>10</sup>

Practices; Expenditures Continue to Grow

While nearly all the states had Medicaid expenditures for school-based activities, the extent of participation varied widely, with the volume of Medicaid administrative expenditures having grown significantly in recent years. Total Medicaid claims for the most recent year of available state data range from \$8,000 in Mississippi to \$682 million in New York; average claims per Medicaid-eligible child range from less than 5 cents in Mississippi to nearly \$820 in Maryland. This variation can be partially explained by the proportion of school districts within a state that choose to file claims. Recent payments for school-based administrative activities reflect the growing number of school districts making claims for Medicaid reimbursement for these activities. Moreover, in addition to the 17 states that currently allow their schools to bill Medicaid for school-based administrative activities, 12 states have indicated that they may do so in the future. As a percentage of total Medicaid administrative expenses, payments for school-based administrative activities range from less than 1 percent in 1 of the 17 states allowing such claims to over 45 percent in Michigan and Illinois.

While nearly all states allow schools to submit claims to their state Medicaid agencies for school-based health services, administrative activities, or both, the extent to which school districts choose to do so varies. Our survey of the 50 states and the District of Columbia found that schools in 47 states and the District of Columbia obtain Medicaid payment for school-based health services, administrative activities, or both. While 15 states allow claims for both health services and administrative activities, 30 states and the District of Columbia allow Medicaid payment for health services only. Two states--Alaska and Arizona--limit their school-based Medicaid payments to administrative activities, and schools in three states--Hawaii, Tennessee, and Wyoming--do not claim Medicaid reimbursement for either type of school-based service. (See fig. 1.)

Figure 1: States Reporting Medicaid Claims for School-Based Services, December 1999

Source: GAO survey of states.

States also vary substantially in the amount of their Medicaid payments for school-based activities. Medicaid payments to schools ranged from less than 5 cents per Medicaid-eligible child in Mississippi to nearly \$820 per child in Maryland. Three states--Illinois, Michigan, and New York--accounted for over 60 percent of total school-based claims. New York comprised 44 percent of all health services payments, while Illinois and Michigan accounted for 74 percent of all administrative activity payments. (See table 1.) Among the 45 states and the District of Columbia that provide Medicaid reimbursement for school-based health services, such claims have been allowed for periods ranging from 2 to 28 years. For the 17 states that provide Medicaid reimbursement for school-based administrative activities, such claims have been allowed for between 1 and 8 years.

Table 1: States' Annual School-Based Claims, Ranked by Average Claim per Medicaid-Eligible Child Aged 6 to 20

Continued

State	Average claim per Medicaid-eligible child	School-based claims (in thousands)		
		Total claims	Health claims	Administrative claims
Maryland	\$818	\$93,824	\$93,824	a
New York	703	682,000	682,000	a
Illinois	674	385,633	82,946	\$302,687
Michigan	674	317,701	93,534	224,167
New Hampshire	658	24,894	24,894	a
Rhode Island	600	27,482	27,482	a
Delaware	394	13,900	13,900	a

Maine	350	22,000	22,000	a
Vermont	309	12,798	11,041	1,757
Kansas	291	25,741	25,741	a
Massachusetts <sup>b</sup>	284	65,250	45,750	19,500
Alaska	265	7,780	a	7,780
District of Columbia	265	12,100	12,100	a
Wisconsin <sup>c</sup>	249	45,904	44,312	1,591
New Jersey	248	66,328	60,671	5,657
Connecticut	174	22,216	22,216	a
Pennsylvania	121	68,507	54,555	13,952
Arizona	115	25,795	a	25,795
Utah	114	7,279	7,279	a
Minnesota	105	23,766	271	23,495
Texas	88	78,030	66,368	11,662
Washington	87	30,367	11,973	18,394
Oregon	85	12,441	12,441	a
South Carolina	79	14,247	14,247	a
New Mexico	72	10,348	5,439	4,909
Ohio	66	31,953	31,953	a
Florida	59	41,518	3,067	38,451
Nebraska	58	3,916	3,916	a
Missouri	55	15,381	4,277	11,104
Iowa	52	5,255	4,171	1,084
Nevada	48	1,900	1,900	a
Arkansas	45	5,428	5,428	a
Colorado <sup>d</sup>	44	4,885	4,885	a
North Dakota	41	826	826	a
South Dakota	31	906	906	a
Montana	29	892	892	a
Louisiana	26	6,269	6,269	a
West Virginia	24	3,044	3,044	a
Georgia	21	9,167	9,167	a
Idaho <sup>d</sup>	20	781	781	a
California	19	42,308	42,020	288
Oklahoma	10	1,311	1,311	a
Kentucky	6	1,228	1,228	a
Virginia	5	1,201	1,201	a
North Carolina	2	722	722	a
Alabama	1	132	132	a
Indiana	e	60	60	a
Mississippi	e	8	8	a
Hawaii	a	a	a	a
Tennessee	a	a	a	a
Wyoming	a	a	a	a
Total		\$2,275,423	\$1,563,150	\$712,273

Note: States provided school-based claims data for the most recent fiscal year for which they were available, which for approximately half the states was state fiscal year 1999. Most of the remaining states provided data for state fiscal year 1998, federal fiscal year 1998, or calendar year 1998; three states provided data for periods before July 1997. The average claim per Medicaid-eligible child was calculated by dividing the total school-based claims by the number of school-aged Medicaid-eligible children.

aThis state did not report school-based claims in this category.

bMassachusetts provided 6 months of administrative claims data, which we extrapolated to reflect a full year of claims.

cWisconsin's school-based health claims and administrative claims do not equal its total school-based claims because of rounding.

dColorado and Idaho provided 11 months of health services claims data, which we extrapolated to reflect a full year of claims.

The average claim per Medicaid-eligible child was less than \$1.

Source: GAO analysis of state-reported claims data and HCFA's fiscal year 1997 eligibility data (2082 report).

Some of the variation in Medicaid payments for school-based services and cost per Medicaid-eligible child is explained by differences in the proportion of school districts submitting Medicaid claims for school-based activities. For some states, schools are part of the state Medicaid health services delivery system, while in other states, schools may not generally provide direct health services. For example, two states that spent relatively little per Medicaid-eligible child--Indiana, at less than \$1 per child, and Alabama, at \$1 per child--both indicated low percentages of school district participation, with an Indiana official estimating approximately 3-percent participation. A state official in California, which spent less per Medicaid-eligible child than 40 other states, estimated that in state fiscal year 1998 about 75 percent of the school districts in the state submitted claims for health services, while only 2 school districts submitted claims for administrative activities.

States also varied in whether they considered certain activities to be health services or administrative activities, which could have affected federal reimbursement because the federal match rate for health services is higher than the rate for administrative activities in many states. According to HCFA's technical assistance guide, Medicaid currently allows states to reimburse transportation and case management as health services, administrative activities, or both. For example, schools in Maryland and Nevada claim school-based transportation as a health service, while those in Massachusetts classify transportation as an administrative activity. Similarly, Illinois schools claim case management as an administrative activity, while those in New York claim it as a health service.<sup>11</sup> A Michigan official reported that schools submit claims for case management as a health service once the individualized plan for a child with a disability has been developed and written, while case management that takes place before such a plan is developed is claimed as an administrative activity.

#### School-Based Administrative Activities

In June 1999, we testified that a growing number of states pay for reimbursement of school-based administrative activities, and our recent survey suggests that this growth will continue. From fiscal year 1995 through fiscal year 1998, Medicaid claims for administrative activities increased fivefold, from \$82 million to \$469 million (see fig. 2).<sup>12</sup> These increased Medicaid expenditures for school-based administrative activities reflect growth in the number of states participating, the number of schools participating, and the size of claims submitted by individual school districts. 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 primarily the result of an increase in the number of school districts submitting claims.

Figure 2: Medicaid School-Based Administrative Claims for 10 States, Fiscal Years 1995-98

Note: States that appear in bold lettering began claiming school-based administrative expenditures in the year listed.

Source: State-reported claims.

Interest in submitting claims to Medicaid for administrative activities performed in the schools was evident in our recent survey of the 50 states and the District of Columbia. In addition to the 17 states that currently allow Medicaid reimbursement for school-based administrative activities,

officials in 12 other states reported that they are considering allowing school-based claims for these activities in the future. Seven other states reported that they were "not sure" if they would allow schools to submit Medicaid claims for administrative activities.<sup>13</sup> (See table 2.) Of those states considering Medicaid reimbursement for school-based administrative costs, eight identified some possible activities for which they would pay, including eligibility facilitation, outreach, transportation, program planning and monitoring, case management, referral, and coordination.

Table 2: Positions on Reimbursement for Medicaid School-Based Administrative Activities of Those States That Do Not Currently Pay Claims

Considering reimbursement	Uncertain	Not considering reimbursement
		Colorado
		Connecticut
Alabama		Delaware
Arkansas		Kentucky
Georgia		Louisiana
Idaho	District of Columbia	Maine
Kansas	Hawaii	New Hampshire
Nebraska	Indiana	New York
Nevada	Maryland	North Dakota
North Carolina	Mississippi	Rhode Island
Ohio	Montana	South Carolina
Oklahoma	Virginia	South Dakota
Oregon	(7)	Tennessee
Utah		West Virginia
(12)		Wyoming
		(15)

Source: GAO survey of states.

a Few States' Total Medicaid Administrative Costs

The school-based administrative claims of a few states constitute a significant share of their total Medicaid administrative activity. For example, these claims represented 47 percent and 46 percent, respectively, of Michigan's and Illinois' total Medicaid administrative claims. Other states--Alaska, Arizona, and Washington--had school-based claims as high as 19 to 20 percent of their total Medicaid administrative expenditures. (See table 3.) A significant portion of the growth in the administrative costs of four states resulted from reimbursing for school-based activities: Alaska, Illinois, Michigan, and Minnesota all showed average annual growth rates for school-based administrative expenditures that were at least twice as high as the growth rate of all their other Medicaid administrative expenditures combined.<sup>14</sup>

Table 3: States' Medicaid School-Based Administrative Claims as a Percentage of Total Medicaid Administrative Expenditures

Continued

State	School-based Medicaid administrative claims (in thousands)	Total Medicaid administrative expenditures (in thousands) <sup>a</sup>	Percentage of total administrative expenditures
Michigan	\$224,167	\$477,138	47
Illinois	302,687	661,188	46
Arizona	25,795	131,577	20
Washington <sup>b</sup>	18,394	91,745	20
Alaska	7,780	40,662	19
New Mexico	4,909	32,078	15
Florida	38,451	289,625	13
Minnesota	23,495	209,412	11
Massachusetts <sup>c</sup>	19,500	190,669	10
Missouri	11,104	131,024	8
Vermont	1,757	35,659	5
Pennsylvania	13,952	387,262	4
New Jersey	5,657	253,991	2
Texas	11,662	576,952	2
Iowa	1,084	70,125	2
Wisconsin	1,591	138,555	1
California	288	1,227,657	Less than .02

Note: States were asked to provide administrative claims data for school-based services from the most recent fiscal year. Although most states provided data from the year ending June 30, 1999, two states provided data from calendar year 1998, two states provided federal fiscal year 1998 data, and three states provided data from state fiscal year 1998 (July 1, 1997&minus;June 30, 1998).

<sup>a</sup>States provided total Medicaid administrative expenditures for the same period as for the school-based administrative claims data.

<sup>b</sup>Although Washington provided school-based administrative claims data for the year ending August 31, 1999, total Medicaid administrative expenditures were provided for the closest year of data available, federal fiscal year 1999 (October 1, 1998&minus;September 30, 1999).

<sup>c</sup>Massachusetts provided 6 months of school-based administrative claims data, which we extrapolated to reflect a full year of claims.

Source: State-reported claims data.

#### Provided or Administrative Activities Are Properly Identified and Reimbursed

Some methods used to claim Medicaid reimbursement do not adequately ensure that health services are provided or that administrative activities are properly identified and reimbursed. Paying bundled rates for health services can simplify requirements for schools that participate in the Medicaid program; however, bundled rates can also create an incentive to stint on services, or to change what services children receive or where they receive them to increase payment. To counteract these incentives, bundled rate methods should differentiate payments among children with varying levels of need and provide assurances that necessary services are provided. However, not all states using a bundled payment approach differentiate levels of need among children or ensure that services paid for are provided. In addition, poor controls over what constitutes an allowable administrative activity cost claim have resulted in improper Medicaid reimbursements. In some cases, Medicaid claims were inappropriately reimbursed because they represented administrative activities that were not Medicaid-related. In other cases, claims for administrative activities performed by skilled medical professionals, which can be eligible for reimbursement at a higher matching

rate of 75 percent, were submitted and paid without adequate documentation to justify the higher rate.

Incentives

HCFA began to allow states to develop bundled payment approaches in an attempt to simplify schools' reporting requirements under Medicaid. We reviewed the payment approaches of seven states that currently use bundled rates.<sup>15</sup> Bundled payments are somewhat comparable to capitation payments made to managed care organizations. A school district receives a single payment for all the covered services a child needs during a specified period, such as a day or month.<sup>16</sup> Bundled payments have the advantage of simplifying schools' submission of claims. One state official told us that the less complicated paperwork involved with bundled rates has made it easier for smaller schools to submit claims for Medicaid reimbursement.<sup>17</sup>

Bundled rates can also reduce the negative incentives that may exist under other payment approaches. For example, reimbursing schools on the basis of their actual costs may undermine interest in delivering services efficiently. In addition, a fee-for-service approach, which is used by the majority of states, does not provide schools with an incentive to control the volume of services provided because schools in these states receive more revenue for providing more services. (See table 4.) Counteracting the adverse incentives that may exist under these other payment approaches is challenging. Reviewing utilization or cost reports to establish that costs are allowable or services are necessary is expensive. In contrast, bundled rates can help limit the costs of delivering services by creating the incentive to provide needed services more efficiently. Under a bundled approach,

however, costs can also be limited by neglecting to provide all needed services or by compromising the quality of individual services provided. These undesirable effects can be reduced by modifying how bundled rates are paid and exercising additional oversight of the services delivered.

Table 4: Incentives Affecting Volume and Cost of Services, by Payment Approach

Payment approach	Do incentives exist for providers to increase	
	Volume of services to an individual?	Unit cost?
Cost-based reimbursement	Yes	Yes
Fee-for-service rates	Yes	No <sup>a</sup>
Bundling rates	No <sup>b</sup>	No <sup>a</sup>

<sup>a</sup>Under this payment approach, incentives to increase the unit cost do not exist, provided the unit costs are based on reasonable and appropriate costs.

<sup>b</sup>Bundled rate payments can, however, provide an incentive to inappropriately decrease the volume of services provided.

Source: GAO analysis of payment incentives.

In order for bundled rate methods to result in appropriate payments, the amount paid should be appropriately aligned with the expected cost of services. For schools, bundled payments that take into account the variation in service needs among children and ensure that services are provided help ensure that Medicaid funds are appropriately spent and children's needs met. However, the methods currently employed by some of the seven states using bundled rates do not satisfy these criteria (see table 5).

