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MEDICAID IN SCHOOLS: A PATTERN OF IMPROPER PAYMENTS

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BEFORE THE

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MEDICAID IN SCHOOLS: A PATTERN OF IMPROPER PAYMENTS

WEDNESDAY, APRIL 5, 2000

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Moynihan and Graham.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please be in order.

Nearly 10 months ago, this committee held its first hearing on the complicated relationship between Medicaid and the schools. The foundation of that relationship is very straightforward and unchallenged.

Let me say, clearly, Medicaid is responsible for reimbursing schools for the cost of providing health care services in the schools to Medicaid-eligible children. This responsibility is entirely appropriate and will be preserved. However, at last year's hearing a number of witnesses told us that the relationship between Medicaid and the schools is being exploited.

Two basic points that we heard over and over again disturbed me greatly. First, we heard that systems were in place that provided no real assurance that vulnerable children in need of health care services were actually receiving those services.

Second, we were told that the Health Care Financing Administration's oversight of billing practices permitted Medicaid funds to be spent inappropriately. Both of these findings are simply unacceptable.

As Chairman of the committee, I take our oversight responsibilities very seriously. Accordingly, with Senator Moynihan, who has been working with me to address this problem every step of the way, I have asked the General Accounting Office to broaden the scope of the investigation and provide us with recommendations to ensure that Medicaid programs in schools are run fairly and responsibly. I look forward to hearing GAO's testimony.

I also look forward to hearing from HCFA, and specifically what will be done to stop the questionable practices identified by the GAO. Frankly, Pat, I am frustrated.

I am frustrated because our basic goals are simple: we want to make sure that Medicaid-eligible children receive the services they are entitled to and we are paying for, and we want to make sure that Medicaid spending is appropriate. These basic goals have not been met.

It is particularly important that we take GAO's findings seriously because of a parallel easily drawn between the patterns we are seeing today in school-based spending and one of the darkest pages in the Medicaid program's history, the disproportionate share hospital spending scandals of the 1980's.

As we learned then, no one benefits when Medicaid dollars are used irresponsibly. In this case, the stakes are high. Children with complicated educational needs depend on the health care services Medicaid provides. We owe it to these children, to the taxpayers, to make sure that we run programs that are solid, defensible, and sustainable in the long run.

Again, I would like to thank Senator Moynihan and his staff for their close cooperation. I would welcome any statement you would care to make.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Well, sir, first to thank you, not just for this occasion, but for raising the level of oversight in this committee. I have not, in 24 years, seen it so effectively done, the IRS, with the Health Care Financing Administration, and such. It is a duty of the Congress and it is a residual function, which we do if we get to. You've put it up front where it ought to be.

This is a troubling report. Again, a very capable job by the General Accounting Office. The thing I came away with, most importantly, is that once again we come into, the HCFA rules are so complicated. I mean, running a school is hard enough, but comprehending the Health Care Financing Administration.

If you understand the Internal Revenue Code, you could make a fortune on K Street. But school administrators do not make a fortune. The rules for the Health Care Financing Administration are twice as long as the Internal Revenue Code.

The CHAIRMAN. It is hard to believe.

Senator MOYNIHAN. So I want to hear from our analysts, Ms. Allen, Mr. Hast, and of course, welcome, Mr. Westmoreland.

The CHAIRMAN. Thank you very much, Senator Moynihan.

We will, first, hear from Kathy Allen, who is Associate Director of Health Financing and Public Health Issues of GAO. With her is Robert Hast, who is Acting Assistant Comptroller General of GAO's Office of Special Investigations. I understand that Mr. Hast will not be presenting testimony, but will be happy to answer questions.

We also are pleased to be joined by Tim Westmoreland, the new Director of HCFA's Center for Medicaid and State Operations. Mr. Westmoreland is making his first appearance before this committee in his new role. I understand, Mr. Westmoreland, it is your birthday. Happy birthday.

Mr. WESTMORELAND. Thank you.

The CHAIRMAN. I do not think it is a very good way to celebrate it. [Laughter.]

Mr. WESTMORELAND. Thank you very much, Mr. Chairman.

The CHAIRMAN. But, with that, we will start with you, Ms. Allen.

STATEMENT OF KATHRYN G. ALLEN, ASSOCIATE DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, GENERAL ACCOUNTING OFFICE (GAO), WASHINGTON, DC; ACCOMPANIED BY ROBERT H. HAST, ACTING ASSISTANT COMPTROLLER GENERAL, OFFICE OF SPECIAL INVESTIGATIONS, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Ms. ALLEN. Thank you, Mr. Chairman and Senator Moynihan. We are pleased to be here today as you continue to explore these very important issues related to Medicaid payment for school-based health services and administrative activities.

Because close to one-third of all Medicaid-eligible individuals are school-aged children, schools are, indeed, a natural, logical place to reach these children. School-based services can include a variety of things, including diagnostic screening, routine preventive care, treatment services for children with disabilities that include physical or speech therapy.

Medicaid also does pay for administrative activities that can facilitate children's access to covered health services. These would include outreach to help inform and enroll children, to coordinate their services, and to refer them to qualified Medicaid providers.

As you indicated, last June we did testify before your committee about questionable practices. You immediately asked that we dig deeper into these early findings. And I must say, barely had we returned to our desks that day, that your follow-up letter was there waiting for us. Obviously, you were eager for us to continue work.

You asked that, in addition to looking at the administrative activities, that we also examine States' use of so-called bundled rates, which are very similar to a managed care capitated fee, whereby schools receive a fixed payment for all the health services that an eligible special-needs child may receive during a set period of time.

In addition, we investigated indications of abusive practices associated with claims for administrative activities and in fee-for-service payments for health services. Mr. Hast would be happy to respond to questions with regard to our investigative activities. Our remarks today will be based on the report that we have released to you today.

Nationwide, nearly all States—in fact, 48, including the District of Columbia—currently receive Medicaid payment to some extent for school-based health services, administrative activities, or both.

These payments, for the last year for which we could obtain data, amounted to $2.3 billion. Medicaid payments to schools ranged from a high of $820 per Medicaid-eligible child, to less than $1 per child in several States. We have some charts to help illustrate this point, the chart in front, and I think you may also have one in front of you.

What this first chart shows, is that for the top 20 States, in terms of Medicaid expenditures per eligible child, that school-based claims were typically for health services, direct health services—this is represented by the yellow bar—not administrative activities. But the dark bar, the green bar, would indicate that there are some exceptions to this.

The next chart illustrates this even further. On our next chart, you can see that, of the $2.3 billion spent for school-based activities, about two-thirds, that is $1.6 billion, were for health services that are provided by almost all States across the Nation. About one-third, just over $700 million, was for administrative activities in 17 States.

But the message here is that two States, Illinois and Michigan, account for the majority of these school-based administrative activity payments, over $500 million for these two States for their most current year.

Just understand the significance of this amount, please consider this. For these two States, the school-based administrative claims constituted almost half of their total administrative costs to run their entire Medicaid program.

Mr. Chairman, we would emphasize that appropriate payment for appropriate services is not the issue. The issue, though, is that methods that are in use by some school districts and States to claim reimbursement are often inappropriate and do not guard against questionable, if not improper, payments.

For example, in the area of health services, a bundled rate for school-based health services has some distinct advantages for schools, particularly because it helps with administrative ease.

We found that seven States are using a bundled approach, but not each of these seven adequately take into account variations in the needs of the child, nor do they necessarily build in assurances that services paid for are delivered.

One State, for example, pays all schools the same State-wide rate regardless of the intensity of the child's needs or the differences in the cost of delivering services. This can result in underpaying some States, and perhaps overpaying others.

Other States pay a school a monthly rate as long as a child attends hool at least 1 day that month, regardless of whether or not services are provided.

We also have concerns about methods that are in use for schools that are claiming administrative activities. Our work in one State alone identified $28 million in Federal payments over 2 years for services that were clearly provided to non-Medicaid-eligible children.

In addition, HCFA interviews with a sample of school personnel whose time was allocated to Medicaid for other administrative activities revealed no connection between their activities and Medicaid.

We found that similar practices are in effect in other States that could also allow comparable improprieties to be occurring.

Despite the significant level of Medicaid payments that are being made, though, not all schools benefit from Federal payments. As can be seen from our third and last chart, a school in a State such as Minnesota, which is represented by the green bar, would be fully reimbursed for all of the claims that it submits, 100 percent. Other schools in other States, however, receive far less.

Several factors explain why so few schools in some States receive so little. First, in many States schools receive no State payment for school-based services. Their local funds provide the State share of the Medicaid match. That represents the yellow bar in the graph.

Second, many States—as many as 18—retain a very significant share of the Federal payment, often as much as 50 percent or more and as high as 85 percent, rather than giving it back to the schools as reimbursement for their claims.

Third, schools often pay private firms as much as 25 percent of their Federal payment for services related to their Medicaid claims. These firms often develop the methods to identify the claims, to train school personnel to use the methods, and then they file the claims that become the basis for their fees.

Taken together, these funding arrangements reduce every incentive to exercise appropriate oversight. They also appear to violate Medicaid's fundamental tenet that Federal dollars are provided to match State or local dollars for Medicaid-covered services.

In conclusion, Mr. Chairman and Senator Moynihan, HCFA is already acknowledging these concerns and is taking steps to respond to the recommendations in our report. HCFA concurs with the need for better policy and its more consistent application.

But we would point out that States also bear a very important fiduciary responsibility with HCFA to administer the Medicaid program and they, too, must be held accountable for its efficient and effective operation to safeguard public dollars.

A program of the magnitude and diversity of Medicaid will always present us with challenges in terms of finding the appropriate balance between State flexibility, public accountability, and administrative simplicity.

Medicaid can obviously make a very significant contribution to the very real needs of eligible children, but there needs to be constant vigilance to guard against potential exploitation that will divert limited resources from their intended purposes.

Thank you, Mr. Chairman. This concludes our statement.

The CHAIRMAN. Thank you, Ms. Allen.

Now we will turn to Mr. Westmoreland.

[The prepared statement of Ms. Allen appears in the appendix.]

STATEMENT OF TIM WESTMORELAND, DIRECTOR OF THE CENTER FOR MEDICAID AND STATE OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION (HCFA), WASHINGTON, DC

Mr. WESTMORELAND. Thank you, Mr. Chairman, and thank you Senator Moynihan. Thanks to the GAO for their study and their recommendations.

In brief, let me say that we agree with the GAO and concur in its findings, and will move to adopt its recommendations expeditiously.

There is a general rule in Medicaid. A Medicaid-eligible child can receive a Medicaid-covered service when furnished by a Medicaid-participating provider in any venue, hospital, clinic, school, or home. There are some additions to that general rule, like outreach and enrollment assistance, but that is the general rule.

We recognize that education and health care need to have a good, cooperative relationship with the overall goal of helping children. Schools are a good place to reach children, to enroll them in Medicaid, in SCHIP, and provide some basic services. Health care services are essential to allow some children, especially chronically ill

and disabled children, to get a public education. Medicaid is a powerful tool to aid in that goal.

So with the general rule and the overall goal in mind, there are a number of complex issues to work through and the GAO has highlighted some of them for us today: bundling of school-based services, claiming Medicaid funds for administrative purposes, and transportation.

Bundling is a catch-phrase for combining several services over a period of time and paying a single payment for them. It is much like what Medicare does for hospitals or for surgeons these days. There are many services involved, but these days they are not usually separately itemized. We pay one rate for one procedure.

These rates have been developed in Medicare over a period of 25 years using detailed cost reports from institutions that are used to providing itemized billing: hospitals. They have been statistically evaluated, they have been regularly adjusted and reviewed, and it is quite a rigorous process.

It is used because it is more flexible and simpler than fee-for-service billing, while still being sound accounting. Bundling in school-based services is a relative innovation. It is usually used to pay for services like physical therapy, speech therapy, hearing services, the kinds of things that Ms. Allen has described to you today.

It is not based on the same detailed history of experience on costs. While it is flexible, it may not be accurate. It may under- or over-compensate individual schools. It may not be risk adjusted by the condition of the child involved. It may be triggered by events that are not related directly to cost like, as Ms. Allen has pointed out, 1 day of attendance in school.

So while bundling is theoretically a good thing, the devil is in the details. As GAO has said, the rates should reflect the need. The rates should not be vulnerable to manipulation or lead to inadequate services to the child. We agree.

We would flesh this out from information from our work group on bundling to say that there should be documentation, especially documentation that the service billed for is actually provided, that there should be an ability to do retrospective review, and that there should be statistically valid sampling methods. This will lead to a good balance between flexibility and accountability.

In the meanwhile, we are not approving any new bundling State planning amendments and, short of fraud and abuse, we will allow the current bundling States to continue for the time being, although we will continue to provide technical assistance to help them adjust the accuracy of their payments.

The alternative to developing a new bundling methodology is unacceptable. It is to wait for 25 years until we get reliable accounting data like we have for hospitals. That is not good for Medicaid and it is not good for the kids who need the care now.

In administrative claiming, in addition to health services, Medicaid also pays for administrative work. As I mentioned before, we pay for outreach, enrollment assistance, and those kinds of services in general, and schools are a very good venue for doing that, but, in addition, we pay for administrative work that is connected with providing health services.

Here, I would say the same general rule applies. Medicaid will pay for administrative work that is associated with any Medicaid-eligible child receiving Medicaid-covered services from a Medicaid-participating provider. But we do not pay administrative expenses that do not meet that general rule, except, of course, for special circumstances like outreach and enrollment assistance.

So we do not pay for administrative services for ineligible children, or uncovered services, or non-participating providers. This is complicated because many school workers do a variety of services during their normal day in the school, some that meet the general rule, some that do not.

One method for accounting for this in a fiscally sound manner is for Medicaid to appropriately require statistical studies on the allocation of the time of the personnel. The draft Administrative Claiming Guide, which was developed after this committee's last hearing, is to try to make these rules clearer and simpler. It is not a new policy.

These are general rules that apply not only to all of Medicaid, but to all of the Federal programs. We are trying to clarify these rules and to put them in one place, for the schools, and for the States, and for HCFA, to promote consistency among HCFA regional offices so that we have the same rules being explained in the same way.

This Administrative Claiming Guide is in draft now. The closing date for comments was this past Monday. We have received a number of comments. We will review those with the Department of Education and make the Guide final. In the meanwhile, we will continue to provide technical assistance on administrative services, especially to those small school districts that may have trouble doing so on their own.

Finally, transportation. Again, the general rule. Medicaid will pay for transportation when it is helping a Medicaid child get to or from a Medicaid service by a Medicaid provider; in school settings, the school often stands in as the provider.

But if no health services or special assistance or equipment are used, then transportation is not covered. There is a need here for clarity and consistency. We are working on program guidance for schools, States, and again, for the Health Care Financing Administration itself.

In conclusion, I would say thank you to the committee, and to the staff, and to the GAO for raising these issues. Medicaid and education have a strong common denominator: kids. We should keep these kids as the focus of the program and work to clarify all of these complications around providing services to them.

Thank you very much.

The CHAIRMAN. Thank you, Mr. Westmoreland.

[The prepared statement of Mr. Westmoreland appears in the appendix.]

The CHAIRMAN. Mr. Hast, in your report you say you are referring certain matters to the U.S. Attorney's Office for appropriate action. Would you please tell the committee why you are making these referrals and what actions you would expect the U.S. Attorney's Office to take?

Mr. HAST. Yes, Mr. Chairman. We are referring certain matters because we believe that, based on the evidence that we collected, that there is prima fascia evidence that some of the school districts, with the aid and instruction of private consulting firms, made claims on Medicaid reimbursement that were wilful and intentional violations of the law.

I would say that we hope that the U.S. Attorney's Offices that we refer this to will take appropriate action in either criminal or civil law proceedings in order to recover improperly obtained funds.

The CHAIRMAN. Could you identify or give us some examples of the type of misconduct the GAO uncovered that led you to make these referrals?

Mr. HAST. Yes. In the area of fee for services, we examples of claiming of transportation services any time a child received a related health care service without regard to whether the service was actually provided.

In this context, school district officials told us that some of the children who are authorized for this service never actually utilized the transportation, but are transported by their parents.

We also identified situations where group therapy sessions are made as if they were individual sessions for billing purposes, but only for the Medicaid-eligible students, not for other students.

On the administrative side, we believe that the $28 million example that Ms. Allen testified about earlier is a situation that requires Justice Department review. It is troubling that persons or entities knowledgeable about this program would submit claims for reimbursement of services for non-Medicaid-eligible students.

Additionally, Deloit & Touche Consulting, who prepared the claims, when testifying before the House Committee on Commerce in November about their fraud detection program, said that they had systems in place to prevent improper payments from being made. It does not appear that they were using these systems in Michigan.

The CHAIRMAN. Did your investigation determine whose decision it was to submit the improper claims in question? Was it the school districts, the consultants?

Mr. HAST. Well, in interviewing officials from both the school district and the consultants, we found that, with respect to the transportation and group therapy billing, both sides are blaming each other. However, with respect to the administrative claiming issues that we developed, our interviews lead us to believe that the consultants were responsible for those.