Table 5: Approaches to School-Based Payments in Seven States Using Bundled Rates

State	Does the bundled rate vary depending on the needs of the child? <sup>a</sup>	What is the unit of payment for services? <sup>b</sup>	What event triggers submitting a claim to Medicaid for reimbursement?
Connecticut	No--one statewide rate	Monthly rate--\$336 per child	Receipt of one service
Kansas	Yes--14 statewide rates; vary by primary disability	Monthly rate--\$151&minus;\$636 per child	School attendance 1 day a month
Maine	Yes--13 statewide rates; vary by primary disability	Monthly rate--\$141&minus;\$442 per child	School attendance 1 day a month
Massachusetts	Yes--seven statewide rates; vary by time spent in a regular classroom	Six daily rates--\$11&minus;\$48 per child; one weekly rate--\$106 per child	School attendance
New Jersey	Yes--four statewide rates; vary by type of school	Daily rate--\$33&minus;\$172 per child	Receipt of one service
Utah	No--school-specific rates	Daily rate--\$21&minus;\$60 per child	School attendance
Vermont	Yes--four statewide rates; vary by number of services actually provided	Monthly rate--\$162&minus;\$1,598 per child	Receipt of a specified number of services

<sup>a</sup>States may exclude certain services, such as development and evaluation of the individualized plan of a child with a disability, EPSDT diagnosis and treatment, and provision of medical equipment, from their bundled rates and separately claim Medicaid reimbursement for these services.

<sup>b</sup>For all but one state, the rates are current and are rounded to the nearest dollar. The rates listed for Vermont are from the 1998-99 school year. Vermont's rates have historically been adjusted annually for salary increases.

Source: State Medicaid agencies.

As table 5 indicates, states' bundled rates vary in the extent to which they adjust payments among children with different medical needs. For example, the bundled rates of two states--Connecticut and Utah--do not recognize that the costs for providing services to children with different medical needs may vary considerably. Participating schools in Connecticut receive a monthly payment of about \$336 for each eligible child, regardless of whether that child has a mild learning disability or has multiple physical and cognitive disabilities. This statewide rate may not cover the full costs incurred by schools that have a disproportionate number of children whose services cost more, which may affect schools' ability to provide necessary services. Conversely, other schools may be paid an amount higher than their actual costs. In two other states, Massachusetts and New Jersey, the payment level is based on the location of the child, and not necessarily on the number or scope of services that he or she receives. Specifically, Massachusetts' schools are paid on the basis of the percentage of time an eligible child spends in a regular classroom, whereas New Jersey has four statewide rates that vary depending on where the child attends school.<sup>18</sup>

Bundled payment rates in other states, such as Kansas, Maine, and Vermont, are more aligned with the expected cost of services for specified groups of children. For example, schools in Kansas and Maine receive the same payment amount for all children with specified disabilities, such as autism or mental retardation. While these rates do not recognize differences in the number and intensity of services provided to children within each disability category, they do recognize that schools can incur significantly higher costs for children with certain disabilities. Vermont does not distinguish among types of disabilities but does have four different levels of reimbursement, which vary depending on the number of services a child actually receives in a given week, as well as on who provides those services.<sup>19</sup>

In addition, states' bundled approaches should ensure that services paid for are actually provided. However, payments currently made in four of the seven states--Kansas, Massachusetts, Maine, and Utah--are not specifically linked to the receipt of services because reimbursement is triggered simply by school attendance. Participating schools in these states are reimbursed the bundled rate for each eligible child, irrespective of whether the child has received any services. For example, schools in Kansas are reimbursed about \$476 a month for each child whose primary disability listed on the individualized plan is autism, as long as the child attended school at least 1 day in a given month. In such an arrangement, there is little accountability for providing needed services because attendance--not the receipt of services--triggers reimbursement.

Varying levels of assurances exist in Connecticut, New Jersey, and Vermont that services are actually provided to eligible children. For example, schools in Connecticut must document on a monthly service information form the number and type of services provided to each child. However, schools have to provide a child with only one service during the month to be eligible for the full payment. Similarly, New Jersey schools can claim the per diem reimbursement for each day an eligible child receives at least one service that is documented by the school. In Vermont, case managers complete for each child a level-of-care form that categorizes the hours of service, type of provider, and setting (one-on-one or group). Using these data, a clerk computes the total units of service each child receives to justify the payment for one of four levels of care.

#### Administrative Claims

Poor controls on the part of states and school districts have resulted in improper reimbursements for Medicaid administrative claims. The methods states allow school districts to use to determine administrative costs strongly influence the amount of Medicaid reimbursement school districts receive. Determining allowable Medicaid-related administrative costs involves identifying direct costs, such as for personnel and supplies, and allocating them between Medicaid and non-Medicaid activities, as well as allocating an appropriate share of indirect (overhead) costs to Medicaid.<sup>20</sup> In most cases, school personnel involved in special education can serve both Medicaid and educational functions; thus, the costs of administrative activities must be allocated to each function.<sup>21</sup> Two aspects of the methods for determining administrative cost allocations are vulnerable to contributing to overstated Medicaid costs: (1) time study methodologies, which are used to identify the portion of staff time spent on Medicaid-related activities, and (2) activity codes, which are used to identify functions performed by school staff in these time studies. In addition, some school districts have received reimbursement for administrative activities at the enhanced 75-percent federal matching rate for skilled professional medical providers, such as physical therapists, without providing adequate documentation that their professional capabilities were needed for such activities, as required by Medicaid regulations.

Different Time Study Methods Have Led to Considerable Variation in

## Reimbursement

Some time study methods that states allow schools and school districts to use in determining Medicaid-related school-based administrative costs are questionable and could be used to inappropriately increase Medicaid payments. Differences in time study methodologies can--and do--affect the level of states' reimbursements. States vary in the extent to which they instruct school districts on the type of time study methodology permitted.

We identified three basic methods used to allocate the time of school personnel to Medicaid-related administrative activities: the representative period, random moment, and continuous log methods.<sup>22</sup> The representative period method is the one most vulnerable to manipulation. In contrast to the random moment time study, for example, which always randomly selects a period of time to be studied, representative periods may not always be randomly selected. This method is also the one most frequently used. Of the 17 states with schools that file administrative cost claims, 15 allow the use of representative period time studies for determining cost allocations.<sup>23</sup> Moreover, 9 of the 15 states that specify the use of a representative period study either specify the use of a nonrandom representative period or allow the school districts or private firms involved in the time studies to make this decision.<sup>24</sup>

How the selection of the sample period can affect study results is illustrated by an example from Florida. When a private firm representing nine Florida school districts changed the time study method they used from a sampling period of 1 week per quarter to a random sample of moments throughout the quarter, the amount of federal reimbursement claimed decreased by 50 percent.

## Loosely Defined Activity Code Categories Have Overstated Costs Related to Medicaid

Loosely defined activity code categories used by time study participants to record time spent on administrative activities have resulted in overstated Medicaid costs.<sup>25</sup> While typical activity code categories may include outreach related to the Medicaid program, coordinating and monitoring of health services, and facilitating Medicaid eligibility determinations, these categories and their codes vary among and within states, particularly when multiple private firms contract with school districts within a state to submit administrative cost claims.

While staff from HCFA's central office and several regional offices emphasized the importance of developing clearly defined activity codes, some states' methods allow certain activities to be inappropriately claimed as Medicaid administrative costs. For example, HCFA's Chicago regional office questioned activities for which \$30 million in federal reimbursement had been claimed and paid for one quarter for participating schools in Michigan. The activity codes in question included general health screenings, communication with families, and staff training as Medicaid administrative activities. However, HCFA regional office interviews with a sample of staff who allocated their time to these activity codes revealed no direct connection between staff activities and Medicaid; these staff did not know what Medicaid covers, where or how to apply for Medicaid, or who might qualify for coverage. Moreover, the only Medicaid-related training activity identified in HCFA's review was for purposes of completing the time study; interviewed school staff indicated that Medicaid was not mentioned during other identified training sessions. The activity codes in question constituted 53 percent of the \$56 million in federal reimbursement claimed for administrative activities by Michigan's school districts for the quarter ending September 1998. HCFA recommended that Michigan revise its time study's activity code definitions to more accurately identify activities related to the Medicaid program or recipients. The HCFA regional office deferred Michigan's claim for \$33 million in federal reimbursements for the quarter ending September 1999, asking again that the state better document

that school-based claims for administrative activities were clearly linked to Medicaid.

Our investigation and HCFA scrutiny of claims in Michigan and Illinois also disclosed federal reimbursements for health reviews and evaluations performed for the benefit of non-Medicaid-eligible children. These improper claims for non-Medicaid-eligible children in schools accounted for \$12.5 million of the \$56 million in federal reimbursement that was reviewed in Michigan for the quarter ending September 1998 and a \$7.7 million reimbursement to Illinois--\$2.4 million for one school district consortium for the quarter ending December 1998 and \$5.3 million for the quarter ending March 1999 for the remaining school districts that claim reimbursement. Our investigation in Michigan identified approximately \$28 million in improper federal reimbursement for 2 years.

Our review of the 17 states that allow schools to file administrative claims showed that some of the questionable activity code definitions used in Illinois and Michigan are also being used for activity codes in 9 other states. Of these nine states, four do not specifically mention Medicaid in descriptions of relevant activities.<sup>26</sup> In contrast, at least one state preferred to develop its own activity codes, rather than adopt those already in use in other states, because the other state codes were "too loose to be appropriate" and did not differentiate Medicaid-related activities from those relating to non-Medicaid-eligible children.

#### Claims Based on Professional Credentials Have Resulted in Questionable Payments

Claims for administrative activities performed by skilled professional medical providers (SPMP) at the 75-percent enhanced matching rate have also resulted in questionable payments. Of the 17 states submitting claims for administrative costs, 11 states allow the use of the SPMP enhanced rate for school-based administrative claims. In general, the SPMP rate can be legitimately used only when the person (1) has the appropriate credential, such as a nurse, occupational therapist, or physical therapist, and (2) performs an administrative activity that requires professional medical knowledge and skills. For example, a nurse who meets with a child and notices a condition that needs medical attention could submit a claim for this activity at the SPMP enhanced matching rate of 75 percent. However, a nurse who only arranges a medical appointment for a child would not need his or her credentials to make an appointment and thus would not be eligible for the 75-percent enhanced matching rate. The enhanced matching rate of 75 percent for SPMP administrative activities can be a strong incentive for those preparing and submitting claims, as it increases by 50 percent the amount of federal reimbursement that can be received.

In two states--Illinois and Michigan--we found that, on the advice of private firms, school districts have submitted claims that inadequately document the need for professional credentials for purposes of submitting an SPMP claim. For example, we found that one private firm told the SPMPs in its client school districts to claim the enhanced rate for every administrative activity they perform, rather than document in each case whether their skill was required. Another private firm told SPMPs that, when tracking their time, they had only to check a box to indicate that their medical credential was necessary for a particular activity, and that no further documentation or proof was needed for the enhanced Medicaid reimbursement.<sup>27</sup> Recent SPMP claims in Illinois totaled \$16.6 million, or 37 percent of its total claims, for one quarter for participating school districts.<sup>28</sup> In Michigan, SPMP claims totaled \$14 million, or 25 percent of the state's total administrative activity for all participating school districts for the quarter ending September 1998.<sup>29</sup>

#### Paid to Private Firms--Reduce the Federal Dollars Schools Receive

Funding arrangements among states, schools, and private firms create adverse

incentives for program oversight and significantly reduce the amount of federal dollars that schools receive for Medicaid-related services and activities. Of the 47 states and the District of Columbia that submit claims on behalf of schools for health services, administrative activities, or both, 18 retain some portion of federal Medicaid reimbursements rather than fully reimbursing schools for their Medicaid-related costs. Because states can benefit directly in this way from higher federal payments, states' incentives to exercise strong oversight over the propriety of school-based claims can be diminished. In addition, many school districts have contingency arrangements with private firms that pay them a share of Medicaid reimbursement, in some cases, a percentage of the federal share of reimbursement received from a claim. Embedded in both of these practices are incentives for states and private firms to experiment with "creative" billing practices, some of which we have found to be improper. Moreover, the result of these actions is that, in some states, schools could receive as little as \$7.50 in federal Medicaid reimbursements for every \$100 spent to pay for services and activities performed in support of Medicaid-eligible children.

Oversight

Eighteen states retain a portion of the federal Medicaid reimbursement resulting from school districts' claims. According to several state officials, because state budgets fund a portion of school activities, Medicaid services provided by schools are partially funded by the state. According to this reasoning, some states believe they should receive a share of the federal reimbursements claimed by school districts. However, it is not clear that state, rather than local, funds support the Medicaid-reimbursable services, as opposed to other educational activities for which states provide funds. Moreover, we believe that such a practice severs the direct link between Medicaid payment and the services delivered and increases the potential for the diversion of Medicaid funds to purposes other than those intended.

We found that seven states retain from 50 percent to 85 percent of the federal Medicaid reimbursement for health services, while another nine states retain between 1 and 40 percent of federal payments. Among the states that claim Medicaid reimbursement for administrative activities, three retain 50 percent or more of the federal reimbursement, while another seven keep between 1 and 40 percent. (See table 6.)

Table 6: Amount and Percentage of Federal Medicaid Reimbursement for Health Services and Administrative Activities Retained by States

State	Percentage of federal reimbursement for health services retained	Percentage of federal reimbursement for administrative activities retained	Amount retained by state (in thousands) <sup>a</sup>
New Jersey	85	85	\$25,815
Iowa	75	0	1,984
Delaware	70	b	4,865
Vermont	60	15	4,266
Alaska	b	52	2,023
New York	50	b	170,500
Pennsylvania	50	50	18,079
Washington <sup>c</sup>	50	0	3,122
Connecticut	40	b	4,443
Michigan	40	40	69,156
Wisconsin	40	40	10,749
Illinois <sup>d</sup>	10	10	6,391
New Mexico	5	5	314
Ohio	4	b	741
Utah	2	b	105
Colorado	2	b	50

Massachusetts	1	326
Minnesota	0	587
Total		\$323,516

aStates provided school-based claims data for the most recent fiscal year for which they were available, which for approximately half the states was state fiscal year 1999. Most of the remaining states provided data for state fiscal year 1998, federal fiscal year 1998, or calendar year 1998; three states provided data from before July 1, 1997.

bThis state does not claim reimbursement for this type of school-based activity.

cWashington retains at least 50 percent of federally reimbursed funds but can retain a higher percentage depending on whether the school district is "fully participating" in billing Medicaid for school-based services.

dWhen total Medicaid payments to an Illinois school district exceed \$1 million in a year, 10 percent of the portion exceeding \$1 million is retained for the state's general revenue fund. According to the state, 22 of its 900 school districts received more than \$1 million.

Source: State-reported data.

When a state benefits directly from federal reimbursements for schools, questions arise concerning its incentives to exercise appropriate oversight of Medicaid program operations for school-based claims. The improper activities cited in this report--particularly those for administrative cost claims--are symptomatic of the lack of sufficient oversight, such as state-level reviews of school-based claims for their appropriateness. For example, one auditor from the Department of Health and Human Services' Office of Inspector General told us that Medicaid program oversight in one state is geared toward ensuring adequate documentation of claims and not toward examining claims for appropriateness. Our contacts with the auditors' offices of six states revealed that these states conducted no state-level reviews of Medicaid school-based claims.

Moreover, we identified similar concerns about states' oversight in our investigation of improper practices in making school-based fee-for-service claims for health services. For example, our investigation of fee-for-service payments for health services in one state revealed that schools were submitting, and the state was paying, transportation claims for all Medicaid children who had received a Medicaid health service at school without verifying that the child had used school bus transportation. Our investigation further identified instances in which the transportation services for which the state submitted claims were not provided, resulting in improper Medicaid reimbursements. In another investigation, we uncovered practices under which Medicaid was inappropriately billed for health services in one state, and other investigators identified similar practices in another state. Specifically, in both states, some group therapy sessions were billed as individual therapy sessions, which resulted in a higher payment for the school.

Claims

Some school districts paid private firms fees ranging from 3 percent to 25 percent of the federal reimbursement amount claimed; fees most commonly ranged from 9 to 12 percent. These firms are usually hired to assist with administrative cost claims, generally designing the methods used to make these claims, training school personnel to apply these methods, and submitting administrative claims to state Medicaid agencies to obtain the federal reimbursement that provides the basis for their fees.<sup>30</sup> By receiving a percentage of reimbursement rather than a fixed fee, these firms have an incentive to maximize the amount of reimbursements claimed.

Private sector interest in working with states and school districts to seek Medicaid reimbursement for administrative activities is high. In addition to the 17 states that currently submit administrative claims, officials from at least 7 other states told us that private firms interested in developing administrative claims methodologies had recently contacted them or schools in their state.

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

While schools can--and do--pay private firms on a contingency basis for Medicaid-related services, these contingency fees do not qualify for federal Medicaid reimbursement.<sup>31</sup> OMB Circular A-87, which establishes the principles and standards for determining "reasonable" and "allocable" costs for federal programs such as Medicaid, states that the costs of professional and consultant services rendered are allowable when reasonable and when not contingent upon the recovery of costs from the federal government.<sup>32</sup> In one state, our investigation determined that contingency fees were improperly included in one school district's Medicaid administrative cost claim. We estimate that the resulting unallowable costs claimed for reimbursement may approximate \$1 million for a 5-year period.

Reimbursement

In some states, schools can receive a small portion of Medicaid reimbursement for performing covered health services and administrative activities on behalf of eligible children. In addition to states' policies to retain a portion of federal Medicaid reimbursement and school districts' contractual arrangements to pay private firms a share of their federal reimbursements, the school districts' budgets often serve as the local funds that are used to supply the state's share of Medicaid funding for school-based claims. When school funds provide the state share of Medicaid reimbursement, the maximum additional funding that a school district can receive for delivering services or performing administrative activities is what the federal government contributes. This is substantially less than what a private sector Medicaid provider would receive for delivering and submitting a claim for similar services.<sup>33</sup> For example, a physician who submits a claim with an allowable amount of \$100 will receive \$100: \$50 in state funds and \$50 in federal funds.<sup>34</sup> In contrast, when a school district submits a claim for \$100, and the school district pays the state's share of this claim, the maximum the school district can receive is the \$50 federal share. Of the 47 states that allow Medicaid claims for school-based activities, 38 use local funds for the state match to federal dollars.<sup>35</sup> Table 7 shows the variation in the amounts different schools might receive in Medicaid reimbursement for the claims they submit, given the source of the states' share of funding, states' policies to retain portions of the federal reimbursement, and contingency fee arrangements with private firms.

Table 7: Variations in Schools' Receipt of Medicaid Reimbursement for Health Services

	State					
	Florida	Illinois	Vermont	Michigan	New Jersey	Minnesota
Amount claimed	\$100.00	\$100.00	\$100.00	\$100.00	\$100.00	\$100.00
Local funds used	(44.18)	(50.00)	(38.03)	(47.28)	(50.00)	0
Amount retained						

by state	0	(5.00)c	(37.18)d	(21.09)	(42.50)	0
Total Medicaid funds received						
by school district	55.82	45.00	24.79	31.63	7.50	100.00
Amount paid to private firm by school district	(10.05)f	(8.25)	0	(10.54)	g	h
Net amount to school district	\$45.77	\$36.75	\$24.79	\$21.09	\$7.50	\$100.00

aThis amount reflects the state's share of Medicaid funding for health services for fiscal year 1999. For administrative activities, states' shares would generally be 50 percent.

bThe amount retained by the state is deducted from the federal reimbursement.

cWhen total Medicaid payments to an Illinois school district exceed \$1 million in a year, 10 percent of the portion exceeding \$1 million is retained for the state's general revenue fund. According to the state, 22 of its 900 school districts received more than \$1 million.

dThe percentage retained by Vermont varies from year to year. The amount noted reflects the percentage retained for Vermont's 1999 school year.

ePrivate firms' contingency fees vary across school districts and states; thus, the dollars reported in this table are estimates of typical contingency fees paid by school districts.

fEffective February 14, 2000, contingency fee reimbursement contracts are prohibited for school districts in Florida.

gThe state of New Jersey pays the firm \$2.55 from the \$42.50 it retains.

hMinnesota state officials were not aware of any contingency fee arrangements being used by school districts; thus, we did not report dollars in this example.

Source: GAO analysis of state data.

Claims

HCFA oversight practices--past and present--have not ensured the appropriateness of school-based practices for claiming Medicaid reimbursement. As we testified in June 1999, HCFA's guidance in the past has generally left much to regional office discretion, resulting in inconsistencies in the oversight and review of claims. Written guidance has consisted primarily of a technical assistance guide and a direction for states to follow the federal requirements for administrative cost allocations found in OMB Circular A-87. Despite HCFA's May 21, 1999, letter, which was partially intended to provide clarification in areas concerning bundling and submitting claims for administrative activities and special transportation services, HCFA regional offices continue to interpret policies inconsistently.<sup>36</sup> This lack of adequate direction and oversight has permitted the development of an environment of opportunism and has led to improper Medicaid claims for administrative activities and limited assurances that children are receiving appropriate services.

Methods Have Not Been Developed

In its May 21, 1999, letter, HCFA instructed states with bundled rates to develop and implement an alternative reimbursement methodology but did not provide a time frame in which to do so.<sup>37</sup> To assist states in this effort, the agency also announced that it would create a work group of officials

from states using bundled approaches, the Department of Education, and other federal agencies to discuss alternative arrangements.

However, since HCFA issued this letter, the seven states that were using a bundled approach continue to do so. In fact, officials in some of these states told us that they intend to continue to use their bundled approaches

until HCFA clarifies its position or issues additional guidance.

Furthermore, the work group that was established as a result of the HCFA letter is currently inactive. While the group initially met weekly via telephone, its members neither made any formal decisions about the future of bundling nor developed alternative payment approaches. In October 1999, HCFA officials announced that the group would not reconvene until sometime in 2000, because it needed time to discuss issues concerning bundling. As of March 1, 2000, the work group had not yet reconvened.

HCFA has made some efforts to improve oversight of school-based administrative claims. It has conducted individual reviews of practices identified in this report in a few states and is working with a few states to revise their activity codes to more accurately capture the costs associated with Medicaid-related activities in schools. Finally, the additional guidance that HCFA testified in June 1999 would be forthcoming was released for public comment in February 2000.

Despite these efforts, the lack of clear guidance on how to develop methods for submitting administrative claims continues to result in significant inconsistencies among regions. For example, while some HCFA regional offices have scrutinized the details of states' methodologies for developing administrative claims, other regional offices have had little or no involvement in the development of their states' methodologies. The area of enhanced rates for skilled providers is a specific example of the contradictory policies of regional offices. The Chicago regional office allows Illinois and Michigan school districts to claim administrative activities provided by SPMPs at a 75-percent match rate as opposed to the general administrative match rate of 50 percent. In contrast, the school districts in Massachusetts are not allowed to claim this enhanced rate because HCFA's Boston regional office does not allow the higher rate. According to officials in the Boston office, "there was no way in the world" to document that certain activities required a skilled level of performance. Still other HCFA regional offices, such as San Francisco, have adopted a different approach, allowing the use of the enhanced rate under certain circumstances.

#### More Questions Than It Answers

HCFA's attempt to clarify its policy on school districts' practices in claiming Medicaid reimbursement for special transportation related to school-based services has added to the uncertainty surrounding this issue rather than clarifying the matter. The HCFA letter indicated that school districts should not bill to Medicaid the transportation costs of a child who qualifies for special education under IDEA and who rides the regular school bus with children without disabilities. According to HCFA central office officials, the general intention was to discontinue the practice of allowing Medicaid reimbursement for children who needed no additional assistance and could ride the regular school bus by themselves without any special equipment or the assistance of an aide.

However, regional offices and states have conflicting interpretations of what an appropriate special transportation claim is, with the likely result that Medicaid reimbursement will continue to be inconsistent across states.

• Officials in one of the seven regional offices that we spoke with correctly believed that Medicaid would cover transportation costs if a child was able to ride on a regular school bus but required the assistance of an aide; two other regional offices incorrectly asserted that transportation

costs could not be reimbursed because the child would not be riding a specially adapted vehicle; and officials in the remaining four regional offices did not know whether reimbursement would be allowed.

- Officials in two of the states we visited told us they will now allow school districts to claim Medicaid reimbursement only for the use of vehicles that have a wheelchair lift or some adaptation that would meet the needs of children with physical disabilities--a policy that is inconsistent with the intent that HCFA officials described to us.

- At least two states are awaiting further clarification from HCFA and continue to have school districts that claim transportation costs for children with special education needs who receive a Medicaid service at school--including costs for those riding regular school buses with an aide.

The inconsistent interpretations cited above raise concerns of unequal consideration of children with different types of disabilities. In particular, state and school districts are unclear regarding HCFA's policy for submitting claims for children who have behavioral needs or developmental disabilities, but no physical disability. In many cases, these children have the physical capability to ride the regular school bus but may need the assistance of an aide to ride the bus because of cognitive impairments or behavioral concerns. Further, some contend that requiring a physically adapted bus in order to receive reimbursement--as is currently interpreted by some states and HCFA regional offices--may conflict with the concept of "least restrictive environment"; thus, children may be unnecessarily segregated into specialized transportation.<sup>38</sup>

Almost one-third of Medicaid-eligible individuals are school-aged children, which makes schools an important service delivery and outreach point for Medicaid. Even when schools do not directly provide Medicaid-covered health services, schools can undertake administrative activities that help identify, refer, screen, and assist in the enrollment of Medicaid-eligible children. Outreach and identification activities help ensure that the most vulnerable children receive routine preventive health care and ongoing primary care and treatment. Most states are seeking Medicaid funds to assist them in providing medically related services to children with disabilities and to link children to appropriate health services.

Given the broad range of school and state practices, to date there have been poor controls on the varied approaches to submitting claims for Medicaid reimbursement for school-based health services and administrative activities. Such controls must achieve an appropriate balance between the states' needs for flexible, administratively simple systems and the assurance that federal funds are being used for their intended purposes. HCFA's current oversight practices have failed to provide that assurance, resulting in confusing and inconsistent guidance across the regions and failure to prevent improper practices and claims in some states. Without adequate controls and consistent oversight, Medicaid is vulnerable to paying for unneeded activities and services or for activities and services that have not been provided. Examples of such concerns follow.

- Bundled payment systems have the potential to reduce adverse incentives that are created by other payment systems, such as fee-for-service and cost-based reimbursement. Although additional safeguards can strengthen the benefits associated with bundled rates, we believe that prohibiting the use of bundled rates altogether, as HCFA recently did, is not warranted. Bundling rates can be an acceptable payment mechanism, provided that (1) rates account for children's different levels of need and (2) rates are developed in such a way as to provide assurances that they are not vulnerable to manipulation or resulting in inadequate services.

- With regard to administrative cost claims, poor controls have resulted in improper payments for Medicaid reimbursement in several states. As a result, Medicaid has reimbursed either for activities that were not covered or for

children who were not eligible for Medicaid. Furthermore, claims submitted for administrative activities performed by skilled professionals have been reimbursed at a higher matching rate than available documentation could support.

- Specialized transportation, for which HCFA provided policy clarification in May 1999, continues to be overseen and approved haphazardly, resulting in potentially inequitable practices for children with different types of disabilities across different regions.

Finally, inadequate HCFA oversight has created an environment ripe for opportunism and vulnerable to fraud.

- Contingency fees paid to private firms by school districts have created the incentive to inappropriately maximize claims for Medicaid reimbursement. Improprieties in claims identified by our investigations and those of HCFA demonstrate how weaknesses in federal and state efforts to curtail this incentive can result in improper costs.

- When states stand to benefit financially by retaining a substantial share of schools' federal Medicaid reimbursements, the potential exists for a conflict of interest in ensuring that adequate oversight and controls are in place to ensure the appropriate use of Medicaid funds.

In order to improve the development and application of policies for Medicaid reimbursement of claims for allowable school-based health services and administrative activities, we recommend that the Administrator of HCFA

- allow the use of bundled rates as one of several alternative payment approaches, provided that HCFA establishes consistent principles for bundling that effectively address (1) provisions for rates that reflect or recognize varying levels of services to accommodate children and (2) assurances that children receive appropriate and needed services;

- develop a methodology to approve and monitor state practices regarding allowable costs for administrative activities in schools that establishes consistent federal requirements for methods of allocating costs to Medicaid and accounting for professionals' time; and

- clarify the agency's policy on specialized transportation, with the goal of establishing policies that offer equitable treatment for children with different types of disabilities.

We provided HCFA and the state Medicaid agencies we visited an opportunity to comment on a draft of this report. With respect to bundled rates for health services, HCFA commented that its May 1999 position emanated from its concern that the existing methodologies did not meet statutory requirements for payments consistent with efficiency, economy, and quality care. In considering future requests for bundled rate payments, HCFA indicated it would address such issues as reasonable payment levels, adequate documentation that covered services are provided only to Medicaid-eligible children, and sampling methodologies to verify the accuracy of documentation. This approach should provide better assurances that payment rates reflect children's varying needs and that services paid for were provided, but we would caution that new requirements not create a de facto fee-for-service environment and thus undermine the intended benefits associated with a bundled payment approach.

HCFA concurred with our recommendations on administrative cost claims and specialized transportation. With respect to administrative claiming, HCFA listed a number of steps it said it would take to address our recommendations. Among other things, this list included revising and finalizing a Medicaid school-based administrative claiming guide that it released for public comment in February 2000, providing training and technical assistance to states and school districts to facilitate their

efforts, and developing processes for monitoring existing school-based claiming activities and approving states' changes in this activity. HCFA expressed its commitment to working with its various partners--including the Department of Education, states, and schools--to better ensure the proper and efficient operation of Medicaid school-based programs. (See app. II for HCFA's comments.)

Most of the states that responded commented that our analysis of Medicaid reimbursement received by schools, as shown in table 7, did not reflect the portion of local school funding provided by the states. In addition, some states continue to assert that their retention of a share of federal Medicaid reimbursement is justified as reimbursement for their own level of funding support to schools. We continue to believe that it is not clear that state, rather than local, funds support the Medicaid-reimbursable services as opposed to other educational activities for which states provide funds. Moreover, we believe that such practices sever the direct link between Medicaid payment and services delivered, increase the potential for federal funds to be diverted to purposes other than those intended, and are inconsistent with the program's fundamental tenet that federal dollars are provided to match state or local dollars for Medicaid services delivered to eligible individuals. Finally, a few of the states said that additional guidance is needed for how states should claim federal reimbursement for administrative costs and specialized transportation.

HCFA and the state Medicaid agencies also provided technical comments, which we incorporated as appropriate.

We are providing copies of this report to the Honorable Donna E. Shalala, Secretary of Health and Human Services; the Honorable Nancy-Ann Min DeParle, Administrator of HCFA; appropriate congressional committees; and other interested parties.

If you or your staff have any questions about this report, please call Kathryn G. Allen at (202) 512-7118. For questions regarding our investigation, contact Robert H. Hast at (202) 512-7455. Other staff who made major contributions to this report are listed in appendix III.

Kathryn G. Allen  
Associate Director, Health Financing and  
Public Health Issues

Robert H. Hast  
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Health Care Financing Administration Letter Dated May 21, 1999

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**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.<sup>1</sup>

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.<sup>2</sup> 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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<sup>1</sup>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.