The CHAIRMAN. If they are unable to prosecute based on the referrals, do you think HCFA should recover the improperly obtained funds?

Mr. HAST. Yes, absolutely. I think we should use all legal remedies to obtain the funds.

The CHAIRMAN. Now, Ms Allen, your analysis shows us that school districts often benefit very little from Medicaid reimbursement because of the funding arrangements they have with the States or with the consultants. What can be done to maximize the level of reimbursement that ultimately reaches the schools?

Ms. ALLEN. Mr. Chairman, there are several things that could be done. Probably the two which would have priority consideration

have to do with the State practice to retain certain of the Federal reimbursement, and also to look at the practices by which the schools are paying the consultants who work with them.

Let me take the first one with regard to the State practice to retain. The States would argue that they retain a portion of the Federal Medicaid reimbursement because they provide State funds to local education agencies for the benefit of school children. There is no argument about that.

But at the same time, as we have testified and as can be seen in the graphic, there are large proportions of local funds involved, so it is not clear exactly whose funds are being used to pay for Medicaid-eligible services.

We believe that when a State retains a portion of the Federal Medicaid match, it severs any link that there should be between ensuring that Federal dollars paying for Medicaid-covered services.

We also think that this just violates a fundamental tenet of the Medicaid program, that Federal dollars are used to match State and local dollars for the purposes of Medicaid services.

The second issue has to do with the issue of contingency fees that are paid to consultants. Again, as we have testified, consultants' fees are often tied to the amount of the reimbursement that will be coming from the Federal Government.

Any arrangement such as that removes any incentive for appropriate oversight. It creates every incentive, in fact, to maximize, to push the envelope of what is allowable. As we have indicated, we have found exactly that to be happening. There are various ways that can be done to address that, which we would be happy to delineate, if you desire.

The CHAIRMAN. Yes. Please proceed.

Ms. ALLEN. With regard to the practices for paying the consultants, there are two or three things that one should bear in mind. First of all, Federal law does allow the payment or the reimbursement by Medicaid of consultant fees to the extent that they are necessary and reasonable for the program, and to the extent that they are not based on recovery of Federal payments.

For the most part, we did not find that to be the issue. What is happening, though, is that there is nothing to preclude a local school district from paying a fee to their consultants, but when it is tied to the percentage of federal reimbursement, again, there are problems.

So how does one remedy that? Several ways. First of all, tighten up the criteria for what is allowable or not and that will remove some of the gray area that people are stepping into now.

Second, some States do not allow contingency fees at all. Florida, for example, just in February, adopted a policy to no longer allow contingency fees to be paid on this basis. Some States use a fixed fee schedule. That is another tool that can be used.

Finally, it could be capped. There could be a cap on what is considered reasonable and allowable which would help constrain that portion of funds being drained off from schools.

The CHAIRMAN. Now, you mentioned Florida outlawed contingency fees. Should the Federal Government do the same in these areas?

Ms. ALLEN. I am not sure about that, Mr. Chairman. Again, it would seem that if these other principles are in place, that perhaps there would not be as much of a concern. There are some other States, I believe, who would also ban this.

To the extent that States would disallow contingency fees, then obviously the Federal Government recognizes that as well. At this point, we do not have a position on whether or not we should ban that at the Federal level.

The CHAIRMAN. Let me ask this question, then I will turn to Senator Moynihan.

How pervasive are the problems you identified with administrative cost claiming, in particular, the claims for services for non-Medicaid-eligible children? Is this something occurring in a couple of States or so? What is being done to prevent this practice from growing?

Ms. ALLEN. The magnitude appeared to be greatest in the two States where the administrative claims are the highest, in Michigan and Illinois. Again, HCFA has done some reviews of practices in those States.

For one quarter alone, the quarter ending September 1998, in one State, HCFA has questioned $30 million in administrative claims, for some of the reasons that we delineated.

But when they questioned them in 1998, they asked that practices be changed, but it did not happen. When the next year rolled around, September 1999, at that point HCFA decided to defer $33 million that had been claimed for these questionable practices. At this point, HCFA has not determined that they are unallowable, it is just that they are questionable.

Similar practices are in place in Illinois. Again, the magnitude is very large in those two States. But we have also identified that similar practices are in use in a number of other States. We have not done the work in those other States to identify it, but certainly the vulnerabilities are there.

The CHAIRMAN. Let me turn to you, Mr. Westmoreland. How has all this happened? GAO presents to us a clear pattern of improper payments for both direct services and administrative costs.

What has gone wrong in HCFA's oversight process? For example, why did the regional offices not reject State plan submissions that permitted inappropriate claim methodologies? How did we get here? I mean, what is HCFA doing?

Mr. WESTMORELAND. Mr. Chairman, I think I should begin by saying that we had deferred claims, as Ms. Allen has pointed out, from the State of Michigan. Overall, that is about $50 million that we have deferred.

The second thing I should probably say, is that we accepted the initial bundling of service provision because it seemed like a good, flexible way of responding to the need for the schools to be able, as you were pointing out in your opening statements, to not turn into hospitals, not to have to provide fee-for-service billing.

Having said that, when we initially accepted those we were acting on the belief that we had a reasonable basis for coming up with the bundling methodology, of what the rates would be and what would trigger those rates.

We have since—and I would say in large part because of the GAO and this committee's activities this past summer—put a moratorium on accepting further school bundling amendments because we do not believe that the methodology that is arrived at or how to come at those services with an appropriate rate is as sophisticated and nuanced as it needs to be. It is not the same thing as prospective payment in hospital care.

So we have put that on hold. We are developing a new methodology, and in the meanwhile we are only accepting fee-for-service proposals for school-based services.

In the administrative claiming area, we have developed a draft Administrative Claiming Guide for use by the States on how to claim for school-based services' administrative work. That guide is long and it is in draft now. We have received a number of comments about those drafts. We will be trying to make that into a final form and I have every hope of being able to do so expeditiously.

Let me quickly add, there are other parties that are quite interested in making sure that this Administrative Claiming Guide is clear and useful. We have been working with the Department of Education, especially with the office that deals with special education and the needs of chronically ill and disabled kids who have a special interest in making sure that Medicaid is available to pay for those kids to stay in schools.

So we have been moving to try to clarify this policy. I agree with you, Mr. Chairman, that it has been slow. To that extent, I regret that it has not been faster, but we are moving to do so.

The CHAIRMAN. Now, I understand that these guidelines really set forth what is not reimbursable and the schools are concerned that it does not state what is reimbursable, that consequently it does not give them, really, the kind of guidance that they need. What is your answer to that complaint?

Mr. WESTMORELAND. I agree with that, overall. We have received a number of comments that the tone is actually one that is quite pessimistic, "These are the things you cannot do." I agree that we should state, in turn, "These are the things you can do."

Now, I think that our lawyers would argue that by stating what you cannot do, and having the general rule that I described in my testimony available, that schools should have some comfort that this is what you can do.

But I also have heard from a number of school districts and education associations that is not what they wish to have, and I hope that the final guide will state, in turn, the things that they can do.

One of the things I also would emphasize, which has been important for some of the education groups with whom I have met in the meanwhile, is that the Administrative Claiming Guide is setting out—and I do not use this phrase in its legal sense—a safe harbor. This is one way of doing administrative claiming with an accounting method, in this case random time sampling, that would result in satisfactory accounting of personnel time.

I have been told by a number of people, and indeed, a number of Members' offices, that there are other ways that they feel are sound accounting to arrive at this same basis.

What we are trying to do is lay out one method that would be acceptable, and if schools or States—in this case, I am allowed, legally, only to deal with States—come forward with other methods, that HCFA will review those in detail.

The CHAIRMAN. Let me ask you two more quick questions. Do you intend to recover from the States payments that were drawn inappropriately?

Mr. WESTMORELAND. If, upon further review—and I have pointed out that in the State of Michigan we have taken, overall, about $50 million in deferrals—we find that those claims were, indeed, legally inappropriate, yes, we would seek to recover those funds.

I would also point out that, in a number of States, we have worked with the State on voluntary adjustments which have not required going to deferrals. We have had voluntary adjustments in which regional offices have approached the State, raised questions, and the State has volunteered cooperatively to adjust their future method and, indeed, return some Federal funds. So, it need not always come to the point of recoupment.

The CHAIRMAN. You did make some mention about the inconsistencies between regional offices. This is a constant complaint in almost every program. When are we going to get on top of it and make sure that all States are treated alike?

Mr. WESTMORELAND. I hope that we can move towards finally getting regional consistency, in part, by developing the Administrative Claiming Guide, as I said in my testimony, not just for the purposes of telling the States and the local education authorities, but also telling the HCFA regional offices who are responsible for the implementation of these programs, what acceptable and unacceptable practices are.

I think the development of the guide has an internal purpose as well as an external purpose, so that there are clear and stated rules of what is an appropriate system. I hope that this will promote regional consistency. I would be overly ambitious to say that that would be solving the problem of regional inconsistency, but I hope it will help.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. First of all, I want to thank all of our panel for the candor, especially you, Mr. Westmoreland.

Mr. WESTMORELAND. Thank you, sir.

Senator MOYNIHAN. You have indicated what you hope will come out and not told us what will. Let me ask, if I can, the questions of regional variation. The Chairman mentioned regional matters.

I have been intrigued by the history of the Medicaid sharing formulas with State governments which is based on the Hill-Burton Hospital Construction Act, I believe, of 1947.

A distinguished former chairman of this committee once confided to me, in the good nature Russell Long always had in these matters, and said, "Well, Hill-Burton was the South's revenge for the Civil War." [Laughter.] If you will recall, it allocates funds on the basis of the square of the difference between the State per capita income and U.S. per capita income.

I remember anciently now, in my first commencement address as a U.S. Senator, I suggested, if we are going to have algebra in our

statutes, why not make it square root? Nothing has come of that over the years.

But I look at your chart, Ms. Allen, and it says, there is Maryland paying $820 a year. As far as I can tell, Alaska, Arizona, and Minnesota do not provide anything in the way of health care services, it is all administrative.

Ms. ALLEN. That is what they reported to us, sir. That is not to say that they are not necessarily providing those types of services to their children, but it seems that they are not working through the Medicaid program to help obtain the reimbursement for those services.

Senator MOYNIHAN. So they just charge the administrative costs and pick up the others, do you think?

Ms. ALLEN. It would appear that way.

Senator MOYNIHAN. I wonder if Mr. Westmoreland could not look into that for us, if it is an anomaly.

Mr. WESTMORELAND. Senator Moynihan, I would be delighted to look into it for you. I would say in passing, that the provision of health care services for disabled and chronically ill children through the Medicaid program is, as you point out, in the long history of the Medicaid program, a relative innovation.

It was in 1988 that it was clear that schools and educational organizations could claim for health care services provided in this fashion under the Individuals With Disabilities Education Act.

It may be that, over the years, some schools—I do not know the situation in these States—became accustomed to budgeting for that.

Senator MOYNIHAN. Well, Minnesota is not in the habit of depriving people of education or health care. It may just be the simplest thing for them to do. You could always call them up ask.

Mr. WESTMORELAND. Yes, sir. We will investigate. But the only thing I was trying to follow up on with Ms. Allen's comment is that the fact that it does not show up as a Medicaid expense may not mean that the health services are not provided to the children.

Senator MOYNIHAN. Precisely.

Mr. WESTMORELAND. Yes.

Senator MOYNIHAN. But, then again, the range of health services billed, as it were, ranges from a high of $820 in Maryland to 5 cents in Mississippi. Now, what is that all about? Five cents' worth of health care?

Ms. ALLEN. Well, that is how it averages out, sir. It could be that that is being provided to just a few children, perhaps, in one school district, but when you average it out over all Medicaid-eligible children in the State, the claim per child is low.

Again, the point here, as Mr. Westmoreland said, is that a number of States are adopting a wait-and-see attitude. There is widespread knowledge about some of the activities occurring in some States. Some are very interested, some consultants are working very aggressively to sign up more clients amongst States and schools.

But, quite frankly, some are waiting and watching to see, for example, the outcome of this hearing, because they are not sure whether they can legitimately pursue this and how to do it in a way that they will benefit and, at some point, not be penalized.

Senator MOYNIHAN. I would hope you mean the way the children would benefit.

Ms. ALLEN. Yes.

Senator MOYNIHAN. I am sure the Chairman does not want this hearing to suggest anybody get out of this program. There is a phenomenon, which is obviously related to the welfare legislation of 1996 in which we repealed the Aid to Families With Dependent Children, which was the original focus of the Medicaid, was it went with AFDC. Now there is none, so 600,000 children appear to have lost Medicaid coverage during 1997 alone. Is this not the case? Mr. Westmoreland, you would know.

Mr. WESTMORELAND. I am not sure if the number is 600,000. It is hard to estimate how many children have lost Medicaid, in part because of the difficulties of estimating rising employment levels, which in turn might mean that children do not meet the income and assets standard. But it is quite clear that a number of children and families have been inappropriately terminated from Medicaid as the TANF legislation was implemented.

Senator MOYNIHAN. Is it inappropriate, or did we just write the statute, so this is what happens?

Mr. WESTMORELAND. Well, as I understand it, under the terms of the legislation, children and families should preserve their Medicaid eligibility even if they lose their TANF.

Senator MOYNIHAN. They continue that. I see. So it might be that, even though they have that entitlement, they think, since you are off AFDC, you are off everything.

Mr. WESTMORELAND. Yes, sir. In three States that I know of, that are working either in litigation or working directly with the fear of litigation, efforts have been undertaken to reinstate children and families that have been inappropriately terminated, say, due to a computer system error or something like that.

In the State of Washington, for instance, more than 100,000 children and families have been reinstated into the Medicaid program after finding that there have been errors in the implementation of the TANF legislation.

Senator MOYNIHAN. You are going to have a big issue on your hands in this regard when the 5-year time limit takes place, which is what, next year?

Mr. WESTMORELAND. Yes, sir.

Senator MOYNIHAN. I will not be around to hear it, but I would hope that you might keep the committee in touch with what happens, generally.

Mr. WESTMORELAND. Yes, sir. I will.

Senator MOYNIHAN. And in that regard, one last question, if I can. Do you have a State variation in the number of disabled children eligible from State to State? Anybody. Mr. Hast, you can join in here.

Mr. WESTMORELAND. I do not know those numbers. I am sure it would be relatively easy for us to come up with the numbers, and I would be happy to supply them to the committee by the end of the week.

Senator MOYNIHAN. Would you do?

Mr. WESTMORELAND. Yes, sir.

Senator MOYNIHAN. Because it is the question of disposition to diagnose something like that. DDT. Disposition to diagnose. The variations can be so formidable.

I am sorry that my friend from Florida has just arrived. But a couple of years ago we were able to show that the strongest correlation between mathematical test scores and eighth grade students, by far the strongest correlation, was distance of the State capital from the Canadian border. So, we came up with, if you want to improve your test scores, move your State closer to Canada. It makes perfect sense, and the statistics prove it.

But it would be interesting to find out just how many. Is there a variation? And within the variation, are there specific physical disabilities? What would students be in group therapy for? I mean, that is psychiatric, is it not?

Ms. ALLEN. Or it could be speech therapy, sir.

Senator MOYNIHAN. Speech therapy.

Ms. ALLEN. Yes.

Senator MOYNIHAN. Yes. Sure. Well, tell us more, will you? And thank you for what you have told us already.

Mr. WESTMORELAND. And if I could add, sir, at the risk of being considered facetious, I have in my previous career worked on a statute which is now blessedly amended, which involved a cube root for distributing funds among the States.

Senator MOYNIHAN. A cube root.

Mr. WESTMORELAND. A cube root. Yes, sir.

Senator MOYNIHAN. Would you let us know about that? [Laughter.]

Mr. WESTMORELAND. It is no longer on the books. It has been amended.

Senator MOYNIHAN. It does not matter, it was. The history of algebra in American social legislation. There is a little dissertation there.

Mr. WESTMORELAND. I would actually go so far as to point out that the legislative counsel, in attempting to draft this legislation, could not find a cube root key on his computer and we had to draw one and cut and paste it into the bill. [Laughter.]

Senator MOYNIHAN. Send us a letter.

Mr. WESTMORELAND. I will.

Senator MOYNIHAN. Thank you all very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Moynihan.

There is a vote on. Senator Graham, would you want to proceed to ask any questions, then recess the committee? We can go ahead and vote. There will be two votes. I think we are finished with this panel, but when you complete any questions you have.

Senator GRAHAM. Mr. Chairman, my preference would be, first, to respond to what Senator Moynihan has just said by providing a bit of history of the connection between Florida and Canada. We cannot deal with geography, but we can deal with past events. That should intrigue you.

Second, to suggest that Senator Moynihan is going to be spending his retirement writing salacious novels on the history of algebra in America's social policy as a means of supplementing his Social Security income.

But I would withhold my questions to the next panel, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Graham.

Let me thank the three of you for your testimony. I view this situation most seriously, and I think it is critically important that we proceed in a way that we ensure the young students who are entitled to this care, indeed, have it and that the school districts are reimbursed as we proposed.

So I do not want to come back another year from now and find that we are dealing with the same situation. I want to hear that the program is working for the eligible.