<sup>2</sup>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;<sup>3</sup> others are included through a state's Medicaid plan and are available through Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.<sup>4</sup>

#### 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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<sup>3</sup>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).

<sup>4</sup>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.<sup>5</sup> 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.<sup>6</sup> 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

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<sup>5</sup>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.

<sup>6</sup>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.

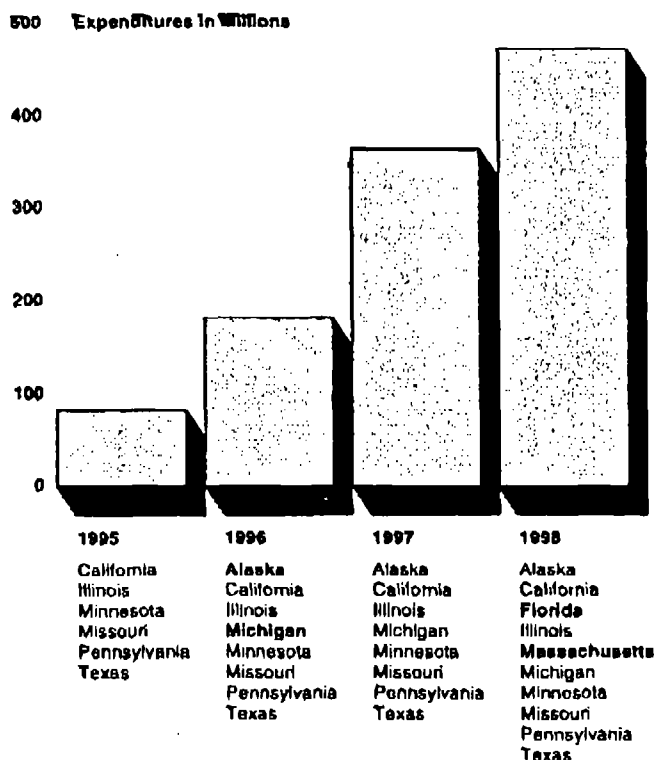
**MEDICAID CLAIMS FOR ADMINISTRATIVE  
EXPENDITURES HAVE INCREASED  
DRAMATICALLY IN SOME STATES**

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.<sup>7</sup> (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.

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<sup>7</sup>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.<sup>8</sup> 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

<sup>8</sup>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.<sup>9</sup> Thus, increases in Illinois' expenditures between 1997 and 1998—from \$89 million to \$145 million—largely reflect increased cost claims from school districts.<sup>10</sup>

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

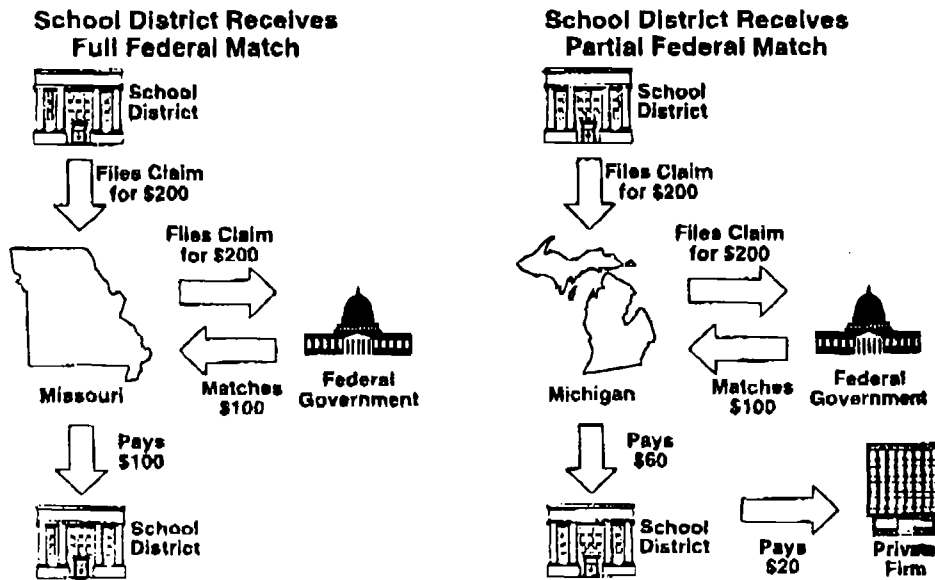
Medicaid funds to reimburse schools for administrative activities are distributed differently, depending on the state. (See fig. 2.)

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<sup>9</sup>Chicago public schools attributed increased Medicaid revenues to additional staff training and development, legal assistance, and claims reporting assistance.

<sup>10</sup>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.<sup>11</sup>

<sup>11</sup>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.<sup>12</sup> 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.<sup>13</sup> Instead, the regional office was told to pay the state but perform a postpayment review of the claims.<sup>14</sup> 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.

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

<sup>13</sup>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.

<sup>14</sup>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<sup>15</sup> 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.<sup>16</sup> 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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<sup>15</sup>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 health care services.

<sup>16</sup>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.

**MEDICAID AND SCHOOL-BASED HEALTH SERVICES (SBHS)  
An informational Briefing for the HCFA Administrator**

2/17/99

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2/17/99, HCFA/CMSO

## BRIEFING OUTLINE

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## Background

- o School-based health services (SBHSs) can play an important role in assuring that adolescents and children receive needed health care in a setting that is appropriate, while assuring that there is minimum disruption in the process of educating the child. Medicaid can play an important role by covering SBHSs for Medicaid-eligible children and assuring that these services are medically necessary and are provided effectively and efficiently. The school setting also offers the unique advantage and opportunity to reach out to children and families to inform and encourage them to enroll in the Medicaid or CHIP programs.
- o Before the Medicare Catastrophic Coverage Act (MCCA) of 1988, some State Medicaid programs were covering and reimbursing for “routine” EPSDT screenings, examinations and treatment of acute, uncomplicated medical problems in school-based/school-linked clinics. HCFA’s policy was to encourage more of this type of activity as a way to more effectively reach Medicaid-eligible children. With enactment of the MCCA of 1988, Medicaid, rather than the Department of Education, became the primary payor for the medical services provided to Medicaid-eligible children with special needs under the Individuals with Disabilities Education Act (IDEA) who have Individualized Education Plans (IEPs). This dramatically broadened the landscape for Medicaid coverage and reimbursement of school-based health services.
- o During the last couple of years we have seen a surge of State interest in claiming for Medicaid reimbursement for school-based health services. Most of this recent activity is related to medical services and associated administrative costs for Medicaid-eligible children with special needs under the Individuals with Disabilities Education Act (IDEA).

Over the past 15 months, HCFA has been engaged in a number of activities to develop and clarify policies related to Medicaid and School-Based Health Services in hopes of preventing abuse and assuring accountability in this area. Attached is a summary of our policies, areas of concern that have arisen, and HCFA’s action plan for resolving these issues.

## Definition and Basic Medicaid Coverage Requirements for SBHSs

- o School-based health services (SBHSs) are those medical services provided to school-aged children on-site at the school or at school-linked clinics. The medical services may include: routine/preventive medical screenings and examinations; diagnosis and treatment of acute, uncomplicated problems (e.g., eye, ear or upper respiratory problems); monitoring and treatment of chronic medical conditions (e.g., seizure disorders and other conditions for which medication is taken regularly); and the provision of medical services to children with special needs under the Individuals with Disabilities Act (IDEA).
  
- o School-based health services are not specifically mentioned in the Social Security Act's 1905(a) listing of coverable Medicaid services. Nevertheless, they may be covered by State Medicaid agencies under a variety of 1905(a) service categories such as: physician services; services of non-physician licensed practitioners (e.g., nurse practitioners, psychologists); physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders; rehabilitative services. In addition to meeting 1905(a) requirements as a listed service category, in order to be covered by Medicaid, school-based health services must meet other basic federal requirements: the services must be considered primarily medical (not educational) in nature; be provided by a Medicaid enrolled and qualified provider; be considered medically necessary for the individual receiving the service.

## Major Problems/Issues

Three major areas/issues of concern have begun to emerge during the past year as States have proposed to cover SBHSs. These areas/issues all deal with providing services to Medicaid-eligible children under IDEA. The areas are: administrative claiming; the reimbursement methodology used to pay for SBHSs (fee-for-service vs bundling vs capitated rate); and transportation.

### \* **Administrative Claiming**

In addition to the direct provision of medical services, schools (or school districts, local education agencies (LEAs)) may also receive Medicaid reimbursement for the cost of performing administrative activities which are necessary for the proper and efficient administration of the Medicaid program. HCFA has developed and approved a series of allowable administrative activity claiming codes which have been used by some regional offices in their review of State claiming plans. Allowable administrative activities for which Medicaid FFP is available include: outreach to inform potential beneficiaries how to apply for Medicaid and access Medicaid services; arranging, either directly or through referral to appropriate agencies, covered Medicaid services; and conducting follow-up to ensure children receive needed services.

Our concerns about administrative claiming involve the methodology used by some states to document their administrative claims, the fact that some states have expanded the definition of approved administrative activities beyond those approved by HCFA and/or some States may have double claimed administrative costs by claiming for activities that have already been claimed as part of the Medicaid service or been paid by DOE.

### \* **Reimbursement**

There are basically three different ways that Medicaid can reimburse for SBHSs.

- Fee-for-Service. The traditional way is to pay for each medical service (e.g., physical therapy session, etc.) on a fee-for-service basis, with each service provided to a Medicaid-eligible beneficiary generating a claim which is submitted to the State Medicaid agency.
- Bundling. More recently, schools have developed and submitted proposals to bundle a package of medical services that would be expected to be provided to IEP Medicaid-eligible children, who are stratified into various disability categories, into a single payment rate that is submitted on a weekly or monthly basis to the State Medicaid agency. As many as seven

or eight services might be included in the bundled rate (e.g., physical therapy, speech therapy, vision services, etc.) depending on the degree of disability and stratification category of the child. The cost for the bundled rate is calculated by looking at the services received by and average costs of a statistically valid sample of children in each stratification category. In order to apply the bundled rate methodology, the same documentation must be kept as in fee-for-service reimbursement and there must be periodic reviews done by the State to reconcile claims to services and costs.

- Capitation. The capitated rate is a per student rate that the State Medicaid agency pays the school to cover the same services as the bundled package of services, but is determined after undergoing a process of competitive bidding and negotiation.

The major problem in this area stems from the desire of schools to receive a bundled rate payment from Medicaid but to **not** have to keep the required documentation or to periodically review and reconcile claims. In other words, the schools want to receive a capitated payment rate for each Medicaid child they serve under IDEA without going through a competitive bidding process, without documenting the services actually provided and without undergoing the review and reconciliation process.

\* **Transportation**

Medicaid is required to ensure that the transportation needs of beneficiaries to and from necessary medical care are met and that when several modes of transportation are available the least costly appropriate to the medical needs of the beneficiary is used. A number of States are receiving payments for the cost of transporting children with an IEP to and from school in regular (yellow) school buses. HCFA policy has not been entirely clear whether such costs can be reimbursed by Medicaid when it is the responsibility of the State educational system to provide regular school bus transportation. Medicaid policy states that reimbursement is available when the child receives a medical service in school on that day and when transportation is listed as a needed service in the IEP. Department of Education policy is that children who ride to school in the regular bus should not have transportation listed in their IEP's. However, a number of States are including transportation in the IEP's of all children so that they can claim FFP. It is Medicaid policy to pay for the costs of transporting Medicaid children with an IEP in specialized buses (i.e., buses where special equipment is needed for transportation) to and from school.

## HCFA Activities to Address these Problems/Issues

HCFA has responded to this recent surge of State interest and activity in Medicaid funding of SBHSs and to these perceived problems in the following ways:

- \* Strategy and Timeline. Developing a “Strategy and Time-Line” which describes the various activities underway by HCFA and the schedule for their completion. The activities are divided into three major areas: those directed at the compilation of basic federal policy for SBHSs; ongoing efforts to manage the Medicaid SBHS program; and those directed at a Hill strategy. (Attachment 1)
- \* School-Based Guide. In August 1997 we published the “Medicaid and School Health” technical guide. The **Guide** was sent to the regional offices, states and others. It is also available on the HCFA Web. The Guide describes the basic federal requirements that must be met by States in covering and claiming for school-based health services for IEP and non-IEP Medicaid children.
- \* Regional Office Memo. In July 1998 we sent a memo to the ROs requesting that they (continue) sending us copies of all school-based health services state plan amendments (SPAs), as a way for us to become more informed about what was happening in this area.
- \* Addendum to the Guide. Based on our discussions with States, ROs and the SPAs that were sent us, we developed a Draft **Addendum** to the **Guide** which was sent to the ROs on October 5, 1998 for their review and comments. The **Addendum** included proposed policy about the key issues and problems that were beginning to emerge from our work in this area such as administrative claiming, bundling vs capitation payment rates for services and transportation. We also asked the ROs to identify any other issues that were of concern to them and for which clarifying policies might be needed. We have now received comments from all the ROs and will be analyzing the comments with our RO counterparts to develop detailed policies in these areas. When completed the **Addendum** along with the SBHS **Guide** will constitute our basic federal policies pertaining to Medicaid and SBHSs and will need to be published and released widely.
- \* Survey the ROs on Major Issues. Several weeks ago, a survey was sent to the ROs to identify the States that are: claiming for SBHSs; using a fee-for-service, bundled rate or capitated rate methodology; claiming administrative costs; and claiming transportation costs for IEP children transported to and from school in a regular (yellow) school bus. (Attachment 2 is a summary of the survey findings.)

- \* State Specific Issues. Recently, the CMSO made decisions regarding two school-based issues in a particular State (i.e., Florida). The decisions clarify HCFA's policies regarding several basic federal Medicaid requirements concerning the use of the bundled vs. the capitated rate methodology (i.e., documentation requirements for bundling of services, requirement to competitively bid contracts for capitated rate, and periodic review and reconciling claims for bundled rate methodology) and transportation of Medicaid children with an IEP by regular (yellow) school buses to and from school. Because policies in these two areas are urgently needed to manage the SBHS program in one state and will have an impact on the SBHS program in a number of other states, we will be sending a policy memo on these issues to the regional offices very soon. (See Attachment 3). A State Medicaid Director's letter on these issues will follow.

In another State (Michigan) HCFA regional office with central office support has been investigating SBHS administrative claims that appear to be inappropriate. The regional office is beginning a financial management review of Michigan's administrative claiming procedures which may ultimately result in a deferral.

- \* Hill Strategy. On November 24, 1998, the CMSO Director and HCFA staff briefed several staff of the House Commerce Committee and the Senate Finance Committee. The Hill staff are very concerned about abuses in this area and the involvement of consultants in developing and negotiating large SBHS plans. Again on December 10, 1998 HCFA staff gave an oral briefing to OMB staff on these same issues. During these briefings questions have been asked about the process that takes place when State Medicaid agencies seek HCFA approval for a program to claim FFP for SBHSs and the process for monitoring the program to prevent abuses. Attachment 4 briefly describe these things and identifies some of the successes the regional offices have had in conducting financial management reviews of school based health services.

## Next Steps

- o We will form a Taskgroup consisting of the Central Office SBHS Team and selected Regional Office DMSO staff to review the RO comments on the **Draft Addendum** and to propose SBHS policies to be incorporated in the Addendum.
- o We will continue our review of administrative claiming in Michigan. The RO has conducted an initial meeting with the State to discuss the problems with the State's claiming methodology. The State has indicated to the RO a willingness to work with HCFA to bring its claiming into compliance with Medicaid requirements.
- o We will work with the Regions to realign their priorities to emphasize review and monitoring of SBHS plans.
- o We will draft and obtain a approval for the memo to the Regions and a State Medicaid Director's letter on two issues, transportation and requirements for using a bundled vs capitated rate methodology, which are urgently needed to correct problems/abuses occurring in these areas.
- o We will conduct site visits alone and with Hill staff to gain more real world experience about the SBHS setting and services.
- o We will conduct training sessions with State and RO staff as decisions are made on SBHS policies.
- o Much of our time will continue to be devoted to ongoing management of the Medicaid SBHS program. This activity involves ongoing review, negotiation and approval of SBHS state plan amendments.
- o We will provide Hill staff with the information they requested at our 11/24/98 briefing as well as additional information as it becomes available so that they may be fully informed about our activities to clarify and resolve SBHS issues.

## Attachments:

1. Strategy and Timeline
2. SBHS Survey
3. Draft ARA Memo to Clarify Transportation and Bundling Policies
4. Oversight: State Plan Process and Financial Management Reviews

**Attachment ISCHOOL BASED SERVICES -- STRATEGY AND TIMELINE**

(Updated -- 1/21/99)

Project	Completion Dates	Lead (in bold)	Status
<i>Compilation of Federal Policy Requirements</i>			
1) Publication of "Medicaid and School Health: A Technical Guide"	Completed August 1997	<b>CMSO/SBHS Team</b>	Completed.
2) Publication of the Addendum to the Guide * Submit Draft Addendum to RO for comment. * Form CO/RO Taskgroup to analyze RO comments and develop SBHS policies to be addressed in Addendum. * Survey States to determine fee-for-service vs. bundling vs. capitated rates, as well as administrative claiming. * Issue ARA memorandum and SMD letter clarifying HCFA policies on transportation and payment methodologies for SBHS.	April 1999 10/5/98  2/1/99  12/7/98 2/1/99 (ARAs) 4/1/99 (SMDs)	<b>CMSO/SBHS Team</b>  Partner: RO/DMSO	Numerous fact finding activities underway. Comments received from all RO's raising a variety of issues. CO staff has completed review and summary of RO comments. SMD letter under development.
3) Publication of Administrative Claiming Operational Guidelines	June 1999	<b>CMSO/QPMG staff</b>	Under development.
<i>Ongoing Efforts to Manage Medicaid SBHS Program</i>			
1) Continue to Review and Approve SBHS State Plan Amendments	Ongoing	<b>RO/DMSO Staff</b>  Partners: CO Staff	This effort has been the most time consuming for CO staff thus far. Conference calls, memos and letters will continue to be required to help States implement Medicaid policies for SBHS.
2) Specifically Review the "Administrative Claiming" Activities in the State of Michigan	5/1/99	<b>RO/DMSO</b>  Partners: CMSO/SBHS Team	Meeting between the RO and Michigan Medicaid Agency staff was held on December 11th. The RO is now working with the state and CO to identify acceptable administrative claiming activities and to revise the administrative codes accordingly. The RO will defer the state's administrative claims pending identification of acceptable codes.

<b>3) Conduct Site Visits at Nearby Schools That Can Provide Positive Examples</b>	Spring/Summer 1999	<b>CMSO/SBHS Team</b> Partners: RO, Hill Staff	These visits were suggested at recent Hill meetings as a means to identify schools with good operating systems and accountability, as well as to provide more information to both the Hill and HCFA about actual practices.
<b>4) Training Meetings for RO Staff/States</b>	Summer/Fall 1999	<b>CMSO/SBHS Team</b> Partners: RO/DMSO	The training will give RO staff an opportunity to learn about SBHS policies related to transportation, bundling, and administrative claiming in order to provide additional technical assistance to the States.
<i>Hill Strategy</i>			
<b>1) Respond to Hill Staff Requests from 11/24/98 Briefing</b> * Reimbursement Methodology * Transportation Issues * "Administrative" claiming Issues	2/99	<b>CMSO/SBHS Team</b> Partners: RO/DMSO	Briefing materials under development for the Administrator. Further materials to be developed for response to the Hill.
<b>2) Proactively Continue to Keep Hill Staff Informed About New Policy Developments</b>	Ongoing	<b>CMSO/SBHS Team</b>	This will allow HCFA to be proactive with the Hill on these issues and may assist us in clarifying policies as well.
<b>3) Joint Site Visits with Hill Staff to Neighboring States to Observe and Learn about Medicaid SBHS Functions.</b>	2/99	<b>CMSO/SBHS Team</b> Partners: RO/DMSO	Visits are being scheduled for February in Philadelphia. Will provide an opportunity for Hill staff to gain more experience in this area.

## 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 does 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

Date: DRAFT

From: Director  
Center for Medicaid and State Operations

Subject: Medicaid Coverage of School-Based Services - Requirements for Bundling and Transportation Payment--ACTION

To: Associate Regional Administrators  
Division of Medicaid and State Operations  
Regions I-X

As you know, a number of issues have arisen recently concerning reimbursement for school-based health services under Medicaid. We were recently asked to brief Congressional and Office of Management and Budget (OMB) staff on HCFA's Medicaid school-based health services policies and activities. Congressional and OMB staff were particularly concerned about State claiming for school-related transportation services and State use of a bundled rate to pay for medical services provided to Medicaid children in schools as well as other issues including administrative claiming. We have had extensive discussions with the Department of Education and the Office of the General Counsel (OGC) on the first two of these issues and believe it is necessary to clarify HCFA policy in these two areas as quickly as possible via this memorandum. At a later date, these policy clarifications will be formally incorporated into the 1997 Medicaid and School Health Technical Assistance Guide as an addendum along with any other issues identified by the central office/regional office school-based services workgroup as requiring clarification. We will also have future clarifications on other areas of concern.

### **Transportation**

The Medicaid and School Health Technical Assistance 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 Individual Education Plan (IEP) as a required service. The Department of Education, which has responsibility for development of IEPs under the Individuals with Disabilities Act (IDEA), has clarified that an IEP should include only specialized services that a child would not otherwise receive in the course of attending school. Therefore, a child with special education needs under IDEA who rides the regular school bus to school with the other non-special education children in his neighborhood should not have transportation listed in his IEP and the cost of that bus ride should not be billed to Medicaid. However, if a child requires specialized transportation, such as a special wheelchair adapted bus, that transportation may be billed to Medicaid if included in the IEP. Transportation from the school to a provider in the community may also be billed to Medicaid. This policy applies whether or not the State is claiming at the service or administrative rate.

When a State claims for transportation services at the service rate, 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. As with any rate, the State

must also describe the methodology used to develop the transportation rate, whether it is claimed as a service or administrative cost. This should include a description of the allocation methodology used to ensure that Medicaid is only paying for that portion of the specialized mode of transportation allocable to Medicaid beneficiaries.

### **Bundled Rate**

A number of States have been claiming for school-based services using a "bundled rate" methodology. This permits schools to minimize billing paperwork by billing on a fee-for-service basis for a package of medical services, rather than for each individual service provided to each child. However, this methodology has raised concerns that Medicaid is paying more than it would on a fee-for-service basis for each individual service. We have had extensive discussions with OGC and with our financial management staff and have identified the requirements that must be met by a State in order to reimburse using a bundled rate.

If a State is providing a range of services to children with a wide variety of disabilities, the State should develop more than one bundled rate, based on the type and level of disability of the child and the services provided. This will help ensure that the payments most accurately reflect the services utilized. For example, a State may have classifications for the mentally retarded, hearing disabled, vision disabled, learning disabled, autistic, multi-handicapped, etc.. A rate would be developed for each disability classification by looking at the services received by, and average cost of, a statistically valid sample of children in each disability classification.

The regional office must review each of the bundled rates before the State begins paying them to ensure that they are based on medical services provided to a statistically valid sample of Medicaid-eligible children and that only those costs appropriately incurred by those children are included in the rate. All services must be medical in nature. Medicaid will not pay for the educational services included in an IEP.

Under Medicaid payment regulations, a bundled rate is considered to be a fee-for-service interim payment rate. Therefore, on an annual basis the State must review all of the services provided to its school-based population (i.e., utilization of each of the service components of the "bundle") and must determine what the cost of those services would have been had they been billed individually on a fee-for-service basis. If use of the bundled rate resulted in an overpayment relative to the actual fee-for-service cost of the individual services, the State must adjust the bundled rate accordingly for the subsequent payment period and may need to make an adjustment in its claim for FFP. The same is true if use of the bundled rate resulted in an underpayment. In order to do this, the State must ensure that documentation on the individual services provided to each child is maintained. The IEP is not sufficient for purposes of documenting services provided since it identifies only those services which a child should receive, not those services that the child actually receives.

### **Results of Regional Office Survey**

Based on the results of our recent regional office survey, we know that nine States are reimbursing for services using some form of bundled rate and sixteen are claiming for transporting IEP children to and from school on regular school buses. It is important that those

States be immediately notified of the requirements for Federal reimbursement in these two areas. We expect the regional offices to work to bring their States into conformance with these policies on a priority basis.

### **Administrative Claiming**

We are aware that, in many regions, administrative claiming for school-based services is of great concern due to the large amounts of FFP being claimed. Central Office financial management staff have developed a series of allowable administrative activity claiming codes which have been used by some regional offices in their review of State claiming plans. They plan to develop administrative claiming operational guidelines by early summer. Questions related to activities in States that are planning to claim or are already claiming at the administrative rate for school-based activities should be directed to Bill Lasowski or Richard Strauss in the Quality and Performance Management Group.

### **State Plan Amendments**

We ask that you continue to send us copies of all school-based health services State plan amendments. This process will enable central office staff to be as helpful as possible to your staff and to the States and will help ensure that coverage and reimbursement policies pertaining to school-based health services are consistent across the country.

Sally Richardson

**Oversight of School-Based Health Services:**  
**State Plan Process and Financial Management Reviews**

**Introduction**

In general, HCFA monitors Medicaid services through the State plan process. The regional offices, with central office support when necessary, review the plan amendments as well as the implementation of service programs to ensure compliance with Federal requirements. Where questions or concerns are identified, the regional offices may conduct financial management reviews to verify the acceptability of claims submitted. Financial management staff also review State requests for Federal matching for administrative activities which are necessary for the proper and efficient administration of the Medicaid program. The State plan process for school-based health services is essentially the same as for other Medicaid services.

**Background on State Plan Process**

The State plan is a comprehensive statement submitted by the State Medicaid agency describing the nature and scope of its program. The plan contains all information necessary for the Department to determine whether the plan can be approved as a basis for Federal Financial Participation (FFP) in the State program. This includes sections describing services covered and any limitations on those services, eligibility groups, and financial requirements and methodologies for reimbursing covered services. A plan amendment is submitted to the HCFA regional office when relevant changes to the plan are required by new Federal statutes, rules, regulations, interpretations, court decisions or by material changes in State law, organization, policy, or in the State's operation of the Medicaid program.

A State plan amendment must be reviewed by HCFA within 90 days from its receipt in the regional office. HCFA must within 90 days 1) approve the plan amendment; 2) send to the State a written notice of disapproval; or 3) request additional information which must be provided before a final determination is made. Once a request for additional information is sent to the State agency, the 90-day clock stops. A new 90-day clock will commence once the State submits the requested additional information. A final determination must be made after the State submits the additional information. The 90-day clock cannot be stopped a second time.

The availability of FFP for plan amendments commences from the effective date of the plan amendment, not with the date of approval. The effective date of a plan amendment may not be earlier than the first day of the quarter in which a plan amendment is submitted to the regional office and expenditures for medical assistance for the new provisions of the plan amendment may not be made earlier than the first day on which the plan is in operation on a statewide basis. A plan amendment need not be approved prior to the State claiming FFP for the revised or new plan amendment provisions. A State may claim FFP for services beginning with the effective date of the plan amendment whether or not the amendment has been formally approved by HCFA. However, should the amendment ultimately be disapproved, the State would be subject to a disallowance of the FFP claimed.

The regional offices are responsible for the review of State plans and amendments to ensure that Federal requirements are met. State plan material about which the regional staff have questions concerning the application of Federal policy is referred to the HCFA central office for technical assistance. The central office staff provides policy guidance and offers comments and suggestions to the regional staff during the course of their negotiations with the State agency. The Regional Administrators have been delegated the authority to approve state plan amendments. Only the HCFA Administrator has the authority to disapprove a state plan amendment.

With regard to administrative claiming, the Medicaid statute and regulations do not contain any explicit requirements for States to submit a State plan for claiming costs related to administrative activities, including those related to school-based activities. In general, the Medicaid statute only requires that State plans provide for "such methods of administration...as are found by the Secretary to be necessary for the proper and efficient administration of the plan." However, States may request HCFA assistance in developing administrative claiming programs, including those related to school-based services. Typically, States' claims for Federal financial participation for administrative costs are submitted through the Medicaid quarterly expenditure reports (the HCFA-64 reports), and are reviewed by the HCFA regional offices. Questions arising from reviews of the expenditure reports may result in more formal financial management reviews of the States administrative claiming activities.

#### **State Plan Process Specific to School-Based Health Services**

If a State wants to reimburse for new services in a school-based setting, a State plan amendment must be submitted which describes the proposed changes in coverage and/or the proposed reimbursement methodology for those services. The covered services and proposed reimbursement methodology must meet the Federal requirements. A State plan amendment for school-based health services is not required if the State is already covering those medical services under its current State plan and the reimbursement methodology will not change (i.e., the rate for providers of school-based services is the same as the rate for non school-based providers). However, if a State is proposing to bundle school-based health services for reimbursement, the State plan amendment must describe the methodology used in developing the bundled rate and the requirements for services documentation. Also, a schedule for the State's periodic review and reconciliation of costs to services provided must be described in the plan amendment. (Note: The bundled rate methodology requirements concerning the services documentation and the reconciliation of costs to services has recently been clarified.)

With regard to school-based health services, we have requested that the regional offices submit copies of all school-based health services plan amendments to central office. This will foster a consistent application of policy throughout the regions and alert central office staff to any potential coverage or reimbursement problems. If additional information is required in making a final determination, central office staff will provide input and technical assistance to the regional office which will compose the request for additional information letter and submit it to the State. The Regional Administrators retain the authority to approve plan amendments. Other aspects of the plan amendment process remain the same, such as the 90-day clock provisions and the FFP funding.

## Financial Management Reviews

Financial Management Reviews are conducted by regional financial management staff. The scope of these reviews may be limited to a specific area. Regional office staff usually do financial management reviews on an exception basis as a result of the State's submittal of the HCFA-64. These reviews may also be conducted on the State's operations/procedures to ensure consistency with Federal policies/requirements. An onsite review may be conducted when specific claims or services are questioned or when concerns are brought to the attention of the regional or central office staff by beneficiaries, interest groups, etc. Central Office may require the regional offices to perform a financial management review on a specific area as indicated in the work plan.

The Medicaid agency submits Form HCFA-37 quarterly which is an estimate of the State expenditures. The State then submits the HCFA-64 quarterly to central office with a copy to the regional office. This report is the State's accounting of actual recorded expenditures.

### Available Results of Financial Management Reviews

#### \*Boston Regional Office

Massachusetts: Onsite review at four school districts resulted in approximately \$700,000 in recovery. This review showed the billing of services for students not in attendance on the dates billed.

Maine: No onsite review but due to regional office review of their proposal, estimate that a reduction of \$6 million was realized.

Vermont: Regional Office is currently reviewing their proposal.