Senator MOYNIHAN. Once again, Mr. Chairman, oversight is a fundamental responsibility which you have revived. We are not the only ones. I mean, they are not the only ones who have to keep up with procedures.

The CHAIRMAN. Absolutely. I could not agree more.

Senator MOYNIHAN. We thank you all.

The CHAIRMAN. Thank you very much.

The committee is in recess.

[Whereupon, at 10:48 a.m., the hearing was recessed to reconvene at 11:32 a.m.]

The CHAIRMAN. The committee will please come to order.

It is a pleasure to welcome our second panel, consisting of Lynn Davenport, who is president, Human Services Division, MAXIMUS; Susan Sclafani, who is chief of staff for Educational Services, Houston Independent School District. It is a pleasure to welcome both of you. And Jacquelin Golden, National Parent Network on Disabilities.

I apologize for the delay, but it seems to be the pattern rather than the exception.

Senator MOYNIHAN. But you always come back, Mr. Chairman, which is not the pattern.

The CHAIRMAN. That is true.

But we will start with you, Mr. Davenport, and work our way up.

STATEMENT OF LYNN DAVENPORT, PRESIDENT, HUMAN SERVICES DIVISION, MAXIMUS, WALTHAM, MA

Mr. DAVENPORT. Thank you, Senator Roth and Senator Moynihan. It is a pleasure to be here.

My name is Lynn Davenport and I am with MAXIMUS. MAXIMUS is a consulting firm that works in the State, federal, and local sector. Among the work we do, is to work with States and school districts to help them obtain their full Federal reimbursement under Medicaid and other Federal programs.

So, it is based on that experience that I am talking about today. We have prepared a statement, which I believe you have, and I will kind of summarize the high points, then look forward to questions.

We are pretty well aware of all of the concerns about school-based billing. To the extent there are issues—and there are issues, we have seen them—we have tried to make sure we have been a positive, rather than negative, force in addressing them. But those concerns are real. I think this series of hearings is very important.

Let me take on three or four of the issues that seem to be important to give our perspective. First, with respect to bundled rates,

truthfully, any kind of rate-setting system can be abused, a fee-for-service system, a bundled rate system can be abused.

Really, what they are is rates divided by a cost. If those costs do not properly reflect real costs, you have a potential issue. So I think the issue is how to develop a good rate-setting system as opposed to fee-for-service versus bundled rates.

The second concern, as people have mentioned, bundled rates can be helpful to schools because they are somewhat easier to implement, so there is a potential advantage to schools to use them, so long as costs are properly recorded.

Third, there are certain kinds of transactions in the school setting that really do not lend themselves to a fee-for-service situation. For example, if you have a personal aid in a classroom whose job is to work with disadvantaged children, and that person spends some of his or her day on instructional kinds of functions which cannot be billed to Medicaid, there are other functions in terms of working with the child that are billable.

So how does that person record those different moments in time in the course of the day in a way that is practical? It is a difficult service to recover under a bundle rate methodology.

But let me turn to some of the ways in which I think you can begin to develop a better system, be it fee for service or bundled rate. First, there has to be a much better definition of what are proper and allowable costs. I think if everybody agrees from the beginning, you are in better shape.

Second, I think it is important to have variation in your rate-setting system. Some of our projects, for example. We have a series of 19 different rates. We have developed a rate for each type of disability category.

We also have different rates by different segments of a State, so that there is variation in terms of State differences. I think you start to have more and more variation, detail, and rigor in your process, you have a better chance for properly representing costs.

Third, there has to be a real statistical foundation behind those rates in terms of allocating time, recording time, to make sure that you can properly show that the time we have billed, the costs we have billed, really is for an allowable function as opposed to an unallowable function. We like to sit down with HCFA at the beginning of our projects and work through our methodologies with them to get agreement. I think that is the process that works best.

Senator MOYNIHAN. Sir, if I may.

Mr. DAVENPORT. Sure.

Senator MOYNIHAN. You said you sit down with HCFA and work these things out.

Mr. DAVENPORT. We certainly try to, yes. It is just a matter of our practice. We think that that is the best way of avoiding a surprise later on.

The next point I was going to mention, is that even though you are billing, let us say, on a blended rate basis, you want to make sure you work with the schools to put in place some sort of record keeping system so that one can go back on an audit and look through their books and records to see if that service was actually rendered.

Last, there needs to be flexibility. People talked about using a month, for example, as an appropriate indicator. There are other kinds of indicators that could be used, so we have got to work towards what makes sense.

Let me move to the second issue, which is administrative claiming. Administrative costs, again, are appropriate costs, within reason. There have been a lot of issues. One of the things that I think has happened, is there has been a tendency in some cases for people to try to move direct service costs into an administrative cost pool. That is not what the administrative cost program was designed to recover.

It is really supposed to be the costs on top of your direct services. It gets back to properly defining which costs are appropriate, which are not, define that in advance through regulation and rules, and ultimately through practice, and I think you have a much better chance of having a good program.

Second, again, your statistical process. There is a sampling that needs to be performed of people to see, are they performing Medicaid or non-Medicaid allowable services or health related services? There are sampling methods that kind of take one little moment in time and extrapolate the results over an entire year. That is a leap of faith.

There are other sampling methods that force you to look at time much more consistently and more constantly. That gives you much more representative views, so these are, again, methods and ways to kind of have an administrative cost system that works best.

Obviously, you want to make sure that you do not see the same costs in both direct service and administrative costs, so structuring the commitment and responsibility on behalf of everybody working in the process is important.

The third area, is the use of contractors. The sense tends to be that using a contractor, in itself, is wrong or abusive. Second, they work on a contingency-based process, even more so. Let me respond to those points.

It takes effort to put in place a school-based billing system, whether it be a school or a consultant. The school is either going to have to hire people, or build a computer system, or assign staff to that process, or they are going to use somebody like our firm to work with them. But if the firm is working properly, it is a proper function for somebody to perform.

Second, with respect to contingency rates, again, you can have abuses in a contingency system, or under a fee-for-service system, or whatever. Abuses can occur. Again, how do you put in place a process that is going to protect against that?

Contingencies, by the way, can be helper in smaller jurisdictions or finally strapped jurisdictions as a way for them to avoid paying until they have benefit from your services.

Some things to think about: making sure that all procurement are on a competitive bid basis; requiring the vendors to share their costs. If I buy a car, every dealer is going to share their costs with me. So should vendors, and that should be something you put in your proposal, whether you charge others for the same services.

Time limits, in terms of how long this contract is supposed to last. I need to make sure that the vendor is required to not only

just identify the services billed for the dollars, but to actually be responsible for training staff, putting in place procedures and systems, and turning over their knowledge to the vendor long term. Lastly, to think about things like caps, limits, dollar constraints, if there is a concern that maybe somebody is getting inappropriate recovery.

I had other comments, but I will leave those. Those were kind of highlight kinds of comments.

Just one thing on the issue of HCFA, if I may. I think the issue there is to try to find a way to get a good, prompt, working process. That would be the most helpful for the people working in the field, so to speak. Thank you.

The CHAIRMAN. Next, I will call on Dr. Sclafani, please.

[The prepared statement of Mr. Davenport appears in the appendix.]

STATEMENT OF SUSAN SCLAFANI, PH.D., CHIEF OF STAFF FOR EDUCATIONAL SERVICES, HOUSTON INDEPENDENT SCHOOL DISTRICT, HOUSTON, TX

Dr. SCLAFANI. Thank you, Chairman Roth and Senator Moynihan, members of the committee. We are very pleased to be here today on behalf of the Houston Independent School District, and as well as a representative of the Council of Great City Schools, the largest urban districts in America.

We are the largest district in Texas, and the seventh largest in the Nation, with over 210,000 children served in nearly 300 schools across our city, which is a very large, spread-out city. Fifty-three percent of our students are Hispanic, 35 percent African-American, 12 percent white and Asian. In fact, 71 percent of our students are served in the free and reduced-price lunch program.

What we see, is that because we are a large city, we tend to get more severely and profoundly disabled students in our schools than many other areas do. We are known for our medical center in Houston. In fact, the number of our multiply impaired students is very high

We also had brought to the committee a very short videotape that shows you some of the students that we serve. Ordinarily, in the past when we were in school, these children were not in school with our kids and we think it is important that they are there. That means that we have got to provide health services for them if they are going to be successful.

We have been doing the Medicaid program in Houston since 1992. We set up a department. We have a staff of 10 who have worked very closely with the State Medicaid service and the regional HCFA to design a program that meets all of the requirements for the State.

Through our annual audits, we have been found to be in full compliance. We also have used our staff to do internal audits during the year to be sure that we are following all of the rules.

Frankly, we do those time studies on a quarterly basis that do take time from our professionals, but they also see that the nearly $9 million a year that we get in Medicaid reimbursement enables us to provide personnel to better serve our students. Because of that, they are willing to do that extra work.

One of the things that we believe, is that as you are providing services across the Nation, that it must be, as you have already asked in the first panel, a system that provides equity across the States.

We are very pleased with the Texas system. We have worked well together. It is a fee-for-service system. We are sure that we are only reimbursed for the services that we provide to children, but as we provide additional services, then we can be reimbursed for those as well.

In Texas, there are 1,000 school districts, and 800 of them have fewer than 1,000 students in them. For each one of those school districts, to create the mechanism to do this on their own, is far more difficult. A student population like that only justifies a central office with one or two people in the professional range. They cannot create a staff.

We have been working with a number of our neighboring districts to help them use our system. We have already developed it, we have got the software in place. So there are alternatives, I think, to going with consultants. The nice part is, all of those dollars then stay in school systems and provide services for students.

In my testimony, I outline the services that we provide and it is far more than one would ordinarily expect a school system to provide. But, as I said, our children are far more medically involved in Houston than we have had before.

We do tube feedings, we do suctioning of lungs so that children are able to breathe, we do inhalation treatments, we provide medication on a daily basis to our students, and we have got to have professionals to do that. As you know, medical professionals are an expensive group of people to hire. We believe, however, that it is worth doing.

One of our challenges, is that the Individuals With Disabilities Education Act was never fully funded as originally conceived, so we only get about $8 million out of Federal funds. Yet, we are spending well over $115 million a year on our special education programs. We spend over $35 million a year on health services.

So we are providing those services because our children need them, and we believe so strongly that all children need to be in schools together.

In fact, it is the interaction of our regular education students with our special education students that enriches the lives of our special education students and builds an understanding on the part of our regular education students, that these are children as well, these are their peers, and that they need, as they grow up, to be concerned about the welfare of these children as well.

So we are looking forward to regulations that tell us consistently how we should operate, that are clear and easy to understand. But we believe that the Medicaid program has enabled us to serve students that otherwise would not be as well-served as we currently do it.

Many of our children in our Child Find program really are served only by our school nurse. It is the only medical personnel they see, unless we can help them and their parents get in touch with the medical professionals available in the city.

So the Child Find services, the case management services that our people provide, are absolutely critical to ensuring that our children have the health services at an early stage where we can intervene easily and keep down the medical costs. So, we are in full agreement with Medicaid's goals, as well as HCFA's goals, of intervening early and reducing the costs on a permanent basis.

The CHAIRMAN. Thank you, Dr. Sclafani.

Senator MOYNIHAN. Right on time.

The CHAIRMAN. Right on the button.

Senator MOYNIHAN. Somebody has been around schools, I think. The bell rings.

The CHAIRMAN. Ms. Golden?

[The prepared statement of Dr. Sclafani appears in the appendix.]

STATEMENT OF JACQUELIN GOLDEN, NATIONAL PARENT NETWORK ON DISABILITIES, BALTIMORE, MD

Ms. GOLDEN. Mr. Chairman and distinguished members of the Finance Committee, my name is Jacquie Golden and it is a pleasure being here today.

The very first thing I wanted to do, is actually give you a visual. This is the young man I am speaking about today, which is my son Joshua. He is the handsome one in the middle.

But I wish to share with you my firsthand experience on how important it is to receive the related, school-based services, paid for by Medicaid for children with disabilities. But, first, I have to tell you about myself and my children. I am a Marylander, a parent of two children. Both of my children have needed special education. My daughter, Jessica, has attention deficit disorder, and my son Joshua has Angelman Syndrome. Children with Angelman Syndrome have significant disabilities.

Although I do not like to place labels on children, I will do so today so you get a better picture of what my son looks like. I would say the following labels would best describe my son: significant physical disabilities that include ataxic gait, profound mental retardation, a complex seizure disorder, non-verbal, a significant sleep disorder, as well as many other labels that would fit my son.

Additional labels that I would like to share about my son, is he is extremely friendly, he loves to be around people, he loves life. He likes nothing better than a good laugh. He is a young man, determined to make the most of what he can be. Joshua enjoys watching NASCAR races on television, he enjoys baseball, movies, friends, and school. Our vision for Joshua is to complete his education, even with the significant disabilities.

However, in order for our vision to become a reality, the educational system must include related services provided to Joshua in his home school among his peers.

Joshua receives, delivered in his home school, speech therapy provided by a speech pathologist, physical therapy, occupational therapy, assistance technology, and behavior management services, although sometimes I wonder whose behavior we are managing.

The related services needed to be a team decision. What has truly made these related services successful is the delivery of these services among his peers, and including his peers.

Joshua learned to walk at age 14. Some well-educated physicians told us early on that Joshua would never walk, never talk, he would sit, never take care of himself. Basically, these physicians gave us very little hope for our son. Yet, Joshua had enough sense not to listen to these predictions. I have said many times, Joshua never read the medical books.

Included in his middle schools, Joshua saw from his other peers their ability to walk. Joshua wanted to keep up with those peers. However, he needed the trained eye of a physical therapist to assist him in learning the difficult task of making his body function. You see, our world is filled with things such as curbs, a small step for you and I, but a mountain for Joshua.

Yet, Joshua did not get discouraged. He kept on trying to be part of those friends that he longed to run with. He achieved his goals with related services such as the physical therapy, and an aid to assist him in getting the practice he needed to successfully complete his first independent steps.

I ask you, Mr. Chairman and members, do you remember watching your children's first steps? I waited 14 years for those first steps. It is wonderful to see any child take first steps, but seeing my child, my son Joshua, doing this was nothing short of a miracle to me.

This came about not only by my son's determination, but by the related services delivered in his school. As I indicated, Joshua is also non-verbal. However, this does not mean he does not have anything to say. It just meant that we needed to find a way to be able to communicate his words in a different manner.

Through the use of assistive technology, Joshua now is able to have a voice. Through the use of a picture exchange system, he can make selections and choices. The picture exchange system is not a complex computer. It is, very simple, pictures that exchanges for his wants and needs. A picture of a banana gets Joshua the snack he desires.

This came through assistive technology specialists and speech pathologists working to include Joshua in places like the school lunch line, in classes that Joshua attends. Joshua probably at this very minute while we are here is in his home school learning how to use his Big Mac as a job-training tool. A Big Mac is not a hamburger, it is actually a small device that you can record a simple phrase on and Joshua presses it and he can relay his dreams.

Joshua is learning a job skill within his home high school. You see, I do have a vision for my son. It does not include becoming dependent on a system to totally care for him for the rest of his life. I see that, with the related services he receives within the school system, he will become independent of the Social Security system some day, that he will have a job, a life, contribute to his community.

Yes, my son will always need supports, but he does have skills and he can learn. He will learn these skills only if the related Medicaid services through the related services in the school system are provided.

We must be assured that related services paid by Medicaid through our school systems are maintained. Schools must assure the services in accordance with the child's individual education

plan, the IEP, are delivered. Without related services, we are taking away the opportunity for children with disabilities to become productive and successful adults.

I believe this to be true for every child with disabilities, even with the most significant disabilities such as Joshua.

I heard earlier in the morning panel about the complex reimbursement system. I would urge you to fix this, but while you are fixing this, remember, you are talking about our children. These are the true people that benefit from these services. I also urge you to protect them.

I have also included in my testimony principles that the disability community supports as you do fix this problem. Thank you.

[The prepared statement of Ms. Golden appears in the appendix.]

The CHAIRMAN. Thank you, Ms. Golden, for sharing with us a very, very moving story. Of course, the purpose of this program is to help ensure that children such as yours have the kind of care and medical assistance that they need.

Ms. GOLDEN. Thank you.

The CHAIRMAN. That is the whole purpose of this hearing, is to try to assure that that will be the case in the future, and the funds are used for that purpose.

Mr. Davenport, let me ask you. Is your school or your organization paid on a contingency fee basis?

Mr. DAVENPORT. On some contracts we are, some we are just on a straight fee basis.

The CHAIRMAN. Let me ask you, how do you respond to GAO's position that consultants do have a conflict of interest when paid on a contingency fee?

Mr. DAVENPORT. Well, in terms of, the incentive is to go in, appropriately, for dollars? I think that it depends on the firm. Contingencies are a vehicle to reimburse for schools that have difficulty in terms of otherwise providing. But I do not think it is a conflict.

I think if the vendor comes in to the project and presents that it is aware of the potential exposures and says it is going to protect itself and the State on those issues in terms of time limits, caps, and such, and if the State or the school responds appropriately, I think you have addressed the conflict. I think that we are aware of the potential for a conflict. We try to address it in our contracts and the way we conduct ourselves.