#### \*New York Regional Office

New York: Two reviews

1) A review of pre-school health claims resulted in a voluntary decreased adjustment by the State for the entire amount of \$32.4 million. The review showed a lack of documentation. 2) A review of administrative claiming resulted in a voluntary adjustment decrease from \$185.1 million to \$96.1 million. This review reflected unallowable claiming of educational rather than medical activities.

3) Another review was planned but has been placed on hold. The Office of the Inspector General may be conducting a review.

New Jersey: A review is planned

#### \*Philadelphia Regional Office

District of Columbia: Onsite review of transportation resulted in a decrease in allowable costs from \$5.8 million to \$1.6 million. The review showed that the claims were not connected to a Medicaid service.

\*Atlanta Regional Office

Florida:

- 1) Review of two school districts in 1995 and 1997 resulted in recommended recovery of the entire payment of \$12,580. This review showed billing for an level of service not provided, provider qualifications not met, and lack of documentation.
- 2) Another review is planned in February.

North Carolina: Review of two school districts resulted in a recommended recovery of \$6.7 million. The review showed a lack of documentation, unacceptable reimbursement rates, duplicate services, etc.

\* Chicago Regional Office

Illinois: A review of an administrative claim resulted in one quarter's claim being deferred.

Michigan: A review of State administrative claiming activities is underway.

\*Kansas City Regional Office

Missouri: Review of administrative case management services was performed in FFY 1995.

Kansas: A review of the bundled rate and State plan amendment was conducted. The plan amendment and payment rate was approved in 1998.

No other financial management reviews have been conducted in the regional offices. The lack of staff, time and workplan priority to conduct these intensive reviews have been the roadblocks.

There have been no financial management reviews of the reconciliation process in the six States which currently have a bundled payment rate. Under a bundled rate, the States must periodically reconcile the costs to services provided.

**Audits**

Audits are only conducted by the Office of Inspector General. They conduct periodic audits of State operations in order to determine whether 1) the program is being operated in a cost-efficient manner, and 2) funds are being properly expended for the purposes for which they were appropriated under Federal and State law and regulations.

According to the New York Regional Office, an OIG audit may be conducted in New York.

## MEDICAID REIMBURSEMENT FOR SCHOOL BASED HEALTH SERVICES

### SUMMARY

GAO released a study in June 1999 that detailed the exponential increase in Medicaid claims for school based services over the past 4 years (from \$82 million to \$469 million in the 10 states surveyed) and testified before the Senate Finance Committee that the financing mechanisms currently being used by states were similar in practice to the recycling schemes used in the late 1980s that substituted provider taxes and donations for state Medicaid match. To address this problem, HCFA released new guidance clarifying and refining its policy on reimbursement for school based services and pledging to release additional guidance in the Fall. This guidance was well received by members of Congress, but has caused considerable unrest in the states.

### SERVICES PROVIDED AT SCHOOL BASED CLINICS

Medical services provided by school based clinics include: routine and preventive medical exams, diagnosis and treatment of acute conditions such as eye, ear, or upper respiratory infections, monitoring and treatment of chronic conditions, such as epilepsy and diabetes, and services provided to children with special health care needs as required under the Individuals with Disabilities Act.

### MEDICAID REIMBURSEMENT FOR SCHOOL BASED CLINICS

In order to be covered by Medicaid, the services provided must be listed under section 1905(a), delivered by a Medicaid provider, and be considered medically necessary for the individual receiving the service.

Currently, 41 states enroll schools as qualified providers under the Medicaid program for covered services provided by school personnel and other qualified practitioners contracting with the school. Medicaid is also authorized to reimburse schools for certain administrative costs, including conducting Medicaid outreach and application assistance and arranging appointments with health care providers. For administrative activities related to Medicaid eligible and non-eligible children, the cost of the activities must be allocated to Medicaid in the appropriate proportion and specified in an approved cost allocation plan.

There are three different ways that Medicaid can reimburse for school based health services: fee for service, bundling, and capitation.

- **Fee for service reimbursement.** Under traditional fee for service reimbursement, each service provided to a Medicaid beneficiary generates a claim which is submitted to the state Medicaid agency. Thirty out of the 41 states providing school based services submit fee for service claims.

- **Capitation.** The state Medicaid agency pays the school a per student rate that covers a package of services. The cost of the capitated rate is determined through a competitive bidding process. Although this is an option, no states reimburse their schools in this manner.
- **Bundling.** More recently, schools have begun to bundle together a package of medical services expected to be provided to children with special health care needs served under individual education plans (IEPs), who have varying degrees of disability, and charge the state Medicaid agency a single payment rate. The cost of the bundled rate is calculated by reviewing the average cost of the services received by a statistically valid sample of children at each level of disability. States are required to periodically review the cost of the claims and reconcile them with services provided. Six states submit bundled claims for reimbursement; three states use a combination of bundling and fee for service claims.

HCFA had no information available on the reimbursement methodologies used by the remaining 8 states.

### **ABUSE OF MEDICAID REIMBURSEMENT FOR SCHOOL BASED SERVICES**

There are three ways for states to use the provision of school based services under Medicaid to shift the burden of costs traditionally assumed by the state to the Federal government.

- **Inappropriate claiming of administrative costs under Medicaid.** HCFA estimates that 18 states are currently claiming reimbursement for administrative costs under Medicaid. Although there is no nationwide estimate of the recent increase in Medicaid reimbursement for the administrative costs associated with school based services, a survey of 10 states conducted by GAO indicated a five-fold increase in claims over the past four years (\$82 million to \$462 million). Two of the states surveyed, Illinois and Michigan, accounted for most of the increases in administrative cost claims over this period of time. In Illinois, claims increased from \$82 million in 1997 to \$145 million in 1998; in Michigan, claims increased from \$79 million in 1996 to \$227 million in 1997.

Insufficient Federal oversight has led to an increase in inappropriate claiming of administrative costs. For example, a school will request 100 percent reimbursement from Medicaid for the cost of a principal's salary because of their role as a "program administrator" of the Medicaid services being provided in their school, regardless of the amount of time they spend on activities related to the provision of services to children with special health care needs. In some school districts, the administrative costs they claim are higher than the costs of the services they provide. In one state, the regional office identified and deferred over \$33 million in inappropriate administrative claims.

HCFA recently issued guidance stating that they are reviewing practices related to State claiming for school-based administrative activities and plan to publish a guide clarifying Federal policy this Fall.

- **Bundling payments without cost reconciliation.** Out of the six states which submit bundled claims, only one of them reviews and reconciles their claims on a regular basis (Connecticut). The remaining states (Massachusetts, New Jersey, North Carolina, Utah, and Kansas) do not.

Failure to review and reconcile claims makes the Medicaid program vulnerable to excessive overpayments for services on two fronts. First, states artificially inflate the rate charged for health care services. Second, states may not provide all of the services included under the bundled rate to students. For example, an on-site review of four school districts in Massachusetts by the HCFA regional office revealed claims of \$700,000 for services that were never provided to students.

Recent guidance published by HCFA eliminates the use of a bundled rate for reimbursement for school based services and states that these claims will be disallowed if submitted after July 1, 1999.

- **Claiming inappropriate transportation costs.** HCFA estimates that 16 states are currently receiving Medicaid reimbursement for the cost associated with busing students – with and without special health care needs – to and from school. Medicaid policy states that reimbursement for transportation costs associated with school based services is available if the child receives a medical service in school on that day, if the transportation takes place in a vehicle equipped for children with special health care needs, and if transportation is listed as a needed service in the child’s individual education plan. The Department of Education’s policy is that children who ride to school in the regular bus should not have transportation listed in the child’s individual education plan.

However, these states are including transportation in the individual education plans of all children with special health care needs, whether they ride to school in the regular buses or not, in order to claim Federal match.

Recent guidance published by HCFA reiterates that Medicaid should not be billed for the transportation costs for children unless they require transportation in a vehicle adapted to serve the needs of the disabled, and states that these claims will be disallowed if submitted after July 1, 1999.

## **FOCUS OF GAO INVESTIGATION**

The GAO report, which focuses primarily on the claiming of administrative costs, indicates that some school district and state claiming procedures are designed to maximize their receipt of Medicaid funds through suspect financing mechanisms. In four out of the 10 states surveyed, a portion of the Federal reimbursement for services provided at schools is retained in the state’s general revenue funds. In FY 1998, Federal dollars contributed about \$8 million in Illinois and \$47 million in Michigan to the state general revenue funds. Since Michigan schools began claiming for administrative costs, the state has retained almost \$106 million of the Federal share.

IEP health care services  
of a section to guide

In their testimony before the Finance Committee, the GAO compared these financing arrangements to the financing mechanism that used provider taxes and donations as a way to increase Federal matching dollars without increase state expenditures before it was outlawed by the passage of OBRA 1993.

GAO also notes that a number of private firms, employed by school districts to help them maximize their Federal reimbursement, typically receive as compensation a share of the revenue, ranging from 3 to 25 percent, generated by the claims the school submits.

## **NEXT STEPS**

**Issuing guidance on administrative claiming.** HCFA and OMB are working internally to develop and release guidance on reimbursement for administrative costs associated with school based services by the Fall. A number of private firms, most notably in Texas and New York, have been lobbying HCFA, the First Lady's Office, and the Vice President's Office, to ensure that they have input into the guidance that is being developed. Because this issue is so sensitive and has been pinpointed as the primary source of the fraud and abuse, HCFA is not taking private sector or state input as they develop their guidance.

**Federal-state workgroup on bundling of services.** HCFA has developed a Federal-state workgroup to bring the states who currently bundle their reimbursement claims into compliance with the new guidance. The states are using the workgroup as a forum to lobby HCFA to change its guidance. Although HCFA is currently considering options, OMB feels very strongly that they should not renege on the original guidance in any way.

All guide used to deny

OH, MI payment deferral

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holding @ state level —  
admit what's happening  
but say not illegal  
too hard to understand

① most eff spend \$ @ ~~the~~ school level

② most eff way to provide MC svcs  
to MC providers / MC eligibles?

10,000 school districts doing this

③ facilitating access to svcs for  
kids MC svcs

④ ensure outreach efforts

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① claiming only for  
outreach for MC eligible  
kids

② IEP Medicaid payer of LAST  
resort  
but IDEA says 1<sup>st</sup>

**Medicaid School-Based  
Administrative Claiming  
Guide**

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# Medicaid School-Based Administrative Claiming Guide - DRAFT

## Introduction

The purpose of this Administrative Claiming Guide is to provide further guidance to all State Medicaid Agencies regarding the requirements for claiming Medicaid reimbursement for administrative activities performed in the school-based environment. Additionally, HCFA believes that this Guide will be of significant benefit in helping school districts and all other interested parties better understand the intent of the school-based administrative claiming program. It is expected that this Guide will promote greater consistency in claiming practices to ensure program integrity, and to assist states in the implementation of effective administrative claiming practices. It is important to note that to minimize the possibility of confusion, this Guide does not, except where there are potential issues of overlap or duplication, address requirements related to LEAs' provision of direct medical services, commonly referred to as fee-for-service (FFS) programs. With regard to the school-based administrative claiming program, this Guide does not supercede or reinterpret any existing statutory or regulatory requirements.

The school environment offers unique advantages and opportunities to reach children and families to inform, encourage and assist them to access needed health care services and to enroll in the Medicaid program. Collectively, the Individuals with Disabilities Education Act (IDEA), Section 504 of the Rehabilitation Act, and certain titles of the Elementary and Secondary Education Act (ESEA), contain numerous requirements related to LEAs' responsibilities to identify, evaluate and accommodate the physical and mental health needs of all children that may place them at-risk for poor school outcomes. These requirements have served to define schools as a vital link for families to needed health care and a cost effective, timely, and accessible source of service delivery.

The administration of the Medicaid program depends upon an effective state and federal partnership. Federal Medicaid guidelines provide a framework for each State to establish and administer its Medicaid program to best meet the needs of its people. States have flexibility to:

1. Establish eligibility standards;
2. Determine the provider, type, amount, duration and scope of service;
3. Set the rate of payment for services; and
4. Administer their own program, including development of administrative requirements to verify claims.

Federal law permits reimbursement of allowable administrative activities when necessary for the proper and efficient administration of the Medicaid State plan. The determination of allowable administrative activities requires close coordination between the LEAs, State Medicaid Agency, State Department of Education, providers and other public agencies.

The Health Care Financing Administration (HCFA) is legally responsible for assessing all such programs in accordance with the applicable Federal Medicaid requirements. Therefore, state's programs for administrative claiming for school-based activities must be reviewed and approved by HCFA, prior to implementation. HCFA review and approval should occur in a reasonable timeframe and the submission date of the state's intent to claim for administrative costs defines the first quarter for which the LEA will receive reimbursement. This Guide should be useful for LEAs, State Medicaid Agencies, and HCFA staff in the process of development, review, approval, and implementation of school-based Medicaid administrative claiming programs.

### **I. Program Basis and Authority**

This Guide provides the basic Federal requirements for administrative claiming in the Medicaid program and is intended to foster better understanding of program parameters and the applicable statutory and regulatory provisions. This Guide lists the relevant legal and programmatic bases and authorities, including sections of the Social Security Act, Parts 42 and 45 of the Code of Federal Regulations (CFR), and the Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments." In addition, OMB mandated in Circular A-87 that the Department of Health and Human Services (DHHS) issue implementing material for Circular A-87 on behalf of the federal government. The resulting document issued by DHHS, ASMB C-10, is intended to assist state, local, and Indian tribal governments in applying OMB Circular A-87. The Guide also references HCFA policy issuances, such as the Medicaid and School Health: A Technical Assistance Guide, issued in 1997.

Please see Appendix A for a detailed list of statutory, regulatory and other federal government references/authorities applicable to claiming federal funding under the Medicaid program for the costs of school-based administrative activities.

### **II. Program Agreements**

#### **A. Interagency Agreements**

In order to claim Federal matching funds for the costs of Medicaid administrative activities performed in schools, the State Medicaid Agency can administer the program directly with the LEAs through provider enrollment agreements or by ~~must~~ entering into an interagency agreement<sup>1</sup> with another appropriate state level entity such as the state education agency or another appropriate entity with oversight of LEAs in accordance with regulations at 42 CFR 431 Subpart M. The interagency agreement serves to describe and define the responsibilities of each party under the agreement. Additionally, the interagency agreement should describe the relationship between the LEAs and the parties to the interagency agreement. For example, the agreement should address whether LEAs will participate in preparing and submitting Medicaid Administrative Claims independently or as participants in a consortium of LEAs.

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<sup>1</sup> See 42 CFR 431.10(b)

The interagency agreement should include:

- A statement regarding the general purpose, basis and mission for the agreement
- The mutual objectives and responsibilities of all parties with respect to this program
- Provisions for a participation agreement with LEAs, either through a consortium or independently
- The activities or services each party performs and under what circumstances
- The general principles of reimbursement
- General guidelines regarding how the program will be structured and administered
- Provisions regarding program oversight and monitoring
- The cooperative and collaborative relationships at the state and local levels
- The methods of payment or reimbursement, exchange of reports and documentation, and a continuous liaison between the parties, including the designation of state and local liaison staff

A cost allocation plan amendment is also required and a copy should be provided as an attachment to the interagency agreement to provide more specific details regarding claim calculation methodology and reimbursement.

Please see Section B below for more information regarding cost allocation plans.