The CHAIRMAN. Well, I have to say that the experience of the Federal Government in many areas, not only in health but in military, have found that contingency fees are abusive, that they do not represent the best interests of the government.

Let me ask you this. What do your contracts with school districts stipulate in the event that Medicaid reimbursement received by the school is later found to be inappropriate and disallowed?

Mr. DAVENPORT. All of our contracts have a clause that, if there is ever a disallowance, we have an obligation to work, at our cost, to whatever it takes, with the school to address that issue. If a disallowance should ever become an audit finding—it never has—then we would have to pay back to the school any dollars that we recovered. That is what our contracts say.

I mentioned before, we try to avoid that in every instance we can by working with the State and HCFA up front to get agreement on

everything we are going to do, so we are trying to make sure that we and they are not surprising one another over the course of the project.

The CHAIRMAN. Let me ask you a question, Dr. Sclafani. In your opinion, what is the most important thing HCFA could do to address the issues of improper payments raised here today so that Medicaid's role in the schools can be sustained in the long run?

Dr. SCLAFANI. I think that our experience in Texas has proved that, if HCFA will work with the local school districts in designing the programs, then everyone is clear up front.

Now, obviously they cannot work with 15,000 school districts across America, but they can put in their guidelines clear and consistent rules so that everyone knows what the design ought to be, what outcomes are required, and what processes will be used to determine whether those are the appropriate services for which to be reimbursed. So, I think that the guidance from HCFA is absolutely critical.

The CHAIRMAN. But you do not find the current guidelines that clear?

Dr. SCLAFANI. The proposed guidelines really are the first guidance that has been published for school districts. In the past, we have worked, as I mentioned, with our regional HCFA office in ascertaining exactly what services can be provided, should not be submitted, for reimbursement.

But this guidance, at first reading, appears, as you pointed out in your earlier panel, to be a very negative guide that simply talks about what you cannot do rather than providing opportunities to say what school districts ought to be doing. We would rather have it clearly spelled out what we ought to be submitting reimbursements for, as well as some things to watch for.

Certainly it is helpful to receive guidance in those areas that they have found to be abused in the past so that people can be assured at the outset that they are designing those not to be included in their program, but positive guidance as to what ought to be done and how it ought to be done would help school districts, and certainly those with less expertise than our district, as a very large district, is able to develop within our own staff.

The CHAIRMAN. In other words, it is not either/or.

Dr. SCLAFANI. It is not either/or, no.

The CHAIRMAN. But basically it would be helpful to lay out what you can do.

Dr. SCLAFANI. Absolutely.

The CHAIRMAN. But also at the same time, make clear what abuses will not be tolerated.

Dr. SCLAFANI. Abuses to avoid. Yes. Yes. That would be very helpful.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Thank you, Mr. Chairman. What a fine panel, and how much we have learned.

We tried to think of the administrative problems that begin here in Washington. Dr. Sclafani, you said at first that you hoped that HCFA would work directly with school districts. But then I thought I heard you say that HCFA would provide guidelines as against having a direct relationship with at least 1,000 school districts.

Dr. SCLAFANI. In Texas. Absolutely. It is a regional office, which has to deal with not just Texas, but other States as well.

I think that, given that there are 16,000 school districts across America, that HCFA may not be able to provide direct assistance to them. They certainly can provide some technical assistance and have meetings and opportunities for people to come together with the HCFA personnel to clarify guidelines. But the guidelines are the first piece up front that would be most helpful.

Senator MOYNIHAN. Yes.

Mr. Davenport, you made, to me, a very impressive statement of what you do. It surely is important to keep the schools as close as possible to their primary function, which is schooling, and managing Federal programs is not, or if it becomes such, then something will be lost. You find you work with HCFA, and what is it you want, what should we say and tell people, and they are responsive?

Mr. DAVENPORT. Well, yes and no. By the way, the way we have gotten around the issue——

Senator MOYNIHAN. Yes. What about the no?

Mr. DAVENPORT. I am sorry. The way we have gotten around the issue working with the schools, some of our projects in Maine, Kansas, and other States, we were first working with the schools in total, and working with the State Department of Education and Human Services.

So that allowed us to recommend to the State that we all need to go to HCFA first to work out the specifics of the program. It becomes more difficult if you are trying to go on behalf of 1,000 school districts. So, that is how our contact with HCFA started.

It has been a mixed bag with HCFA. It has worked best when everybody works together at the beginning, kind of in a work-around-the-table process, and works out the details. That has worked very well in a number of States.

What happened when this whole change in the bundled rate regulations came down, what HCFA stopped doing, was they stopped talking to schools, to States, because the answer was, we are waiting for new regulations to be formulated.

So what happened was, everything was kind of in limbo for a period of time. For example, I agree with the Doctor, when the letter came out that said bundled rates are no longer appropriate, what we and other States were asking was, give us an opportunity to sit with you to think of, what is the option, what is the alternative. We are still kind of waiting for that in a couple of States.

So we have gone ahead and tried to develop what we think is a fee-for-service system that will meet HCFA criteria, but we are kind of moving in the dark a little bit. What happens is, the States and the schools are a little bit reluctant to go forward because nobody is exactly sure, have we guessed right.

So if there is a way to get communication and conversation, we are not looking for "our" answer, we are just looking to try to be a participant in getting a good answer that everybody agrees with.

Senator MOYNIHAN. Is this now, this interregnum, if you like, closing out with the proposed guidelines? Mr. Westmoreland said that he had published them now.

Mr. DAVENPORT. I think that would be very helpful. His comment about, the devil is in the details, is really correct.

Senator MOYNIHAN. Yes.

Mr. DAVENPORT. Because fee-for-service systems, bundled rate systems, they can all be good or bad, it all depends on how they are constructed and how they work. The details are painful to figure out, but that is where this has to be fought out.

So I think the guidelines are a good first start, but a fee-for-service system can be many things. What exactly are we speaking about here? So if we can get conversations down to the details of a good fee-for-service system, then I think we can start to make real progress. I think it's moving in that direction, but it is not there yet.

Senator MOYNIHAN. Doctor?

Dr. SCLAFANI. If I might add something. What was said, was that, yes, the draft guidelines had been published, then information came in to them from a variety of organizations and school districts that have worked with it.

What we are hoping, and what has started, was that there would then be meetings with representatives of the education groups to talk through what guidance they received from all of the input and how they might best develop guidelines that would be clear to educators.

I think the educators are probably best able to help them understand what educators understand about the health care system and what might be good guidance to give them, and if we could have that opportunity.

Senator MOYNIHAN. It makes good sense. Will the HCFA persons in attendance take notes and see that Mr. Westmoreland hears that suggestion?

Dr. SCLAFANI. Thank you.

Senator MOYNIHAN. Ms. Golden, Maryland is one of the States that does not consider income in making available the sort of services that we have talked about, or Medicaid services. Have you found that it works well and that you have had——

Ms. GOLDEN. Actually, Maryland does consider income at this point.

Senator MOYNIHAN. It does?

Ms. GOLDEN. Yes. But Joshua is a Medicaid recipient, and that was one of the issues. The way he became a Medicaid recipient—and this is a whole different subject—was we had to make the heart-wrenching decision to place him out of our home in order to get that Medicaid. Because without that Medicaid, we were devastated financially, physically, emotionally.

Senator MOYNIHAN. Sure.

Ms. GOLDEN. We have changed that slowly in Maryland, and we hope, through improvements in the Federal regulations, as well as Federal laws, so that all children with significant disabilities, or disabilities in general, can get that Medicaid that they need.

Senator MOYNIHAN. Well, I would hope that the National Parent Network on Disabilities would keep the committee in touch with how that is going.

Ms. GOLDEN. I will certainly do that.

Senator MOYNIHAN. If it is not going well, tell us.

Ms. GOLDEN. Well, we need your support.
Senator MOYNIHAN. I am sure you will have it.
Ms. GOLDEN. All right. Thank you.
Senator MOYNIHAN. And thank you all.
Thank you, Mr. Chairman.
The CHAIRMAN. Senator Graham?
Senator GRAHAM. Thank you, Mr. Chairman.

I would like to make, if I could, three preliminary comments before asking questions. First, concerning why the regulations were so delayed in being issued, perhaps that delay may also stem from the absence of dialogue in the development of those regulations, which contributed to confusion that has led to some of the problems we have heard about today.

I might say I am dealing with a similar issue now involving another Federal agency, where Congress passed legislation in 1997, and similar legislation in 1998, which had a terminal date of March 31, 2000.

The regulations to implement the legislation were not issued until March 24, 2000, giving the applicants a week to know what the rules were to apply. I hope that Congress will soon move that application date back to give people a reasonable chance to be able to participate.

A conclusion that I am reaching, is that maybe in the formulation of legislation Congress needs to establish some dates by which the executive agency charged with implementing the proposal produce the guidelines, rules, and regulations under which the program is going to be administered so we do not continue to have a repetition of what we have heard today and the experience that I just recounted.

Second, I believe very strongly in the principle of health care delivered through a school site. My definition of a school is a physical place in which a variety of activities that contribute to the development of children and their families occurs, with education being the principal activity.

If you accept that definition, certainly health care would be one of the appropriate secondary activities to occur because of its central importance to the development of children and their families.

Senator MOYNIHAN. Will the Senator from Florida allow me to say, from watching the evening news, I would have thought basketball was the first activity, then education.

Senator GRAHAM. It is obvious from the result of Monday night's game that it has not been quite sufficient in my State. [Laughter.] So I am a strong supporter of what you are doing as part of that broader role of the school as a site for the delivery of a variety of services that are important to the children.

Third, I am also a strong, I hope, spear-carrier against fraud and abuse against Medicare, Medicaid, and other government-financed health care programs. But I get the sense that what we are dealing with here is a case in which possibly a few aberrant instances are becoming the definition of what the whole program is, and to use the old cliché, we are about to throw the baby out with the bath water.

So with those three comments, I would like to ask, what do you think we in the Congress or HCFA, administratively, should do in

order to sort out the actions which have created this sense of rampant fraud and abuse in the school-based Medicaid program so that the fundamental good that this program can and will do in the future can be continued?

Dr. SCLAFANI. I believe that HCFA needs to work with school districts, school district organizations, organizations of families of disabled children as well, to ensure that they full understand that, indeed, our prime effort is education, but that these services are absolutely required if many of the children are to receive an education.

I think that you just heard an eloquent description of how this education process can change lives of children who otherwise in the past we might have given up on.

I think that if we can continue the dialogue and not just make it written testimony going into HCFA in response to their guidelines, but an ongoing dialogue to not only set up guidelines in the first place, but then to alert the education community if there are things happening that they consider to be abusive, so that everyone becomes aware of those and can redefine their program so that those things do not occur.

The educators that are providing these services are saints, in my estimation. When we see the patience and the love with which they serve children and the physical activities that they engage in so that these children can be educated, then you can clearly see, these are not people trying to engage in fraud or abuse, they are trying to provide services for children. School districts are trying to do their best to comply with regulations that are very different from those that they are used to dealing with.

So I believe, as all of us have said, that we have got to have a continued dialogue. If this committee can continue to ask whether that dialogue, indeed, is occurring, it would be very helpful so that HCFA understands that you intend them to come up with a system that continues to serve children well, and at the same time is one that protects the dollars that Congress has allocated to this service for the children it is meant to serve.

The CHAIRMAN. Thank you.

Ms. GOLDEN. I have another thought. Actually, one of the principles I included with my testimony is that school districts need clear guidance and direction and technical assistance from the U.S. Department of Education, and the Health Care Financing Administration on how to access the Medicaid appropriately, including how to develop inter-agency connections and make that flow a little bit easier.

Mr. DAVENPORT. I would add the same thing. I think the gentleman's comments from HCFA this morning, the devil is in the details, is correct. Each of the things we have talked about today can be abused, fee-for-service systems, bundled rate systems, administrative claiming, contingency contracts, non-contingency contracts, programs administered by schools, programs where consultants participate. So the question is, how do they get down below that and really look at the specifics?

Any encouragement you can give to HCFA to start taking on the details is important in terms of participative processes, time for completing those processes, promptness in terms of working with

the States and schools to reach decisions, trying to be open in those processes, to be not arbitrary, but to seek opinion and to work with those who have opinions and try to reach resolution.

I think you will find that nobody is out there trying to push their opinion, they are just looking for an opportunity to reflect their opinion and their experience. So I think that would be really helpful, if that could happen.

Senator GRAHAM. Thank you.

The CHAIRMAN. I want to thank the panel for their very excellent testimony. I have to say, I continue to be bothered by what should be a relatively clear-cut matter, that is, providing good medical care for those in need is so complex, that nobody understands how to work their way through the system. Somehow, there has to be a way of simplification.

I just want to express my appreciation to each of you for being here today.

The committee is in recess.

[Whereupon, at 12:15 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

United States General Accounting Office

GAO

Testimony

Before the Committee on Finance, U.S. Senate

For Release on Delivery
Expected at 10:00 a.m.
Wednesday, April 5, 2000

MEDICAID IN SCHOOLS

Poor Oversight and Improper Payments Compromise Potential Benefit

Statement of Kathryn G. Allen, Associate Director, Health Financing and Public Health Issues, and Robert H. Hast, Acting Comptroller General for Special Investigations

Medicaid in Schools: Poor Oversight and Improper Payments Compromise Potential Benefit

Mr. Chairman and Members of the Committee:

We are pleased to be here today as you address the issue of Medicaid expenditures for school-based health services and administrative costs. Because Medicaid is a federal-state partnership, the federal government is responsible for paying a share of costs incurred by the states to serve Medicaid's 41 million low-income beneficiaries, including 13 million school-aged children. Medicaid helps finance certain health services that eligible children, including those with disabilities, receive in schools, such as diagnostic screening and physical therapy. Medicaid is also authorized to reimburse schools' costs for performing certain administrative activities, such as conducting outreach to help enroll children in Medicaid and providing referrals to qualified providers.

In June 1999, we testified before your Committee about multimillion-dollar increases in Medicaid reimbursements for administrative activities in 10 states and the need for more federal and state oversight of these growing expenditures.[1] At that time, we found that weak and inconsistent control over the review and approval of claims for school-based administrative activities created an environment in which inappropriate claims could result in excessive Medicaid reimbursements. You subsequently asked us to expand our analysis of Medicaid reimbursement of school-based administrative activities and to examine states' use of "bundled" rates for school-based health services.[2] Our remarks are based on our report being issued today and will focus on (1) the magnitude of states' claims for school-based health services and administrative activities, (2) the appropriateness of the methods used to determine how much Medicaid pays for these services, (3) the extent to which school districts directly benefit from federal Medicaid reimbursements, and (4) the adequacy of the Health Care Financing Administration's (HCFA) oversight of school-based claims.[3]

Our findings are based on a survey of all 50 states and the District of Columbia; work in 7 states that HCFA identified as paying for health

[1]See *Medicaid: Questionable Practices Boost Federal Payments for School-Based Services* (GAO/T-HEHS-99-148, June 17, 1999).

[2]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.

[3]See *Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight* (GAO/HEHS/OSI-00-00, Apr. 5, 2000).

services using a bundled, rather than a fee-for-service, approach; and work in 17 states we identified as submitting claims for administrative activities. We also conducted investigative work in two states where we identified abusive or potentially fraudulent practices associated with claims for administrative activities or fee-for-service health payments.

In summary, despite growing expenditures for school-based Medicaid services and activities, the potential benefits to schools and the children they serve are being compromised by poor HCFA guidance and oversight and by improper payments that divert public funding from its intended purpose. In total, 47 states and the District of Columbia have reported $2.3 billion in Medicaid expenditures for school-based activities for the latest year for which they have data. Although this spending level reflects a small share of total Medicaid expenditures, more schools are expressing interest in availing themselves of Medicaid as a source of funds, especially to reimburse administrative activities, which creates the potential for continuing expenditure growth.

Payment for covered services for Medicaid-eligible children is not at issue. But methods used by some school districts and states to claim Medicaid reimbursement for school-based services lack sufficient controls to ensure that these are legitimate claims. For example:

- Bundled payment methods that seven states use to pay for 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. HCFA last year banned the use of bundled rates because of concerns about their development and use. However, we believe that it would be better for HCFA to work with states and schools to build in these missing assurances rather than to ban the use of bundled rates altogether.

- Poor guidance and oversight have resulted in improper payments in at least 2 of the 17 states that allowed schools to submit claims for administrative activities costs. Our work in Michigan alone identified $28 million in federal reimbursement for improper payments for administrative activity claims over 2 recent years. The lack of effective controls in other states could allow comparable improprieties to occur elsewhere.

Despite the significant level of Medicaid payments for school-based services in some states, school districts may receive little in direct reimbursements because of certain funding arrangements among schools, states, and private firms contracting with them. Seven states retain from

50 to 85 percent of federal reimbursement for Medicaid school-based claims. In addition, some school districts may pay private firms up to 25 percent of their federal Medicaid reimbursement. These firms often help schools develop claiming methodologies, train school personnel to apply these methods, and submit the claims for reimbursement. As a result of these arrangements, schools may end up with as little as $7.50 for every $100 claimed. These funding arrangements can create reduced incentives for appropriate program oversight and an environment for opportunism that drains funds away from their intended purposes.

HCFA has historically provided little or inconsistent direction and oversight of Medicaid reimbursements for school-based claims, which has contributed to the problems we have identified. For example, some HCFA regional offices allowed payments to be made without approving the methods proposed by some states to claim reimbursement for administrative activities. HCFA has recently focused more attention on these issues by reviewing the claims for school-based administrative activities by at least one regional office and developing a draft school-based administrative claiming guide. However, states are still awaiting further guidance on bundled rates and allowable transportation costs for children with special needs.

We are making recommendations to the Administrator of HCFA aimed at improving the development and consistent use of clear policies and appropriate oversight for school-based Medicaid services. HCFA generally has agreed with our findings and is already taking steps to respond to these recommendations. We are also making referrals to the U.S. Attorney's Offices for those instances in which we have uncovered evidence of inappropriate and potentially fraudulent claims.

Background

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 were school-aged children. States operate their programs within broad federal requirements and can elect to cover a range of optional populations and benefits. Medicaid costs shared by the federal government and the states fall under one of two categories: medical assistance (or "health services") and administrative activities. Each state program's federal and state funding shares of health services payments are determined through a statutory matching formula. Under this formula, the federal share ranges from 50 to 83 percent, depending on a state's per capita income in relationship to the national average. The federal share of costs for administrative activities varies by the type of costs incurred, but most administrative costs are shared equally between

the federal government and the individual state.[4] Over 95 percent of Medicaid's $177 billion in total expenditures in fiscal year 1998 was spent on health services.

Schools can help identify, enroll, and provide Medicaid services to eligible low-income children, 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 Medicaid-eligible children under the Individuals With Disabilities Education Act (IDEA). In particular, IDEA obligates schools to identify and provide the "related services" that are required to help a child with a disability benefit from special education, including transportation, speech therapy, and physical and occupational therapy. Because some services required to address the specific needs of a child with a disability are health-related, Medicaid is an attractive option for funding health-related IDEA services for Medicaid-eligible children.

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 the state and must have a provider agreement with the state Medicaid agency. Payment rates are established by the state Medicaid agency and described in a state plan that is 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.

Until recently, states have been allowed to develop methods to create bundled payments for a specified group of services, which in most instances means a fixed payment for all services a child receives during a set period of time, such as a day or month. However, in a May 21, 1999, letter to state Medicaid directors, HCFA prohibited states' use of this approach, having 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 and directed states with

[4]Certain administrative expenditures are eligible for higher federal matching funds. For example, federal matching funds pay 90 percent of costs for the development of automated information systems and 75 percent of costs for some administrative activities performed by skilled professional medical personnel.

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, states with approved bundled rates continue to use them.

Schools may also receive reimbursement for the costs of performing administrative activities related to Medicaid, such as 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 the school district and (2) an acceptable reimbursement methodology for calculating allowable costs of administrative activities. States must abide by the cost allocation principles described in 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.

In August 1997, HCFA issued a technical assistance guide for Medicaid claims for school-based services that provides general guidelines regarding Medicaid reimbursement for the costs of school health services and administrative activities.[5] More recently, HCFA's May 21, 1999, letter to state Medicaid directors, in addition to addressing bundled rates, also attempted to clarify several policies, including payments for transportation for children with disabilities. The letter stated that HCFA was in the process of updating its guiding principles related to claims for school-based administrative activities costs. In February 2000, HCFA issued for comment a new draft technical assistance guide aimed at clarifying guidance for submitting school-based administrative claims.[6]

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

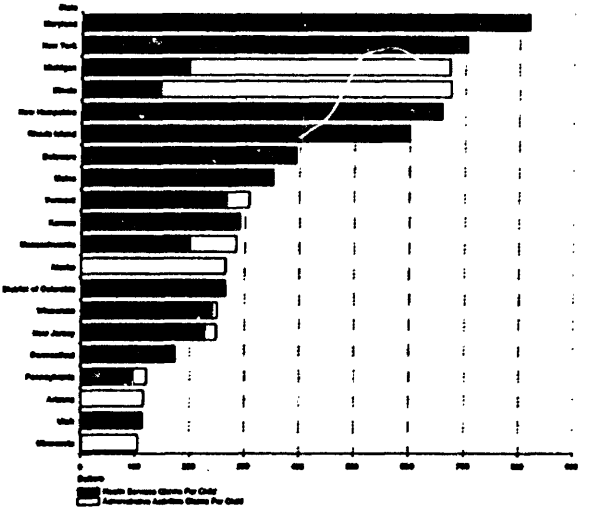
[6]See HCFA, *Medicaid School-based Administrative Claiming Guide* (Draft) (Washington, D.C.: HCFA, Feb. 2000). The guide can be accessed at http://www.hcfa.gov/medicaid/schools/maclmpg.htm.

Medicaid School-Based Activities Involve a Variety of Practices Across States

Schools in 47 states and the District of Columbia obtain Medicaid payment to some degree for school-based health services, administrative activities, or both. These payments totaled $2.3 billion for the latest year for which data were available.[7] Medicaid payments to schools ranged from a high of $820 per Medicaid-eligible child in Maryland to about 5 cents per Medicaid-eligible child in Mississippi. Figure 1 shows the 19 states, and the District of Columbia, with the highest average expenditures per Medicaid-eligible child for school-based services. (App. I provides more detail on school-based claims for all states.)

[7]States were asked to provide school-based claims data for the most recent fiscal year for which they were available, which for approximately half of 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.

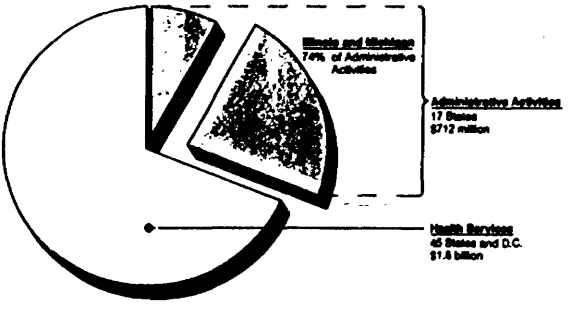
Figure 1: Highest Average Claims Per Medicaid-Eligible Child (18 States and the District of Columbia)



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

The majority of Medicaid payments—about $1.6 billion—were for health services provided by schools in 45 states and the District of Columbia, and about $712 million were for administrative activities billed by schools in 17 states. Although schools in 17 states submit claims for reimbursement of Medicaid-related administrative activities, 2 states—Michigan and Illinois—accounted for 74 percent of all school-based administrative activity payments. (See fig. 2.)

Figure 2: $2.3 Billion Claimed for School-Based Medicaid Reimbursement



Source: GAO survey of states.

The school-based administrative claims of a few states have grown rapidly and now constitute a significant share of these states' total administrative costs for all Medicaid program activities. For example, school-based claims represented 47 percent and 46 percent of total Medicaid administrative claims for Michigan and Illinois, respectively. Other states—Alaska, Arizona, and Washington—had school-based claims representing about 20 percent of their total Medicaid administrative expenditures. (See table 1.) Alaska, Illinois, Michigan, and Minnesota each showed average annual growth rates for school-based administrative expenditures that were at least twice as high as the growth rate of other Medicaid administrative expenditures .

Table 1: States' Medicaid School-Based Administrative Claims as a Percentage of Total Medicaid Administrative Expenditures

State	School-based Medicaid administrative claims (in thousands)	Total Medicaid administrative expenditures (in thousands)[a]	Percentage of total administrative expenditures
Michigan	$224,167	$477,136	47
Illinois	302,687	661,188	46
Arizona	25,795	131,577	20
Washington[b]	18,394	91,745	20
Alaska	7,780	40,662	19
New Mexico	4,909	32,078	15
Florida	36,451	289,625	13
Minnesota	23,495	209,412	11
Massachusetts[c]	19,500	190,869	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	138,556	1
California	288	1,227,657	Less than .02

Note: States provided administrative claims data for school-based services from the most recent fiscal year for which data were available. Most states provided data from the year ending June 30, 1999, while 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–June 30, 1998).

[a]States provided total Medicaid administrative expenditures for the same period as for the school-based administrative claims data.

[b]Washington provided school-based administrative claims data for the year ending August 31, 1999, and total Medicaid administrative expenditures for federal fiscal year 1999 (October 1, 1998–September 30, 1999).

[c]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.

Certain Methods Used to Claim Medicaid Reimbursement Lack Sufficient Controls

Some methods used to claim Medicaid reimbursement do not adequately ensure that health services are provided or that administrative activity costs are properly identified and reimbursed. Bundled payment methods used to claim Medicaid reimbursement may lack sufficient controls to ensure that health services paid for are actually provided and may not differentiate levels of need among children. In addition, our investigation of fee-for-service payments for health services in one state also identified inappropriate practices that resulted in improper payments by Medicaid. Similarly, poor controls over what constitutes an allowable administrative activity have resulted in millions of dollars of improper Medicaid reimbursements.

Some States' Bundled Payment Methods for Health Services Lack Sufficient Accountability

Bundled payments are somewhat comparable to capitation payments in a managed care setting, in that 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.[8] HCFA began to allow states to develop bundled payment approaches in an attempt to simplify schools' reporting requirements under Medicaid. When appropriately used, bundled rates can help limit Medicaid costs 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. In some cases, such a payment approach can also create an incentive for schools to change what services children receive or where they receive them to increase schools' reimbursement. The seven states that used bundled rate payments for health services account for 12 percent of total health services claims in schools. These states' rates vary in the extent to which they differentiate levels of need among children, ensure that services paid for are provided, or both. (See table 2.)

[8]Services included in the bundled rates are relatively similar among the seven states and typically include audiology; counseling; and physical, speech, and occupational therapy. One notable exception is transportation, the cost of which only four of the seven states include in their bundled rates.

Table 2: Approaches to School-Based Payments in Seven States Using Bundled Rates

State	Does the bundled rate vary depending on the needs of the child?[a]	What is the unit of payment for services?[a]	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–$836 per child	School attendance 1 day a month
Maine	Yes—13 statewide rates; vary by primary disability	Monthly rate—$141–$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–$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–$172 per child	Receipt of one service
Utah	No—school-specific rates	Daily rate—$21–$60 per child	School attendance
Vermont	Yes—four statewide rates; vary by number of services actually provided	Monthly rate—$162–$1,566 per child	Receipt of a specified number of services

[a]States may exclude certain services, such as development and evaluation of the individualized plan of a child with a disability; the receipt of Early and Periodic Screening, Diagnostic, and Treatment services; and provision of medical equipment, from their bundled rates and separately claim Medicaid reimbursement for these services.

[b]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.

States do not always adjust bundled rate payments for children with different medical needs. For example, Connecticut pays the same bundled rate to all participating schools for each eligible child, regardless of whether that child has a mild learning disability or multiple physical and cognitive disabilities. The single 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 Massachusetts and New Jersey, the payment levels vary depending on the location of the child, such as the classroom type or school in which a child is enrolled, and not necessarily on the number or scope of services provided. To a greater extent, the bundled rates in Kansas, Maine, and Vermont vary among children with different levels of need and are thus aligned more closely to the expected costs 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. 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.[9]

In addition, states' bundled approaches may not provide adequate assurance that services paid for are actually provided. Payments in 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 paid the bundled rate for each eligible child, irrespective of whether the child has received any services. Better assurances that services are actually provided to eligible children exist in Connecticut, New Jersey, and Vermont. Schools in Connecticut and New Jersey must document services provided to each child to obtain the full bundled payment. In Vermont, case managers complete for each child a level-of-care form that describes the amount and scope of services provided, which determines which one of four payment levels the school receives.

Investigation Identified Improper Fee-for-Service Health Claims

Our investigation into fee-for-service school-based health services identified certain examples of inappropriate health services claims. Our investigation of practices in one fee-for-service 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. Medicaid was also inappropriately billed for health services in two states, where some group therapy sessions were billed as individual therapy sessions, resulting in a higher payment for the schools.

[9]Schools are reimbursed a lower amount for children in level one, who receive fewer than 6 units of service a week, than for those in level three, who receive from 12 to 24 units of service a week. Vermont's approach also recognizes differences in the costs of services provided by aides and professionals. For example, 1 hour of individual therapy provided by a certified physical therapist is equal to three units of service, while an hour of therapy provided by an aide equals one unit.

For Administrative Activity Claims, Poor Controls Have Resulted in Improper Reimbursement

With regard to administrative activities, poor controls have resulted in improper payments in at least 2 of the 17 states that allowed schools to claim such costs, and the similar lack of effective controls in other states could allow comparable improprieties to occur.

- In Michigan, the HCFA Chicago regional office questioned $30 million in administrative claims for activities not clearly related to Medicaid, for the quarter ending September 1998. School staff interviewed by HCFA revealed that activities they performed, related to general health screenings, family communications, or training, had no Medicaid component or benefit, although a portion of staff time was claimed and reimbursed as such. The HCFA regional office subsequently deferred a $33 million claim made for the quarter ending September 1999, again asking the state to better document that the activities were clearly linked to Medicaid. We identified similar practices for submitting administrative claims in as many as seven other states.

- Our investigation and HCFA scrutiny of claims in Michigan and Illinois identified administrative cost claims, submitted and paid, for activities performed for the benefit of non-Medicaid-eligible children, including administrative costs related to health reviews and evaluations that specifically excluded Medicaid-eligible children for whom separate claims were submitted as direct services. Our work in Michigan alone identified $28 million in federal reimbursement for improper payments for administrative activity claims over 2 recent years.

- In Illinois and Michigan, on the advice of private firms, school districts have submitted claims that inadequately document the need to have skilled medical personnel involved in certain administrative activities. When such personnel are involved, the federal government reimburses schools 75 percent rather than 50 percent for the administrative activities they perform.[10] For recent school-based administrative activity claims in Illinois, activities performed by skilled medical personnel totaled $16.6 million, or 37 percent of the state's total claims, for one quarter for participating school districts.[11] In Michigan, this type of claim totaled $14

[10] In general, administrative activity claims based on professional credentials 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 knowledge and skills.

[11] For one school district, the claims were from the quarter ending December 1998; for all other school districts, the claims were from the quarter ending March 1999.

million, or 25 percent of its total administrative activity for all participating school districts, for the quarter ending September 1998.[12]

In Some States, Schools Receive a Small Portion of Medicaid Reimbursement

Funding arrangements among schools, states, and private firms can significantly reduce the amount of federal dollars that schools receive for Medicaid-related services and activities. As a result of these arrangements, a school can receive as little as $7.50 for every $100 it spends to pay for services and activities for Medicaid-eligible children. In addition, these arrangements may create adverse incentives for program oversight.

Rather than fully reimbursing schools for their Medicaid-related costs, eighteen states retain from 1 to 85 percent of federal Medicaid reimbursements (see table 3). According to several state officials, because states fund a portion of local education activities, Medicaid services provided by schools are partially funded by the state. Under 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 that the states fund. Moreover, we believe that such a practice severs the direct link between Medicaid payment and services delivered, increases the potential for the diversion of Medicaid funds to purposes other than those intended, and is inconsistent with the program's fundamental tenet that federal dollars are provided to match state or local dollars to provide services to eligible individuals.

[12]In these two states, overall skilled professional medical personnel claims for administrative expenditures have increased four- and fivefold since the states began paying for school-based administrative costs.

Table 3: Federal Medicaid Reimbursement Retained by States

State	Percentage of federal reimbursement retained: Health services	Administrative activities	Amount retained by state (in thousands)[a]
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[c]	50	0	3,122
Connecticut	40	[b]	4,443
Michigan	40	40	69,156
Wisconsin	40	40	10,749
Illinois[d]	10	10	8,391
New Mexico	5	5	314
Ohio	4	[b]	741
Utah	2	[b]	105
Colorado	2	[b]	50
Massachusetts	1	1	326
Minnesota	0	5	587
Total			$323,816

[a]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 from before July 1, 1997.

[b]This state does not claim reimbursement for this type of school-based activity.

[c]Washington 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.

[d]When 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.

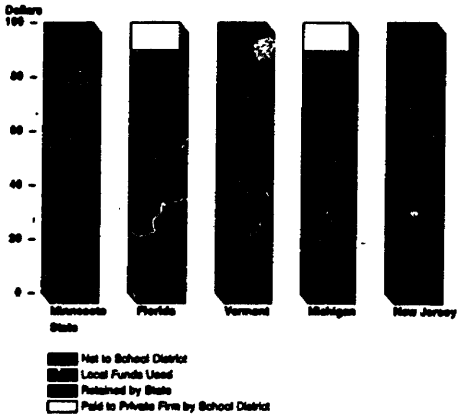
In addition, some school districts pay private firms fees ranging from 3 to 25 percent of the federal reimbursement amount claimed, with fees most commonly ranging from 9 to 12 percent. These firms are usually hired to assist with administrative cost claims, generally designing the methods used to make 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.