## **B. Cost Allocation Plan**

### **1. Overview**

Federal regulations<sup>2</sup> require that under the Medicaid State plan, the single state agency shall have an approved public assistance cost allocation plan (CAP) on file with the Federal Department of Health and Human Services (DHHS) that meets certain regulatory requirements.<sup>3</sup> As indicated in OMB Circular A-87, Attachment D, a state's public assistance cost allocation plan is an official document which describes the grouping and allocation of administrative costs to federal awards performed by the State under such programs as Temporary Assistance to Needy Families (TANF), Medicaid, Food Stamps, Child Support Enforcement, adoption assistance, Foster Care and Social Service Block Grants.

There are certain items that should be included in the public assistance CAP that a State Medicaid Agency must submit in order to claim reimbursement for administrative activities performed by LEAs. The public assistance CAP should reference the methodologies, claiming mechanisms, interagency agreements, and other relevant approaches that will be used by the LEAs for making such claims and appropriately allocating costs.

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<sup>2</sup> 42 CFR 433.34

<sup>3</sup> Subpart E of 45 CFR part 95

## 2. General Principles

School district employees routinely engage in activities that involve providing direct medical services and/or the performance of administrative activities, as well as other social programs, and educational programs. Time spent on activities associated with the administration of the Medicaid program may be reimbursed by following an appropriate claiming methodology.

The CAP amendment provides details regarding the method used to allocate the costs associated with Medicaid administrative activities. The CAP amendment should specify that all claims for reimbursement will be made in accordance with OMB Circular A-87, the State Medicaid Plan, Early and Periodic Screening Diagnosis and Treatment (EPSDT) regulations, and all appropriate Federal regulations. The CAP amendment should contain the following information:

- A list of identified LEA personnel who are performing Medicaid administrative activities.
- A mechanism to identify and categorize activities performed by personnel who are eligible for administrative reimbursement.
- A method to identify the level and amount of reimbursable activity performed by eligible personnel.
- A method to identify and allocate costs based upon the level of reimbursable activity being performed.

## 3. Time Allocation Methodology

### Overview

In order to ascertain the portion of time and activities that are related to administering the Medicaid program, States must develop a time allocation methodology that adheres to acceptable cost allocation principles. This methodology should meet acceptable statistical sampling standards and may use contemporaneous time sheets or other quantifiable measures of employee effort.

### Time Study Surveys

OMB A-87 provides a variety of options for collecting data to allocate the time spent by individuals who work on multiple activities and cost objectives. The most common mechanism for identifying and categorizing activities performed by the LEA employees is a time study.<sup>4</sup> A time study is a survey documenting how personnel eligible for

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<sup>4</sup>While activity reports are the most common method used to allocate time, they are impractical for purposes of this program. For individuals who work on multiple activities and cost objectives, OMB Circular A-87 permits the use of "a statistical sampling system (see subsection (6)) or other substitute system . . . approved by the cognizant Federal agency" for allocating salaries and wages as an alternative to an activity report. [OMB A-87 Attachment B, Section 11, (h) (4)]

OMB Circular A-87 states that, with regard to sampling:

"Substitute systems for allocating salaries and wages to Federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not

reimbursement (or a sample of eligible personnel) are spending their time. Activities are recorded based upon predefined activity codes, over a predetermined period of time. The time study should incorporate a comprehensive, all-inclusive list of the activities performed by staff whose costs are to be claimed under Medicaid. The time study should account for 100% of the time and activities (whether allowable or unallowable) performed during the time study period by employees participating in the Medicaid administrative claiming program.<sup>5</sup>

### Sampling Universe

A basic step in the development of a time study is the determination of the sampling universe (i.e., identifying all of the LEA personnel whose activities may be reimbursed under the Medicaid Administrative Claim). Medicaid administrative activities may be performed by staff who provide any direct medical services (for example, nurses and physical therapists), as well as any staff who focus on activities related to special education, exceptional children's programs, or other administrative duties related to the Medicaid program. The sampling universe should include individuals who spend a portion of their paid work time performing administrative activities that are eligible for Medicaid reimbursement.

It may also be appropriate to exclude some personnel from the sample universe. For example, there may be medical providers in the LEA under contract who furnish specific services to students and who are paid on a fixed fee per service (for example, audiologists who are paid a set amount for each hearing test performed) and who do not perform any other activities that would be claimable. These providers should not be included in the sample universe and their costs should be excluded from the base to be allocated.

The sampling universe must include all employees whose salaries are to be allocated to the Medicaid program (e.g., physical therapists or speech therapists). Costs associated with direct support personnel<sup>6</sup>, are allocable and reimbursable at the same level as the employees they support. Direct support personnel would not need to be included in the sample population since they do not directly perform Medicaid administrative activities. However other paraprofessional staff who do perform Medicaid administrative activities, such as physical therapy aides, or speech therapy aides, should be included since they do not qualify as direct support personnel.

### Sampling Guidelines

In accordance with OMB Circular A-87, valid statistical sampling methods may include, but are not limited to: random interval sampling, random moment sampling, case counts, or other quantifiable measures of employee effort or outcomes.

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limited to, random moment sampling, case counts, or other quantifiable measures of employee effort." [OMB A-87 Attachment B, Section 11, (h) (6)]

<sup>5</sup> See OMB A-87 Attachment B, Section 11 for additional guidance.

<sup>6</sup> **42 CFR §432.50 In the context of FFP relating to skilled professional medical staff, defined as follows:**

(v) The directly supporting staff are secretarial, stenographic, and copying personnel and file and records clerks who provide clerical services that are directly necessary for the completion of the professional medical responsibilities and functions of the skilled professional medical staff.

In order to meet acceptable “statistical sampling methods”, the sample method should be valid for application to the entire sampled period, such as a quarter, but should not include weeks when schools are not in session. It should be structured to meet a high confidence level for statistical compliance. For time studies, all activities need to be documented in the sample even if they are not strictly related to Medicaid.

### **Training**

All personnel who complete a time study should be trained in advance of completing the survey. Training should cover all aspects of the time study process and should assist the LEA personnel to understand the Medicaid program and the relationship of the activities and services they routinely provide in the school setting to services covered by the Medicaid State plan and EPSDT. Staff should be sufficiently familiar with how to complete forms, how to determine the appropriate activity designation, the difference between Medicaid health related and other activities, and where to obtain technical assistance if there are questions. In addition, skilled professional medical personnel should be trained to document when their professional medical knowledge and skill was required in performing a particular function or activity.

### **Documentation**

The State Medicaid Agency shall determine the required documentation to be maintained to support the claims submitted to the State. Time study documentation to be retained will be based on the time study methodology and instructions, as well as the cost allocation requirements issued by the State Medicaid Agency to the LEAs and should include the following: the population to be included in the time study, sample selection, results, and forms as appropriate for the method utilized.

The documentation for administrative activities should clearly demonstrate that the activities are performed for administering services covered under the Medicaid State plan.<sup>7</sup>

### **Reimbursable Activities**

“There is much flexibility in what services may be properly claimed as administrative, and some activities can be billed as either medical services or administration.”<sup>8</sup> According to section 1903(a)(7) of the Act and the implementing regulations at 42 CFR 430.1 and 42 CFR 431.15, for the cost of any activities to be allowable and reimbursable under Medicaid, the activities must be “found necessary by the Secretary for the proper and efficient administration of the plan” (referring to the Medicaid State plan).

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<sup>7</sup> In accordance with the statute, the regulations, and the State Plan, the State is required to retain adequate source documentation to support the Medicaid payments for administrative claiming. See §1902(a)(4) of the Act and 42 CFR 431.17; see also 45 CFR 74.53 and 42 CFR 433.32(a) (requiring source documentation to support accounting records) and 45 CFR 74.20 and 42 CFR 433.32(b and c) (retention period for records). The administrative claiming records must be made available for review by State and Federal staff upon request during normal working hours (§1902(a)(4) of the Social Security Act, implemented at 42 CFR 431.17).

<sup>8</sup> Medicaid And School Health: A Technical Assistance Guide, p. 72

In order for Medicaid to reimburse for health services provided in schools, the services must either be included among those listed in the Medicaid statute (section 1905(a) of the Act) and included in the State's Medicaid plan or be available under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. Correspondingly, the administrative expenditures appropriate for reimbursement by Medicaid are those that are *in support of* the health services defined in the state's Medicaid plan and/or EPSDT.

### **Non-Reimbursable Activities**

Activities and services that are direct, face-to-face medical services, including but not limited to, those paid as part of an established fee-for-service reimbursement rate, should be clearly delineated in the activity codes. These activities cannot be included in claims for reimbursement for administrative activities.

Additionally, administrative activities that support the provision of or access to non-medical or non-health related services such as: academic instruction, healthy lifestyle education programs, and social service programs including the free and reduced price meal program, TANF, WIC, child abuse and neglect, and employment assistance, are non-reimbursable activities.

### **Activity Codes**

#### ***General Guidelines***

A key objective of these HCFA guidelines is to help States address certain basic tenets with regard to Administrative Claiming. HCFA and States determine allowable Medicaid administrative activities in accordance with the regulations related to reimbursable administrative activities (see Appendix C, page 17-7217). However, because the Medicaid Administrative Claim program is a Federal Medicaid program implemented by the State Medicaid Agency, each State should implement a program that reflects the unique delivery model in that State.

#### ***Activity Code Categories***

It is essential to develop activity codes, with recognition and consideration of the actual functions and responsibilities being performed by LEA employees, the requirements of the programs, and in accordance with principles that appropriately distinguish between and account for all these factors.

In general, activity codes should be developed and organized to capture time spent on activities according to the following general categories of allocable cost:

- **100% Medicaid Share** - the activity fully supports the administration of the State Medicaid plan and/or EPSDT program and as such is fully reimbursable.
- **Proportional Medicaid Share** - the activity is reimbursable as administration under the Medicaid program, but the Medicaid allocable share of costs must be determined by the application of the percentage of the Medicaid eligible population.
- **Reallocated** – the activity supports the general requirements of the position and is partially reimbursable based on the percentage of time spent on reimbursable versus non-reimbursable administrative activities.

- **Non-reimbursable** - the activity is not reimbursable as a Medicaid administrative cost.

Activity codes should be designed to effectively differentiate and distinguish between the types of activities that fall into each of these categories. Appendix B provides general examples of appropriate activities for each designation. However, specific activity codes should reflect the distinct characteristics of each state and be compatible with the State Medicaid plan.

### ***Capture 100 Percent of Time***

Time study activity codes must be developed to capture all of the possible activities performed by the time study participants. This may be accomplished through a variety of coding conventions, such as detailed examples with respect to reimbursable and non-reimbursable activities, or through development of a parallel coding structure that can differentiate between similar activities performed for multiple purposes, some of which may be non-reimbursable. Regardless of convention, however, thorough training on coding procedures is integral to appropriate differentiation.

In order to ensure that 100% of the activities performed by staff participating in the time study are reflected in the time study results, the staff classifications and associated supporting documentation (such as position descriptions) for time study participants should be reviewed and considered in developing the time study activity codes.

### ***Administrative Case Management***

While some case management activities may fall within the scope of both administrative and targeted case management, a State may not claim the same costs at the same time both as targeted case management and administrative case management for a given population.

School districts may, subject to the provisions of the State Medicaid Plan and based upon administrative and cost-efficiency considerations, choose to define their case management activities as either administrative case management or targeted case management or, as a non-duplicative combination of both.

### ***Identification of Activities Eligible for Enhanced FFP***

Skilled professional medical personnel (SPMP) perform many Medicaid administrative activities that are reimbursable. They may require their professional medical knowledge and skills to perform specific Medicaid and non-Medicaid activities. However, some activities may not necessitate skilled medical knowledge. The coding structure and/or time study documentation should include a means to differentiate allowable activities for which the SPMP required his/her specialized training and knowledge.

## 4. Cost Reporting Methodology

### General Overview

Cost reporting methodology should capture the allowable costs associated with personnel who perform Medicaid administrative activities. OMB Circular A-87, which contains the cost principles for state and local governments for the administration of federal awards, provides that “Governmental units are responsible for the efficient and effective administration of federal awards.” Under these provisions, costs must be reasonable and necessary for the operation of the governmental unit for the performance of the federal award.

Claim calculation methodology should be developed which supports the ability to isolate costs that will be claimed as Medicaid administration from all other costs incurred for those same personnel.

### Duplicate Payments

Claims for allowable administrative activities should not duplicate payments that are included and paid as part of a rate for services, part of a capitation rate, or through some other federal program. The methodology used to calculate claims related to allowable administrative activities should eliminate costs related to non-reimbursable activities, and costs already reimbursed using federal funds. The State must provide assurances to HCFA of non-duplication through their administrative claims and the claiming process to HCFA.

### Indirect cost rates

Claims for the LEA's indirect costs are allowable and may be allocated based on an approved indirect cost rate issued by the cognizant agency, or the use of predetermined rates, as defined by the state, where the cognizant agency has reasonable assurance based on past experience and reliable projection of the costs, that the rate is not likely to exceed a rate based on actual costs.

### Offset of Revenue

It may be necessary to offset costs allocated to the Medicaid program by amounts received from other funding sources. Federal Financial Participation (FFP) may not be claimed by applying federal funds as matching funds. Any federal funds relating to costs claimed for Medicaid administrative activities must be offset from the claim prior to submission. Also, costs may only be included net of applicable credits such as discounts, rebates, recoveries or adjustments.<sup>9</sup> The following include some of the revenue-offset categories that must be applied in developing the net costs:

- All federal funds, along with any state/local matching funds required by the federal grant.

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<sup>9</sup> See OMB Circular A-87, Attachment A, Part C., Items 4.a. and 4.b.

- All state expenditures which have been previously matched by the federal government (includes Medicaid funds for medical assistance (e.g., fee-for-service funds)).

### Documentation

As with all administrative costs that are related to time study activities, there must be documentation of the costs that will be claimed for reimbursement. LEAs should maintain copies of the cost information reported for eligible personnel, and any supporting documentation related to developing these costs. The state should determine an appropriate method to assure that costs reported by LEAs are accurate and adhere to relevant regulations.

Additional guidance regarding documentation for compensation of salary and wages is found in OMB Circular A-87, Attachment B, Section 11.h.

## 5. Claim Calculation Methodology

### Overview

The Claim Methodology should be designed to allocate reimbursable costs based on the selected time allocation methodology and apply the appropriate Federal Financial Participation (FFP) rates and Medicaid share percentages to develop a claim. The methodology must be designed to apply the rates and percentages that are appropriate to the activity type, the skill level of the personnel performing the activity, and the medical credentials employed.

### Criteria for Enhanced FFP for Skilled Professional Medical Personnel

Federal Financial Participation (FFP) at the enhanced rate of 75 percent may be available for state claims for expenditures related to the costs of activities performed by SPMPs (and their directly supporting staff) in the administration of the Medicaid program if the appropriate criteria are met (see Appendix A: Citations).<sup>10</sup>

Federal regulations contain specific requirements for SPMPs, including that SPMPs have completed a two-year or longer program leading to an academic degree or certificate in a medically related program. State qualification requirements for SPMPs can differ from (be more or less stringent than) the qualification requirements for participating as a Medicaid provider. The State is responsible to provide assurances to HCFA that the appropriate criteria for claiming enhanced reimbursement for qualifying activities have been met.

When the individual meets the SPMP qualifications, those administrative activities that require the use of medical knowledge are eligible to be reimbursed at the enhanced rate of 75 percent. The coding structure and/or time study methodology should include the means to differentiate allowable activities for which the SPMP required his/her

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<sup>10</sup> **Law:** Section 1903(a)(2) of the Social Security Act. **Regulations:** 42 CFR 432.2 - Definition of SPMP; 42 CFR 432.50 - FFP rates (personnel); 42 CFR 433.15 - FFP rates (program); SPMP Review Guide (dated June 1986)

specialized training and expertise. Allowable administrative activity codes are discussed on page ~~7727~~ and in Appendix B.