Finally, school districts' funds often are used to supply the state's share of Medicaid funding for school-based claims.[13] In these cases, the maximum additional funding that a school district can receive is what the federal government contributes. This is substantially less than what a private sector Medicaid provider would receive for delivering similar services. 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 in those states with equal matching between federal and state sources. Given the source of the states' share of funding, states' policies to retain portions of the federal reimbursement, and schools' contingency fee arrangements with private firms, the net amount of federal funds returned to a school district varies considerably. As shown in figure 3, a school district may receive as much as $100 in Minnesota to as little as $7.50 in New Jersey in federal Medicaid reimbursement for every $100 spent to pay for services and activities performed in support of Medicaid-eligible children.

[13]Local funding as the source of a state's share of Medicaid reimbursement is not unique to schools; it is most likely to exist when there are multiple governmental entities involved. For example, local funds are being used as a source of the state share of the cost of publicly funded hospitals and mental health services.

Figure 3: Some School Districts Receive Little Federal Medicaid Reimbursement



Note: For Illinois, when total payments to a 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. In Florida, effective February 14, 2000, contingency fee reimbursement contracts are prohibited for school districts.

Source: GAO analysis of state data.

In addition to affecting the payment a school ultimately receives, these funding arrangements may create adverse incentives for program oversight. Because states can benefit directly from higher federal payments, states' incentives to exercise strong oversight over the propriety of school-based claims can be diminished. Similar questions are raised about the incentives of private firms that are paid a share of schools' Medicaid reimbursement. 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.

HCFA Oversight Does Not Consistently Ensure the Appropriateness of School-Based Claims

While HCFA has made some recent efforts to improve oversight of Medicaid school-based claims, efforts to date have not consistently ensured the appropriateness of these claims. For example, 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. The work group that HCFA created to explore alternatives to bundled rates included representatives from the Department of Education and some states; this group is currently inactive, and all seven states that were using a bundled approach before HCFA's May 1999 letter continue to do so while they await further guidance.

With regard to administrative activity claims, some HCFA regional offices have had little or no involvement in the development of states' methodologies for developing administrative claims, while other regional offices have worked in concert with states to develop these methodologies. Moreover, contradictory policies exist across the regional offices regarding when states may obtain the 75-percent enhanced matching rate for skilled medical providers performing administrative services. We found that different regional offices (1) allow an enhanced match, (2) completely disallow the practice, or (3) specifically review the use of the enhanced match to ensure its appropriateness. Finally, HCFA's attempt to clarify its policy on specialized transportation has resulted in inconsistency and confusion. Only one of the seven regional offices that we spoke with correctly understood that Medicaid will cover transportation costs if a child is able to ride on a regular school bus but requires the assistance of an aide. Two regional offices incorrectly believed that such costs would not be reimbursed, while four did not know whether reimbursement would be allowed.

HCFA has taken some steps to improve oversight of school-based claims. One regional office recently conducted a review of one state's practices, identified cases of improper payments, issued deferrals of claims, and is now working with a few states to revise their practices to more accurately capture the costs associated with Medicaid administrative activities in schools. Guidance that HCFA testified in June 1999 would be forthcoming was released for public comment in February 2000.

Conclusions and Recommendations

Schools are a logical place to reach Medicaid-eligible children and their families—to inform them about and encourage their enrollment in the program and to provide assistance in accessing health services. But schools' primary mission is education, not health care delivery; thus, many schools may face difficulties in understanding and navigating the Medicaid program and obtaining reimbursement for services provided. Given the

potential benefits of Medicaid-financed school-based services—which ultimately support the children who need the care and services—it is important that schools not be dissuaded from pursuing this path because of unfamiliarity with Medicaid program requirements or uncertainty about what is permissible. Approaches to obtaining federal financing for covered services and activities must therefore appropriately balance schools' needs for administrative simplicity with providing an acceptable level of assurance that services and activities paid for were actually provided.

HCFA has a critical role in this process. It must set the proper course by providing consistent policy guidance and then facilitating its interpretation and implementation across the many states and school districts that are already participating in the Medicaid program or will in the future. HCFA generally agreed with our findings and is already taking steps to respond to the recommendations set forth in our report, which address the need to

- better ensure that bundled rates for health services provide for children's varying levels of need and that services paid for were provided,
- provide consistent guidance for and monitoring of allowable administrative activities, and
- clarify policy on allowable specialized transportation costs for children with disabilities.

HCFA also expressed its commitment to work with its partners in the education community and states to address these issues in a consistent yet flexible fashion to ensure that Medicaid dollars are used only on behalf of Medicaid-eligible children for Medicaid-covered services. At the same time, the states also have an important role in this program. They share with HCFA the fiduciary responsibility to administer the Medicaid program efficiently and effectively and must also be held accountable for safeguarding public dollars while providing services to which beneficiaries are entitled.

A program of the magnitude and diversity of Medicaid—with its broad range of program goals, policymakers, providers, and beneficiaries at the federal, state, and local levels—will always present demanding challenges in terms of finding the appropriate balance between state flexibility and public accountability. The emergence of these issues associated with school-based services is just the latest example of the need for constant vigilance to guard against potential exploitation that would divert limited resources from their intended purposes. We are committed to continuing

to work with this Committee and HCFA to help address these important issues.

Mr. Chairman, this concludes our prepared statement. We would be happy to answer any questions that you or Members of the Committee may have.

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, call Kathryn G. Allen at (202) 512-7118; for questions regarding our investigation, call Robert H. Hast at (202) 512-7455. Staff who made key contributions to this testimony include Carolyn L. Yocom, Susan T. Anthony, Connie Peebles Barrow, Laura Sutton Elsberg (Health, Education, and Human Services Division); William Hamel and Andrew A. O'Connell (Office of Special Investigations); Ray Bush and Paul D. Shoemaker (Atlanta Field Office); and Daniel Schwimer and Richard Burkard (Office of the General Counsel).

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

State	Average claim per Medicaid-eligible child	School-based claims (in thousands) Total claims	Health claims	Administrative claims
Maryland	$918	$93,824	$93,824	[1]
New York	703	682,000	682,000	[1]
Illinois	674	385,633	82,946	$302,687
Michigan	674	317,701	93,534	224,167
New Hampshire	658	24,894	24,894	[1]
Rhode Island	600	27,492	27,492	[1]
Delaware	394	13,800	13,800	[1]
Maine	350	22,000	22,000	[1]
Vermont	309	12,798	11,041	1,757
Kansas	291	25,741	25,741	[1]
Massachusetts[2]	284	65,250	45,750	19,500
Alaska	265	7,780	[1]	7,780
District of Columbia	263	12,100	12,100	[1]
Wisconsin[3]	249	45,804	44,312	1,501
New Jersey	248	68,328	60,671	5,657
Connecticut	174	22,218	22,218	[1]
Pennsylvania	121	68,507	54,555	13,952
Arizona	115	25,795	[1]	25,795
Utah	114	7,279	7,279	[1]
Minnesota	105	23,786	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	[1]
South Carolina	79	14,247	14,247	[1]
New Mexico	72	10,348	5,439	4,909
Ohio	66	31,853	31,853	[1]
Florida	50	41,518	3,087	38,451
Nebraska	50	3,916	3,916	[1]
Missouri	55	15,381	4,277	11,104
Iowa	52	5,255	4,171	1,084
Nevada	48	1,900	1,900	[1]
Arkansas	45	5,428	5,428	[1]
Colorado[4]	44	4,885	4,885	[1]
North Dakota	41	826	826	[1]
South Dakota	31	906	906	[1]
Montana	29	892	892	[1]
Louisiana	28	6,280	6,280	[1]
West Virginia	24	3,044	3,044	[1]
Georgia	21	9,167	9,167	[1]
Idaho[5]	20	781	781	[1]
California	19	42,308	42,020	288
Oklahoma	10	1,311	1,311	[1]
Kentucky	6	1,228	1,228	[1]
Virginia	5	1,291	1,291	[1]

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

State	Average claim per Medicaid-eligible child	School-based claims (in thousands) Total claims	Health claims	Administrative claims
North Carolina	2	722	722	[a]
Alabama	1	132	132	[a]
Indiana	[a]	60	60	[a]
Mississippi	[a]	6	6	[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 1998. 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.

[a]This state did not report school-based claims.

[b]Massachusetts provided 6 months of administrative claims data, which we extrapolated to reflect a full year of claims.

[c]Wisconsin's school-based health claims and administrative claims do not equal its total school-based claims because of rounding.

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

[e]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).

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United States General Accounting Office

GAO

Report to the Chairman and Ranking Minority Member, Committee on Finance, U.S. Senate

April 2000

MEDICAID IN SCHOOLS

Improper Payments Demand Improvements in HCFA Oversight

GAO/HEHS/OSI-00-69

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CONTENTS

ABBREVIATIONS

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

United States General Accounting Office
Washington, DC 20548

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.[1] 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.

[1]See Medicaid: Questionable Practices Boost Federal Payments for School-Based Services (GAO/T-HEHS-99-148, June 17, 1999).

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.[1] 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.

[1]States can cover transportation services either as administrative activities or as direct health services; thus, our selection of states covered both these methods of submitting Medicaid claims.

B-283378

RESULTS IN BRIEF

Nearly all states reported Medicaid expenditures for school-based activities, which totaled $2.3 billion for the latest year of available state data.[1] 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 6 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

[1]States were asked to provide school-based claims data for the most recent fiscal year for which they were available, which for approximately half of 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.

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.

BACKGROUND

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 two 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.[4] Over 95 percent of Medicaid's $177 billion in total expenditures in fiscal year 1998 was spent on health services.

Medicaid, IDEA, and School-Based 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).[5]

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 Medicare-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

[4]For example, federal matching funds pay 90 percent of costs for the development of automated information systems and 75 percent of costs for some activities performed by skilled professional medical personnel.

[5]IDEA, 20 U.S.C. 1400, covers public school children with disabilities and emphasizes special education; it also covers such related services as transportation, speech-language pathology and audiology, psychological services, physical and occupational therapy, and counseling.

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.[4] 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.

Medicaid Claims for 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.[5]

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

[4]EPSDT is a benefit that provides certain comprehensive treatment and preventive health care services for Medicaid-eligible children under age 21 if these services are medically necessary, regardless of whether they are covered under a state's Medicaid plan. Under the EPSDT benefit, states are required to conduct activities to inform individuals about EPSDT and to encourage their participation in the Medicaid program.

[5]Schools providing Medicaid services employ a variety of service delivery models, including directly employing health providers, making contractual arrangements with providers for specific services, operating fully equipped and staffed school health clinics, or some combination thereof.

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.

Medicaid Claims for 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.[4]

HCFA Guidance on Medicaid Reimbursement for School-Based Health Services

In August 1997, HCFA issued a technical assistance guide for Medicaid claims for school-based services.[5] 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

[4]Other relevant provisions of the Medicaid statute and regulations include sec. 1903(a) of the Social Security Act and implementing regulations at 42 C.F.R. 430.1 and 42 C.F.R. 431.15. In order for the costs of any administrative 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."

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

revised technical assistance guide on submitting school-based administrative activity claims.[9]

MEDICAID SCHOOL-BASED ACTIVITIES INVOLVE A VARIETY OF STATE 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.

The Extent of School-Based Claims Varies

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.)

[9]HCFA's draft guidance can be located on the Internet at http://www.hcfa.gov/medicaid/schools/machmpg.htm.

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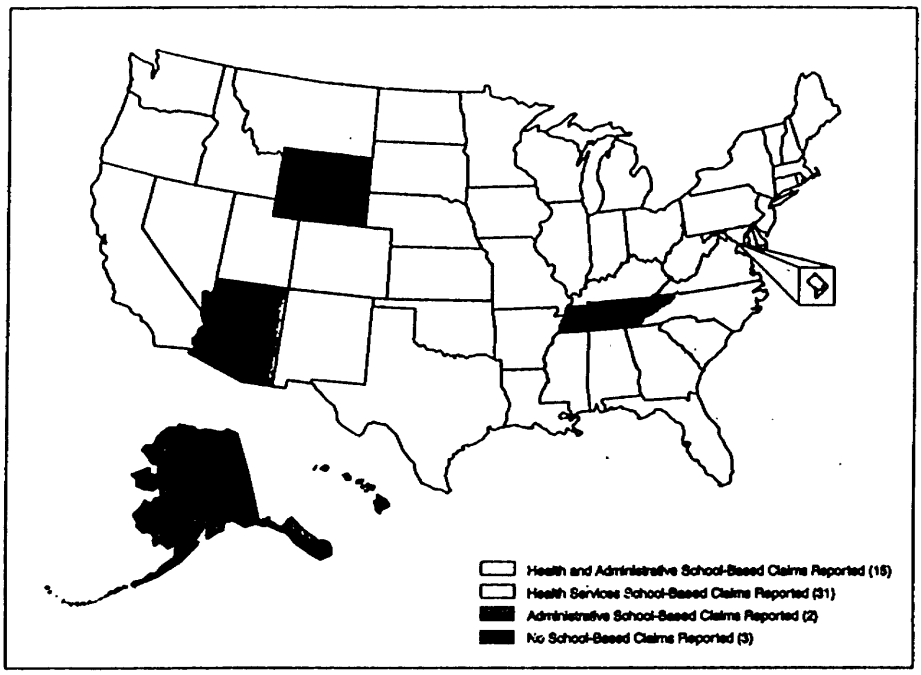
Figure 1: States Reporting Medicaid Claims for School-Based Services, December 1999



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

		School-based claims (in thousands)		
State	Average claim per Medicaid-eligible child	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[b]	284	65,250	45,750	19,500
Alaska	265	7,780	[a]	7,780
District of Columbia	266	12,100	12,100	[a]
Wisconsin[c]	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	116	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[d]	44	4,885	4,885	[a]
North Dakota	41	826	826	[a]
South Dakota	31	906	906	[a]
Montana	29	892	892	[a]

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Louisiana	26	6,269	6,269	[a]
West Virginia	24	3,044	3,044	[a]
Georgia	21	9,167	9,167	[a]
Idaho[d]	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	[a]	60	60	[a]
Mississippi	[a]	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.

[a]This state did not report school-based claims.

[b]Massachusetts provided 6 months of administrative claims data, which we extrapolated to reflect a full year of claims.

[c]Wisconsin's school-based health claims and administrative claims do not equal its total school-based claims because of rounding.

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

[e]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.[11] 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.

An Increasing Number of States Pay—or Are Considering Payment—for 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).[12] 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.

[11]In New York, schools actually claim targeted case management, which differs from case management in that states are allowed to waive certain Medicaid requirements. In other words, the state may target individuals by different criteria, such as age, degree of disability, illness, or condition.

[12]Ten of the 17 states that allow reimbursement for school-based administrative services were readily able to provide trend data: Alaska, California, Florida, Illinois, Massachusetts, Michigan, Minnesota, Missouri, Pennsylvania, and Texas.

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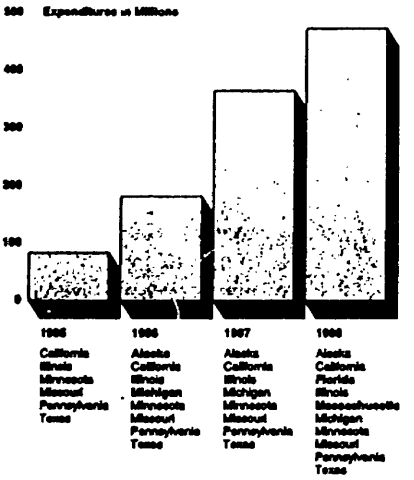
Figure 2: Medicaid School-Based Administrative Claims for 10 States, Fiscal Years 1995-98



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.[18] (See table 2.) Of those states

[18]As part of our survey on school-based services, states were asked whether they were considering submitting Medicaid claims for school-based administrative activities. States had the option of selecting "yes," "not sure," or "no."

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
Alabama	District of Columbia	Colorado
Arkansas	Hawaii	Connecticut
Georgia	Indiana	Delaware
Idaho	Maryland	Kentucky
Kansas	Mississippi	Louisiana
Nebraska	Montana	Maine
Nevada	Virginia	New Hampshire
North Carolina	(7)	New York
Ohio		North Dakota
Oklahoma		Rhode Island
Oregon		South Carolina
Utah		South Dakota
(12)		Tennessee
		West Virginia
		Wyoming
		(15)

Source: GAO survey of states.

School-Based Administrative Claims Represent a Significant Share of 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.[14]

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

State	School-based Medicaid administrative claims (in thousands)	Total Medicaid administrative expenditures (in thousands)[a]	Percentage of total administrative expenditures
Michigan	$224,167	$477,138	47
Illinois	302,687	661,188	46
Arizona	25,795	131,577	20
Washington[b]	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[c]	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—June 30, 1998).

[a]States provided total Medicaid administrative expenditures for the same period as for the school-based administrative claims data.

[b]Although Washington provided school-based administrative claims data for the year ending August 31,

[14]Of the 17 states that claim Medicaid reimbursement for school-based administrative costs, we examined administrative expenditures for the 8 states that could readily provide data for multiple years and compared the growth rates for school-based administrative expenditures against all of the 8 states' other Medicaid administrative expenditures. The eight states were Alaska, California, Illinois, Michigan, Minnesota, Missouri, Pennsylvania, and Texas. In Michigan and Minnesota, the base year for this calculation is the year the states began claiming school-based administrative activities and may not represent a full year of claims activity.