### **Criteria for Reimbursement of Family Planning at 90 Percent FFP**

The enhanced family planning matching rate of 90 percent is available for the administrative activities associated with family planning services.<sup>11</sup> In order to be reimbursed at the enhanced rate, the time study methodology utilized should differentiate allowable administrative activities related to family planning from similar activities unrelated to family planning.

### **Allocable Share of Costs**

Many school-based medical or medical-related activities are provided to both Medicaid and non-Medicaid eligible students. Some activities fully support the administration of the State Medicaid plan and/or EPSDT program and as such do not require the application of the Medicaid share percentage. For certain activities, however, costs are reimbursable only to the extent that they are allocable to activities performed on behalf of Medicaid eligible students. For these activities, it is necessary to develop and apply a Medicaid share percentage.

The Medicaid share percentage is the number of Medicaid eligible students in the relevant claiming population as a percentage of the total number of students in that same population. The State will determine the relevant population. The Medicaid share is then applied to the total costs applicable to those activities that are categorized as "proportional Medicaid share" to determine the costs applicable to Medicaid administrative activities. The purpose of applying a proportional Medicaid share is to determine the amount to be allocated between Medicaid and non-Medicaid students.

Whatever method is used to determine the rate, the number of Medicaid eligible students and the total number of students must be identified for the same time period.

## **6. Review / Approval Requirements**

Prior approval by HCFA of the administrative claiming programs and codes is not explicitly required in Medicaid statute and regulations, but HCFA is required to and will review claims made by State Medicaid Agencies for federal reimbursement related to Medicaid administrative activities. In situations relating to the establishment of a new program such as a school-based administrative claiming program, the review will focus on determining the allowability of such claims for federal matching funds. States are required to submit amendments to cost allocation plans and have them approved before they may be reimbursed for Medicaid administrative costs.

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<sup>11</sup> **Law:** Section 1903 (a)(5) of the Social Security Act. **Regulations:** 42 CFR 432.50(b)(5) as referenced by 42 CFR 433.15(b)(2)

See Committee Print accompanying the Social Security Amendments of 1973, Brief Description of Senate Amendments to H.R. 3153, at p. 41 (statement by Conference Committee that "Federal payments for family planning expenditures[are] not limited to administrative costs. . . .90 percent Federal matching for family planning is available for the cost of providing family planning services and not merely for the cost attributable to administering such programs").

In accordance with federal regulations and OMB Circular A-87, a public assistance CAP must be amended and approved by the Division of Cost Allocation (DCA) within DHHS before FFP would be available for school-based administrative claims in the Medicaid program. The public assistance CAP amendment must provide (in accordance with the approved interagency agreements) for reimbursement of the administrative activities performed in the school setting and for claims which will be made on behalf of the LEAs by the State Medicaid Agency. The public assistance CAP amendment must make explicit reference to the methodologies, claiming mechanisms, interagency agreements, and other relevant criteria that will be used by the LEAs for making such claims and appropriately allocating costs. HCFA does not have direct authority for approval of the public assistance CAPs; that is the purview of the DCA. However, HCFA works directly with the DCA in the public assistance CAP review and approval process; under this process, the DCA will not approve such public assistance CAPs without HCFA's review and approval of the methodologies referenced in the public assistance CAP.

The required elements of public assistance CAPs are further discussed in the Cost Allocation section on page ~~3323~~ as is the review and approval process for such plans.

### **Timely Filing**

Section 1132(a) of the Act requires that a claim by a State for FFP with respect to an expenditure made during any calendar quarter must be filed within the two-year period that begins on the first day of the calendar quarter immediately following such quarter. This section also provides that with certain exceptions, no payment shall be made for expenditures not claimed within this period.<sup>12</sup>

### **State Law Requirements**

FFP for school-based services and administrative outreach claims is not available if the State is not in compliance with its own laws. The OMB Circular A-87 states in item 1.c. of Attachment A, "General Principles for Determining Allowable Costs," Section C, Basic Guidelines: "To be allowable under Federal grants, costs must meet the following criteria: ... c. Be authorized or not prohibited under state or local laws and regulations." A question of state law may surface during a review of state practices or be brought to light by other means; however, it is not expected that an exhaustive review of all state laws be conducted. If there is a question of whether the state agency is in violation of state law, a legal opinion should be sought.

## **III. Program Integrity**

State oversight is the cornerstone to maintaining the integrity of the Medicaid School-based Administrative Claiming program. Through appropriate reviews, the State can be assured that claims are accurate and that methodology adheres to the provisions specified in the Cost

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<sup>12</sup> 45 CFR §95.4 Definitions *State Agency*

45 CFR §95.7 Time limit for claiming payment

45 CFR §95.13 In which quarter we consider an expenditure made.

Allocation Plan. Ideally, maintaining claim integrity should be a joint responsibility shared by HCFA, LEAs, the state agencies and any claims processing agents involved.

HCFA may review the results of the state oversight on a periodic basis. This review can be based on a report submitted by the State. This annual report can be augmented if the situation warrants more detailed and/or on-site review.

Please see Appendix C for recommended monitoring parameters.

## **IV. Conclusion**

This Guide contains information for LEAs, State Medicaid Agencies, HCFA offices and staff, and other interested parties about the existing requirements by which LEAs can claim Medicaid reimbursement for activities that are performed under the administrative claiming program. It is important to note that to minimize the possibility of confusion, this Guide does not, except where there are potential issues of overlap or duplication, address requirements related to LEAs' provision of direct medical services, commonly referred to as fee-for-service (FFS) programs. With regard to the school-based administrative claiming program, this Guide does not supercede or reinterpret any existing statutory or regulatory requirements. This Guide is intended to support and enhance the goals shared by Medicaid and education of ensuring that all children, especially those who are economically disadvantaged or disabled, have access to needed health care; that all eligible children are enrolled in Medicaid, and that LEAs have equal access to the resources available to support those efforts.

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## Appendix A: Details Regarding Basis and Authority

The following sections provide selected statutory, regulatory and other Federal Government references/authorities applicable to claiming Federal funding under the Medicaid program for the costs of school-based administrative activities.

### Statute/Regulations

- Proper and efficient methods of administration: section 1903(a)(7) of the Social Security Act (the Act)
- Federal matching rate for administration: section 1903(a)(7) of the Act
- Maintenance of Documentation section 1902(a)(4) of the Act
- Timely filing: section 1132 of the Act, Title 45 of the Code of Federal Regulations (CFR) Subpart A 95.1 ff
- Skilled Professional Medical Personnel (SPMP): section 1903(a)(2)(A) of the Act, 42 CFR 432.50
- Family Planning: section 1903(a)(5) of the Act, 42 CFR 433.15(b)(2), 432.50(b)(5)
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT): section 1902(a)(43) of the Act; 42 CFR Part 441, Subpart B
- Medical Assistance Case Management: section 1905(a)(19) and 1905(r)
- Section 504 of the Rehabilitation Act: 34 CFR Part 104, Subparts A and D
- Individuals with Disabilities Education Act (IDEA): section 612(A)(B) and (C)
- Regulatory citations related to documentation

<u>42 CFR</u>	<u>Description</u>
Subpart M	Interagency Agreements
430.1	Scope of subchapter C - Proper and efficient administration
430.10(b)	Interagency Agreement
430.12	Submittal of State plans and plan amendments
430.30(b)	Grants procedures - Program estimates (HCFA-37)
430.30(c)	Grants procedures - Expenditure reports (HCFA-64)
430.32	Program reviews
430.33	Audits - OIG audits including cost efficiency
430.40	Deferral of claims for FFP
430.42	Disallowance of claims for FFP
431.15	Methods of Administration
431.17	Maintenance of Records
431.53	Assurance of transportation

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431.107	Required provider agreements
432.2	Definition of SPMP
432.30	Training Programs: General Requirements
432.50	FFP: Staffing and training costs - Availability of FFP at various rates, allocation basis for personnel costs
432.50(b)(5)	FFP for Family Planning
432.55	Reporting training and administrative costs
433.15	Rates of FFP for administration
433.15(b)(2)	FFP for Family Planning
433.32	Fiscal policies and accountability
433.34	Cost allocation
433.51	Public funds as the state share of financial participation
433.53	State plan requirements - for state funds
441.61	Utilization of providers and coordination with related programs

### 45 CFR

Part 74	Subpart C – Post Award Requirements
Part 95	Subpart A – Time Limits for States to File Claims
Part 95	Subpart E – Cost Allocation Plans

### **OMB Circular A-87**

The OMB Circular A-87 establishes cost principles and standards for determining costs for Federal awards carried out through grants, cost reimbursement contracts, and other agreements with state and local governments and Federally recognized Indian tribal governments (governmental units).

## Appendix B: Skilled Medical Personnel

### 42 CFR §432.50

- (1) *Medicaid agency personnel and staff.* The rate of 75 percent FFP is available for skilled professional medical personnel and directly supporting staff of the Medicaid agency if the following criteria, as applicable, are met:
- (i) The expenditures are for activities that are directly related to the administration of the Medicaid program, and as such do not include expenditures for medical assistance;
  - (ii) The skilled professional medical personnel have professional education and training in the field of medical care or appropriate medical practice. "Professional education and training" means the completion of a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is demonstrated by possession of a medical license, certificate, or other document issued by a recognized National or State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. Experience in the administration, direction, or implementation of the Medicaid program is not considered the equivalent of professional training in a field of medical care.
  - (iii) The skilled professional medical personnel are in positions that have duties and responsibilities that require those professional medical knowledge and skills.
  - (iv) A State-documented employer-employee relationship exists between the Medicaid agency and the skilled professional medical personnel and directly supporting staff; and
  - (v) The directly supporting staff are secretarial, stenographic, and copying personnel and file and records clerks who provide clerical services that are directly necessary for the completion of the professional medical responsibilities and functions of the skilled professional medical staff. The skilled professional medical staff must directly supervise the supporting staff and the performance of the supporting staff's work.
- (2) *Staff of other public agencies.* The rate of 75 percent FFP is available for staff of other public agencies if the requirements specified in paragraph (d)(1) of this section are met and the public agency has a written agreement with the Medicaid agency to verify that these requirements are met.

## Appendix C: Activity Code Categories

The manner by which each state establishes a comprehensive and detailed set of activity codes for the school-based administrative claiming program will vary based upon each state's existing Medicaid program organization and delivery, applicable demographics, state and local funding levels and mechanisms. The following defines the broad range of activities by category of allocable cost that should be accommodated in each State's set of activity codes. The specific activity code definitions that a State proposes to use must be included in the cost allocation plan amendment.

### **100% Medicaid Share:**

***These activities are not subject to the application of the Medicaid share percentage.***

- Informing children, parents/guardians, LEA staff, and the community about the benefits and availability of the Medicaid program and Medicaid covered services.
- Seeking out and identifying children within the general student population or within a targeted student population(s) who are in need of Medicaid covered health services.
- Assisting potentially eligible students and their families to enroll in Medicaid.
- Providing or participating in training designed specifically to enhance the effectiveness of Medicaid outreach and the identification and referral of children in need of Medicaid covered services.
- Identifying and coordinating program planning and development of Medicaid covered services with individual providers and provider agencies.

**Citations: 42 CFR 433.135, 42 CFR 435.905, 42 CFR 435.940, 42 CFR 432.30, 42 CFR 441.61, SMM 5230**

**Proportional Medicaid Share:**

***The proportional Medicaid share percentage must be applied to allocable costs associated with these activities.***

- Referring, coordinating, planning and monitoring health services designed to address an individual child's health needs.
- Arranging and/or providing translation or transportation services to enable a student to access needed medical care.
- Arranging or referring for family planning services.

**Citations:** 1903(a) SSA, SMM 4302.2(G)(2), 42 CFR 431.53, 42 CFR 441.62, 42 CFR 441.56(a)(3), 42 CFR 432.5(b)(5), 42 CFR 433.15(b)(2)

**Reallocated Activities:**

***These activities support the general requirements of the position and are partially reimbursable.***

- Performing administrative or clerical duties relating to the general functions or operations of the LEA including paid time off and breaks.

**Citations:** 45 CFR 95.507

**Non-Reimbursable Activities:**

***These activities are not reimbursed under the Medicaid Administrative Claim program.***

- Providing direct medical care, treatments or counseling interventions.
- Performing activities relating to the provision of a direct health service that is included in a fee-for-service rate for which the LEA is claiming reimbursement.
- Providing instruction, supervising students, or conducting extra-curricular activities.
- Arranging or providing services associated with social service programs, or other programs that do not yield health-related outcomes.

**Citations:** OMB A-87 Attachment A, C. 1. a. and h.

## Appendix D: State Oversight

To ensure that the Medicaid School-based Administrative Claiming program is relevant to the “proper and efficient administration of the State’s Medicaid plan” and that it complies fully with all applicable federal and state requirements, the State Medicaid Agency should administer certain oversight mechanisms on a periodic basis.

Oversight, as described below, should be maintained in the following areas: time allocation methodology, cost reporting methodology, verification of Skilled Medical Professional Personnel (SPMP) eligibility and utilization standards, and claims processing. State reviews should be frequent enough to maintain the integrity of the program, while taking into account the objectives of the effort, the resources of the agency, and the administrative burden upon the LEAs.

As appropriate, the State may utilize independent professional services firms in its oversight of the Program. The LEAs should provide assurance that resources shall be reasonably available if a more detailed audit of the program is required.

### ***Time Allocation Methodology***

In order to ensure that the time study is statistically valid (for example, at the 95 percent confidence level), the State Medicaid Agency should monitor the compliance of the LEAs to the requirements of the time allocation methodology. The description of this effort should include information on the frequency of reviews at the local level, staff performing the reviews, and the review protocol.

Recommended activities may include:

- Review of training materials used to instruct the time study participants.
- Periodic observations of time study training.
- Interviews with a sample of personnel who completed time study surveys.
- Random examination of a representative sample of time study surveys.

### ***Cost Reporting Methodology***

School district auditors provide assurance of cost reporting procedures through the annual audit process, which includes adherence to requirements of the A-133 Single Audit Act. In addition, the following or similar measures are recommended:

- Desk reviews of a sample of LEAs conducted by an independent audit professional services firm to determine the accuracy of submitted data.
- Periodic on-site visits to verify that reported expenditures conform to OMB Circular A-87, applicable claim guidelines and Generally Accepted Accounting Procedures.

### **Verification of SPMP Criteria**

Federal Financial Participation (FFP) may be available at the enhanced 75 percent for activities performed by SPMP based on the activities of SPMP (see “Criteria for Enhanced FFP for Skilled Professional Medical Personnel”, page ~~1010210~~). The State Medicaid Agency, or its designated agent should verify that SPMP providers have met all of the requirements for the SPMP designation as outlined in 42 CFR 432.50.

### **Claims Processing**

To ensure that the claim calculation methodology as defined in the cost allocation plan is adhered to, the State Medicaid Agency may require any claims processing contractor to engage in a SAS 70 Review (Statement of Auditing Standards Review) or other generally accepted review of claim processing integrity. This annual review provides independent validation that the controls, policies and procedures employed in the development and calculation of claims are sufficient to ensure accurate claim results. The review also addresses design, and description of the reliability of the security, control or processing techniques implemented in processing claims.

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