1999, total Medicaid administrative expenditures were provided for the closest year of data available, federal fiscal year 1999 (October 1, 1998—September 30, 1999).

[a]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.

METHODS USED TO CLAIM MEDICAID DO NOT ENSURE THAT SERVICES ARE 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.

Bundled Rates Simplified Claims and Were Expected to Limit Adverse 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.[a] 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

[a]These states are Connecticut, Kansas, Maine, Massachusetts, New Jersey, Utah, and Vermont. Although HCFA identified the District of Columbia and North Carolina as having bundled rates, we did not include these states in our analysis. We eliminated the District of Columbia from our discussion because it applies a bundled rate to only two schools; all other schools submit claims on a fee-for-service basis. We also excluded North Carolina, because all of its schools currently submit claims on a fee-for-service basis, although a number of schools had previously used a bundled approach.

during a specified period, such as a day or month." 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."

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

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

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

[b]Bundled rate payments can, however, provide an incentive to inappropriately decrease the volume of services provided.

Source: GAO analysis of payment incentives.

"Services included in the bundled rates are relatively similar among the seven states and typically include audiology; counseling; and physical, speech, and occupational therapy. One notable exception is transportation, the cost of which only four of the seven states include in their bundled rates.

"See Medicaid and Special Education: Coordination of Services for Children With Disabilities Is Evolving (GAO/HEHS-00-20, Dec. 10, 1999).

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Some States' Bundled Payment Methods Lack Sufficient Accountability

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 6).

Table 6: Approaches to School-Based Payments in Seven States Using Bundled Rates

State	Does the bundled rate vary depending on the needs of the child?[a]	What is the unit of payment for services?[a]	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–$636 per child	School attendance 1 day a month
Maine	Yes—13 statewide rates; vary by primary disability	Monthly rate—$141–$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–$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–$172 per child	Receipt of one service
Utah	No—school-specific rates	Daily rate—$21–$60 per child	School attendance
Vermont	Yes—four statewide rates; vary by number of services actually provided	Monthly rate—$162–$1,598 per child	Receipt of a specified number of services

[a]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.

[b]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.[a]

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.[b]

[a]New Jersey pays schools according to four categories: in-district school, out-of-district school, nonpublic school, and state facility.

[b]Thus, schools are reimbursed a lower amount for children in level one, who receive fewer than 6 units of service a week, than for those in level three, who receive from 12 to 24 units of service a week. Vermont's approach also recognizes differences in the costs of services provided by aides and professionals. For example, 1 hour of individual therapy provided by a certified physical therapist is equal to three units of service, while an hour of therapy provided by an aide equals one unit.

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.

Poor Controls Have Resulted in Improper Reimbursement for 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.[20] 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.[21] 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

[20]Of the 17 states that reimburse for administrative costs in schools, school districts in 4—Alaska, California, Vermont, and Wisconsin—do not include indirect costs in their claims.

[21]In a few instances, school personnel may be completely allocated to Medicaid administrative activities. For example, schools may employ "Medicaid clerks," whose primary function is to provide the administrative support necessary for schools to submit Medicaid claims to the state.

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.[a] 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.[b] 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.[c]

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 60 percent.

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[a]For representative period time studies, participants record all their activities in 15-minute increments for a given period of time, typically 1 week. For random moment time studies, participants record their activities for randomly selected moments in a specified period of time, such as a federal fiscal quarter. In contrast, the continuous log approach requires specified service providers to track how their time is spent on an ongoing basis.

[b]Five states—Florida, Illinois, Iowa, Missouri, and Washington—allow more than one type of time study methodology.

[c]The remaining six states that use a representative period time study specify that the time period must be randomly selected. Minnesota and Vermont, the two states that do not allow representative period time studies, use random moment and continuous log studies, respectively.

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.[8] 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

[8]School personnel completing an administrative claim time study allocate their time to different categories, or activity codes, depending on the activities performed in a given period of time. Activity codes are generally not limited to Medicaid-reimbursable activities and may include codes for educational activities and general administration.

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 allo· ' 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.[a] 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 diffe·.·.tiate 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 c >sts, 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

[a]For example, Medicaid-related activities might be one component of a code that is widely used in education, such as staff training. Under these circumstances, non-Medicaid activities could constitute a disproportionate share of the total costs in one activity code, even if the code was subsequently allocated between Medicaid and non-Medicaid costs. A more appropriate approach for assigning costs would be to establish two activity codes for training—one that identified all Medicaid-related training and one that identified all other training.

credential was necessary for a particular activity, and that no further documentation or proof was needed for the enhanced Medicaid reimbursement.[27] Recent SPMP claims in Illinois totaled $16.6 million, or 37 percent of its total claims, for one quarter for participating school districts.[28] 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.[29]

STATES' RETENTION OF FEDERAL REIMBURSEMENT —AND CONTINGENCY FEES 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.

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[27]HCFA regulations state that federal reimbursement rates in excess of 50 percent should apply only to those portions of the individual's work time that are spent carrying out duties in the specified areas for which the higher rate is authorized. The regulations further state that the allocation of personnel and staff costs must be based on either the actual percentages of time spent carrying out duties in the specified areas or another methodology approved by HCFA. See 42 C.F.R. 432.50(c)(2), (3).

[28]The time period of the claims for one group of school districts was the quarter ending December 1998, and the time period for the remaining school districts' claims was the quarter ending March 1999.

[29]In these two states, overall SPMP claims for administrative expenditures have increased four- and fivefold since the states began paying for school-based administrative costs. With the exception of Iowa, whose claims for SPMP activities increased twelvefold from 1994 to 1998, other states that submitted administrative claims prior to 1998 had much lower increases. We excluded California from our analysis because it reported significantly less than $1 million in school-based administrative claims ($286,000).

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States' Ability to Retain Federal Medicaid Funds May Weaken 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)[a]
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[c]	50	0	3,122
Connecticut	40	[b]	4,443
Michigan	40	40	69,156
Wisconsin	40	40	10,749
Illinois[d]	10	10	6,391
New Mexico	5	5	314
Ohio	4	[b]	741
Utah	2	[b]	105
Colorado	2	[b]	50
Massachusetts	1	1	326

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Minnesota	0	5	587
Total			$323,516

[a]States provided school-based claims data for the most recent fiscal year for which they were available, which for approximately half of 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.

[b]This state does not claim reimbursement for this type of school-based activity.

[c]Washington 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.

[d]When 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.

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Contingency Fees Paid to Private Firms May Encourage Questionable 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.[40] 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.[41] 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.[42] 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 dollars for a 5-year period.

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[40]Of the six states we visited, only Vermont did not reimburse a private firm on a contingency basis. Instead, to develop its bundled approach, Vermont used a firm that had been under contract with the state for several years and was paid on a fixed-fee basis.

[41]See 45 C.F.R. secs. 74.1(3), 74.27, 92.22.

[42]See attachment B to OMB Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments (Washington, D.C.: OMB, revised 5/4/95, as further amended 8/29/97).

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In Some States, Schools Receive a Small Portion of Medicaid 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.[33] 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.[34] 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.[35]

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.

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[33]Local funding as the source of a state's share of Medicaid reimbursement is not unique to schools; it is most likely to exist when there are multiple governmental entities involved in the delivery of Medicaid health services or administrative activities. For example, local funds are being used as a source of the state share of the cost of publicly funded hospitals and mental health services.

[34]This example assumes a 50-percent matching rate and that the claim submitted is a legitimate statement of health services or administrative activities performed in support of the Medicaid program.

[35]Because the District of Columbia does not distinguish between state and local funds, we excluded it from this analysis.

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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[a]	(44.18)	(50.00)	(38.03)	(47.28)	(50.00)	0
Amount retained by state[b]	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[e]	(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**

[a]This 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.

[b]The amount retained by the state is deducted from the federal reimbursement.

[c]Illinois retains a 10-percent share only for those school districts with claims that exceed $1 million in a year.

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

[e]Private 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.

[f]Effective February 14, 2000, contingency fee reimbursement contracts are prohibited for school districts in Florida.

[g]The state of New Jersey pays the firm $2.55 from the $4.50 it retains.

[h]Minnesota 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.

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HCFA OVERSIGHT DOES NOT ENSURE THE APPROPRIATENESS OF SCHOOL-BASED 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.[8] 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.

Without Additional Direction From HCFA, Alternatives to Bundled Rate 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.[9] 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

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[8]See app. I for the full text of the HCFA letter issued on May 21, 1999. The letter addressed three areas. First, HCFA directed that bundled rates for school-based health services that were previously evaluated and approved by HCFA would no longer be acceptable for purposes of submitting a Medicaid claim. Second, HCFA stated that it was conducting a review of practices to develop administrative cost claims and that it expected to publish a guide in the summer 1999 to clarify the requirements for submitting claims for Medicaid administrative activities in schools. Finally, HCFA informed states that children with special education needs who ride the regular school bus to school with children without disabilities should not have transportation listed as part of their individualized plan and that the cost of that bus ride should not be billed to Medicaid.

[9]HCFA raised concerns that bundled rates could not be connected to a specific type of procedure and were not available to other community providers. Also, the agency said that schools did not maintain sufficient documentation to establish the reasonableness of the bundled rates, and, thus, Medicaid could be overpaying for certain services.

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.

Inconsistencies in HCFA Oversight of Administrative Claims Continue

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.

HCFA's Attempt to Clarify Its Special Transportation Policy Raises 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.[34]

CONCLUSIONS

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

[34]IDEA requires that, to the maximum extent possible, children with disabilities be educated with children without disabilities and that special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occur only when the nature or severity of the disability of a child is such that education in regular classes with the use of supplementary aides and services cannot be achieved satisfactorily. See 20 U.S.C. 1412(a)(5)(A).

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.

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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 assure the appropriate use of Medicaid funds.

RECOMMENDATIONS TO THE ADMINISTRATOR OF HCFA

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.

AGENCY AND STATE COMMENTS

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.

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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
Acting Assistant Comptroller General
Office of Special Investigations

APPENDIX I APPENDIX I

HEALTH CARE FINANCING ADMINISTRATION LETTER

DATED MAY 21, 1999

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

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

May 21, 1999

Dear State Medicaid Director:

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

Bundled Rates for School-Based Services

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

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

Page 2 - State Medicaid Director

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

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

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

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

Page 3 - State Medicaid Director

Transportation

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

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

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

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

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

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

Page 4 - State Medicaid Director

Administrative Claiming for School-Based Services

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

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

Sincerely,

/s/

Sally K. Richardson
Director

cc:

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

COMMENTS FROM THE HEALTH CARE FINANCING ADMINISTRATION

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

Washington D.C. 20201 - 0001

DATE: MAR 29 2000

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

FROM: Michael M. Hash
Deputy Administrator
Health Care Financing Administration

SUBJECT: Draft Report: "Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight" GAO/HEHS-00-69

We appreciate the General Accounting Office's (GAO) review of state practices regarding Medicaid reimbursement of school-based administrative activities and the use of "bundled" rates for school-based services.

The Health Care Financing Administration (HCFA) is committed to ensuring that Medicaid-eligible children are enrolled in Medicaid and receive the services they need. Schools offer unique advantages and opportunities to reach children and encourage their families to enroll in the Medicaid program, as well as to provide assistance to students in accessing medical services.

At the same time, however, we share your concerns about --and are taking action to prevent-- improper claims for federal Medicaid funds for the cost of such services. Clearly, there are challenges that must be overcome. We are committed to working with states and school districts to ensure that Medicaid dollars are only used on behalf of Medicaid eligible children for Medicaid covered services. To help achieve this goal, we have developed a new and comprehensive guide for states to ensure proper identification and allocation of administrative costs associated with the provision of Medicaid services.

Overall, we share with the GAO's concerns and believe active efforts that we have underway will help ensure that children covered by Medicaid receive the necessary services they need to grow-up healthy and that funds are spent correctly under the law.

Attached are our comments on the specific recommendations in the report. We thank you and your staff for your work on this report and for the opportunity to review the draft. We look forward to working closely with GAO on these and other issues in the future.

Attachment

Comments of the Health Care Financing Administration on the General Accounting Office (GAO) Draft Report "Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight"

School-based health programs provide a broad range of services that are covered by Medicaid, affording access to care for children who otherwise might go without needed services. School-based programs can be effective and efficient providers of care, and can play a powerful role in identifying and enrolling children who are eligible for Medicaid. The Health Care Financing Administration (HCFA) is committed to ensuring that Medicaid-eligible children are enrolled in Medicaid and receive the services they need. We strongly support the provision of Medicaid covered services by schools.

We agree with the GAO that states have faced challenges in making proper claims for administrative costs related to providing school-based Medicaid services, using bundled rate methodologies, and billing for school-related transportation. We have acknowledged that confusion about the requirements for claiming Federal funds may have resulted in inappropriate claims. And, in the case where one state clearly had claimed improperly, we have taken action to defer claims.

We appreciate the GAO's acknowledgement of our efforts to improve the oversight of administrative claiming, and we agree that more needs to be done. We are committed to ensuring that states understand their opportunities and obligations regarding the use of Medicaid in schools.

To that end, we have been working with Congress, the Office of Management and Budget (OMB), and others to develop the *Medicaid School-Based Administrative Claiming Guide* (the Guide). A draft of this guide is now being circulated to State Medicaid Agencies, schools and other interested parties for feedback. It is intended to help schools provide Medicaid services by consolidating existing requirements for claiming-related administrative costs, and to provide a consistent national statement of these requirements. It does not establish new policies. Once we have reviewed public comments and issued a final guide, we will work aggressively to help all relevant parties understand how to use it.

The Guide and the training effort will only be part of our approach to resolving these issues. As discussed in detail below, we also are working to improve the collection and analysis of data on state Medicaid school-based program expenditures, and reviewing our

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oversight and monitoring in this area overall. And, we will provide additional guidance and technical assistance on both the school-based transportation and bundling issues.

GAO Recommendation 1

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.

HCFA shares the GAO's concern that payment methodologies should appropriately balance the need to ensure the proper expenditure of Medicaid funds and the flexibility of states to expend funds without facing undue administrative burdens. That is why, in our May 1999 letter on this issue, we said that HCFA would not approve any more bundling methodologies. This suspension was to allow time for HCFA to review our policies so that improved methods of reimbursing for school-based services that meet the requirements of the law and our commitment to program integrity could be considered. We agree with the GAO report that bundling methodologies can place Medicaid at risk for improper claims.

Under a bundling system, states make weekly or monthly payments to schools based on a package of services that are needed by children within various categories of disabilities, rather than paying separately for individual services. Many different services may be included in the bundled rate, such as physical therapy and speech therapy. The payment is the same regardless of the number of services actually provided or the specific costs of the services involved.

As noted by the GAO report, there is concern that school-based providers may not maintain adequate or readily available documentation for bundled payments, may not have the administrative infrastructure needed to do so, or may not have used such documentation in developing bundled payment methodologies. Without proper documentation, there is no reliable basis for determining whether the needed service was delivered at a reasonable rate. This creates the opportunity for states to obtain Federal matching funds for services that have not been provided. It also allows for the possibility that states could claim funds for services that are not covered by Medicaid.

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Therefore, we have determined that existing bundled rate methodologies do not meet the statutory intent of the law. Section 1902(a)(30)(A) of the Social Security Act requires that states have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care. The process used for bundling was inconsistent with economy, since the rates were not designed to accurately reflect true costs or reasonable fee-for-service rates. The process was not consistent with the efficiency requirement, since it required substantial Federal oversight to establish the accuracy and reasonableness of state expenditures. As a result, there was no reliable basis for determining that the rate was related to the actual cost.

Underlying the May 1999 letter is a simple, but critical, principle for bundled payment methodologies -- Medicaid funds must only be used to provide Medicaid covered services to Medicaid-eligible children. The law is clear on this. There are a few additions to this principle (such as outreach and enrollment assistance, but they are the exceptions that prove the rule.) However, identifying a means of implementing this principle while balancing the need for appropriate program integrity measures without undue administrative burden has been difficult.

That is why, since our May 1999 letter, we have worked continuously to identify alternative approaches that will fulfill the law's requirements. We created a workgroup with representatives of State Medicaid Agencies, the Department of Education, local education agencies and OMB. The workgroup was designed to make sure that HCFA staff could hear a variety of perspectives on this topic, but it was not intended to be a decision making body, as implied by the GAO report. Through this activity, we identified several issues that should be considered in bundled payment methodologies for school based services. These issues -- in some ways implicit in the ones identified by the GAO -- are:

- **Provision of adequate documentation that goes beyond requiring simple "assurances." States need to provide detailed information at the provider or school level to establish an audit trail and develop methods for the maintenance of documentation**
- **Utilization of retrospective reconciliation of services and costs or other safeguards. There must be safeguards to assure that the bundled payment methodology continues to reflect the services that are delivered to Medicaid-enrolled children.**
- **Creation of reasonable payment levels. States need to identify the specific services and their reasonable costs for inclusion in bundled payment. The rates must recognize varying levels of services needed by children with different health care needs.**

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- **Development of sampling methodologies to accurately identify services provided to Medicaid-eligible children with disabilities who have an Individualized Education Plan (IEP). The sampling methodology should take into account the medical needs of children with varying disabilities and geographic distribution of children with disabilities.**

Any methodology that does not address these issues could place the Federal government at risk for expenditures not permitted by law.

GAO Recommendation 2

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

HCFA concurs. As stated earlier, HCFA is committed to supporting the use of schools as centers for providing Medicaid outreach, assistance in the eligibility process and services as allowed by law and as necessary to fit each State's particular needs. While state flexibility is important, states also have the obligation to exercise their flexibility in the constraints of the law. HCFA encourages state flexibility but is required to ensure the integrity of the Medicaid program and to ensure that proper financial controls are consistently applied. Therefore, we are already taking a number of steps that respond to the above recommendation, including:

- **Developing the Medicaid School-Based Administrative Claiming Guide. We agree that there must be a uniform national statement of requirements for claiming the costs of school-based administrative activities. The Guide should address many of the concerns raised by the GAO. It is intended to summarize and clarify all existing Federal laws, regulations and policies. It will serve as a reference on all aspects of school-based administrative claiming. For example, it includes a thorough discussion of claiming for administrative activities performed by skilled professional medical personnel, one of the areas highlighted in the GAO report. We released a draft of the guide in February 2000 and extended the deadline for public comments until April 3rd. And we are committed to working with the states, schools, and the Federal Department of Education to appropriately revise and clarify it before issuing in final. The Guide is currently available on the HCFA web site at www.hcfa.gov.**

- **Providing Training and Technical Assistance to States.** Once the guide is released, we will follow an aggressive schedule of training for interested parties. This will include regional conference calls as well as a national training session in Baltimore within 60 days of the Guide's final release.
- **Providing Training and Technical Assistance to School Districts.** School districts will be a critical part of our training effort. In fact, we have already begun working with school districts to foster an understanding of related policy. We will take steps to ensure that materials and technical assistance are part of our training effort.
- **Developing a Process for Monitoring Existing Claiming Activities.** We will review existing Medicaid expenditure reporting and work with states to identify additional data that should be gathered. This effort will also include gathering information regarding specific State activities on school-based claiming both from the States and from documents within the Department of Health and Human Services (HHS).
- **Developing a Process for Approving Changes in School-Based Administrative Claiming Activities.** States are already required to submit public assistance cost allocation plans to the Division of Cost Allocation (DCA) at HHS. These plans must reference the Medicaid school-based administrative claiming programs which must be reviewed prior to any final approval prior of the cost allocation plan. We are taking concrete steps to strengthen this process so that any future changes in claiming procedures by states will be part of the formal review and approval process.
- **Providing Clear Feedback to States to Ensure Compliance.** We will work with states as partners to ensure that, prospectively, proper claiming methodologies are used. When required by law, HCFA will recoup inappropriately claimed funds.
- **Developing Financial Management Strategy/Review Guides.** We will review existing procedures, review guides, and manuals on the oversight of school-based services and administrative activities and incorporate the Medicaid School-Based Administrative Claiming Guide into formal financial management tools.
- **Increased Oversight of Conflicts of Interest.** We will strengthen our review of state claims to ensure that contingency fees are not claimed. We share the concerns expressed by the GAO that private firms who receive a percentage of reimbursement as payment for consulting and billing services, rather than a fixed fee, have an incentive to maximize the amount of reimbursement claimed. In addition, while we also share GAO's concerns about states retaining a share of Federal funds related to schools' claims, this practice is allowable under current law.

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These activities will help to address concerns raised by the GAO, including time study sampling methodologies and the use of activity codes. The time study is the primary mechanism for identifying and categorizing activities performed by school or school district employees, and for developing claims for the costs of these administrative activities that may be properly reimbursed under Medicaid. The draft Guide provides standard activity codes that may be further tailored to reflect local differences. Such an approach addresses the GAO's concern for r balance between state/local flexibility and consistency within and across states.

We recognize that many difficult issues and challenges remain to ensure state compliance with the law. We are committed to taking all necessary steps to ensure the proper and efficient operation of Medicaid school-based programs, and will be working with our Federal, state, and local partners to continue to identify and address these issues.

GAO Recommendation 3

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 concur. The May 1999 letter did provide useful guidance to states on several issues:

- 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 a student's Individual Education Plan as a required service.
- If a child requires transportation in a specially adapted vehicle, including a specially adapted school bus, that transportation may be billed to Medicaid.
- Transportation from school to a provider in the community may be billed to Medicaid.
- States must provide documentation of transportation service, usually in the form of a trip log maintained by the provider of the specialized transportation service.
- States must describe the methodology used to establish the transportation rate in the State Medicaid plan.
- States must develop a cost allocation methodology to ensure that Medicaid only pays for that portion of the specialized transportation attributable to Medicaid beneficiaries.

We agree with the GAO that the policy described in the May 1999 letter resulted in some confusion on the part of HCFA regional offices and states. We will issue additional guidance, especially as it relates to transportation issues. We plan to further clarify the specific types of specialized transportation that may be claimed for children with an IEP. We will work to assure that there is a uniform application of this policy.

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GAO CONTACTS AND STAFF ACKNOWLEDGMENTS

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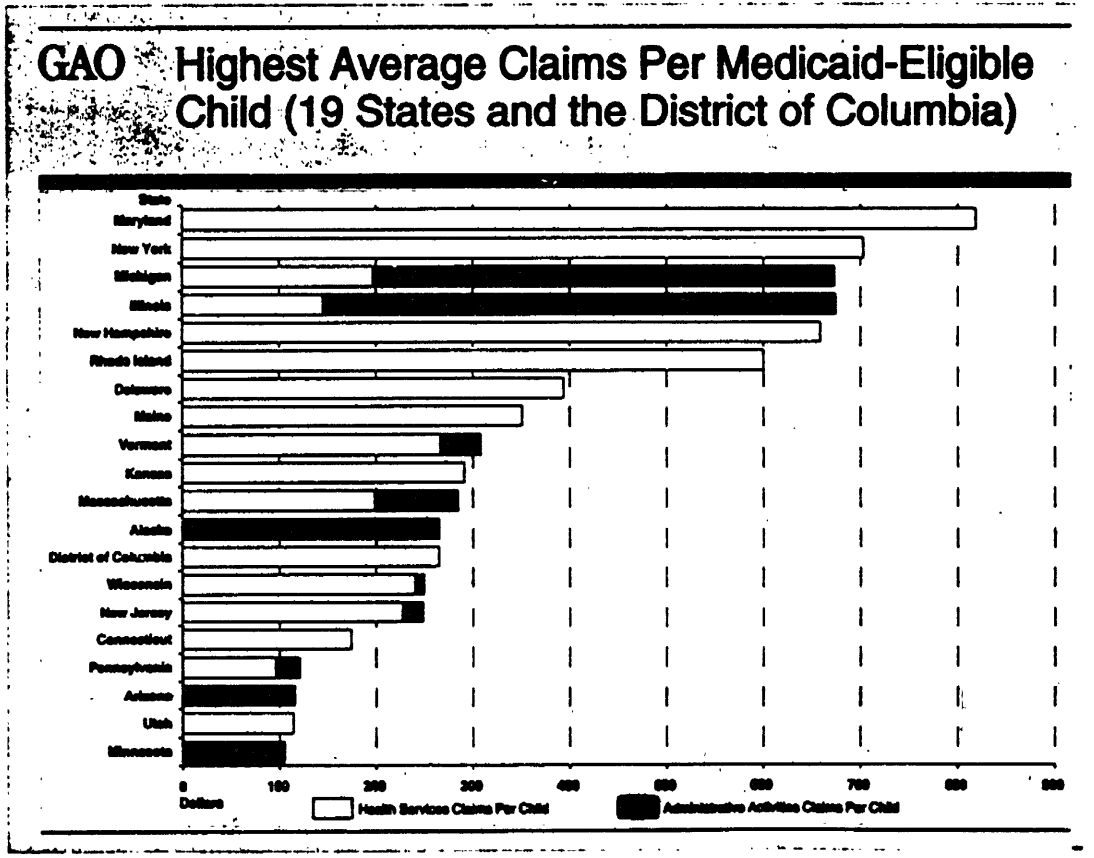
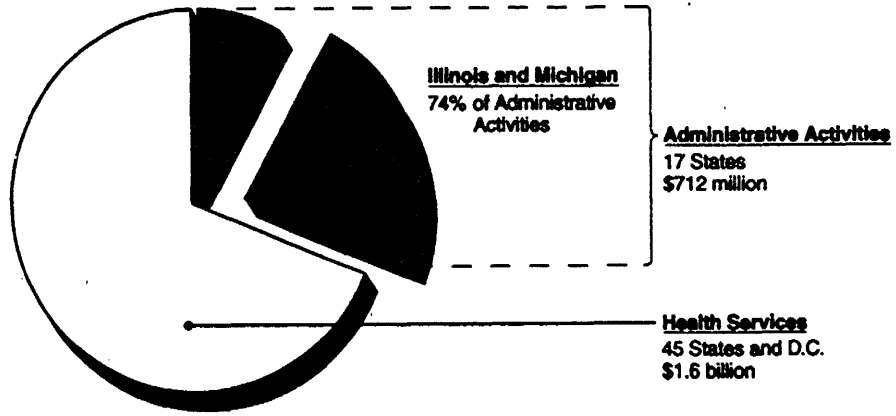
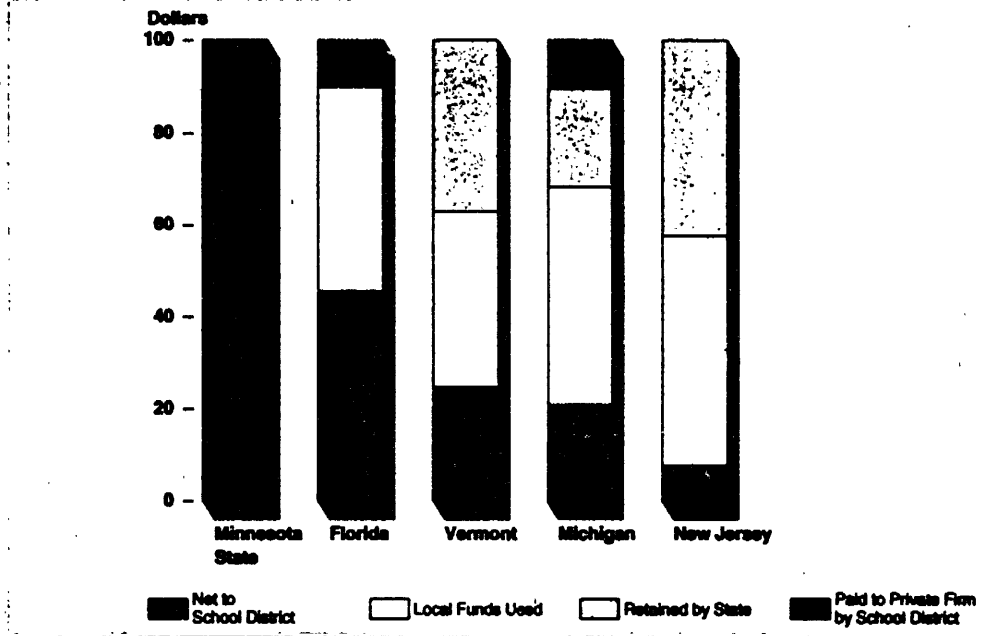

GAO
Highest Average Claims Per Medicaid-Eligible Child (19 States and the District of Columbia)
State
Maryland
New York
Michigan
Illinois
New Hampshire
Rhode Island
Delaware
Maine
Vermont
Kansas
Massachusetts
Alaska
District of Columbia
Wisconsin
New Jersey
Connecticut
Pennsylvania
Arizona
Utah
Minnesota
0
100
200
300
400
600
600
700
800
900
Dollars
Health Services Claims Per Child
Administrative Activities Claims Per Child

GAO $2.3 Billion Claimed for School-Based Medicaid Reimbursement



GAO Some School Districts Receive Little Federal Medicaid Reimbursement



PREPARED STATEMENT OF HON. PAUL COVERDELL

Mr. Chairman, I appreciate your willingness to hold this hearing to discuss the issue of Medicaid payments to schools and the problems associated with HCFA oversight and management of this service.

Medicaid is the largest program providing medical and health-related services to America's poorest people. With annual health care costs in the U.S. now exceeding $1 trillion, fraud and abuse in the Medicaid program is costing tax payers billions of dollars each year. The Medicaid program's price tag has risen from, $3.9 billion in 1968 to more than $130 billion in 1993.

A recent GAO investigation revealed that millions of dollars meant for services for poor and disabled children have been mismanaged by HCFA. Ms. Allen and Mr. Hast of GAO are here this morning, and I hope that they will lend us their insight as to what exactly went wrong and how we can ensure that, in the future, these funds get to needy children.

It is my understanding that HCFA has prepared a guide to ensure that schools meet the existing requirements for claiming Federal funds under the Medicaid program for the costs of administrative activities, such as Medicaid outreach, that are performed in the school setting. While I hope that by issuing this guidance nationally, HCFA will be more able to promote consistency in administrative claiming practices and the fiscal integrity of the program, I believe that we should not assume this guide is a panacea to the problem of Medicaid expenditures. HCFA oversight is, and must continue to be, of utmost concern. Mismanagement of these funds is unacceptable as is the misuse of taxpayer dollars.

Again, I thank you, Mr. Chairman for holding this hearing, and I look forward to working with my colleagues on the committee on this important issue.

PREPARED STATEMENT OF LYNN DAVENPORT

Chairman Roth, Senator Moynihan, and Members of the Finance Committee:

Thank you for inviting our company, MAXIMUS, to testify this morning. We have been asked to comment on how you might ensure appropriate use of the Medicaid program as a source of funding for school health services. MAXIMUS has assisted over 25 states with the claiming of federal revenue. Our work for a number of states, including Maine, Kansas, Arkansas, and others has included implementing or expanding Medicaid billing by school districts and education agencies. So, we bring this experience to the discussion.

MAXIMUS is aware of the concerns raised about the way Medicaid funding is being drawn down by schools and about the participation of private vendors in the process. My comments today will focus on: 1) the most critical issues in determining appropriate federal action in this area; and 2) the most important measures for ensuring that Medicaid is used properly and that vendors participate properly in Medicaid school billing initiatives. Before I begin my discussion of key issues and possible solutions, though, I would like to spend just a moment summarizing the basis for Medicaid billing of school services and what we believe should be the objectives of any Medicaid billing approach developed for schools.

MEDICAID IS AN APPROPRIATE SOURCE OF FUNDING FOR SCHOOL-BASED HEALTH SERVICES

As I am sure many members of the Committee are aware, schools provide a broad range of medical and health-related services that are covered by the Medicaid program, and schools also are important providers of Medicaid outreach and enrollment support services in many states. Although historically Medicaid funding of school health-related costs was fairly limited, the Medicare Catastrophic Coverage Act of 1988 established the obligation of Medicaid—rather than education agencies—to pay for medical services needed as part of an individualized education plan for Medicaid-enrolled children in special education.

This expansion in the role of Medicaid led to a surge of interest among states and school districts in developing and implementing Medicaid billing programs. As we have heard from the GAO and others, virtually all states are involved to some degree in recovering Medicaid funding for health-related school expenditures and this funding has allowed many school districts to expand the services they provide to students.

TWO OVERALL OBJECTIVES SHOULD SHAPE ANY MEDICAID BILLING APPROACH SET FORTH FOR SCHOOLS

Given the clear propriety of schools drawing on Medicaid funding and the clear interest of school districts in supporting the delivery of health and health-related services with federal Medicaid funds, the question becomes not whether school Medicaid billing is allowable and desirable, but how that billing is to be carried out. In our school billing work for states, we have kept two overall objectives in mind.

1. One is that only reasonable costs fairly attributed to the Medicaid program should be included in Medicaid reimbursement rates or administrative payments, and no costs should be counted twice.

2. The other is that Medicaid direct billing and administrative claiming requirements for schools should be reasonable and workable for school districts of all sizes and levels of relative affluence.

These goals reflect the tension that exists between safeguarding the use of Medicaid funds through stringent rules and oversight activities, and keeping Medicaid participation feasible for most school districts. In our experience, it is possible to structure and operate programs that reflect these goals and support the recovery of appropriate costs from the Medicaid program.

FOUR MAJOR CONCERNS REGARDING THE USE OF MEDICAID BY SCHOOLS

Our involvement in Medicaid school billing has made us aware of four major concerns that have been raised by the GAO or others regarding the use of Medicaid to fund school health costs:

1. the use of bundled rates for direct service billing, which may result in payment for services never delivered;

2. Medicaid administrative claims that have been inflated with inappropriate costs by school districts;

3. contingency fee arrangements with private vendors, which may create an incentive to improperly increase billing or claim levels; and

4. shortcomings in HCFA guidance in the area of Medicaid school billing and claiming.

I have comments to offer regarding each of these concerns.

CONCERN THAT BUNDLED RATES RESULT IN PAYMENT FOR SERVICES NOT DELIVERED

As you know, a "bundled rate" is a single payment rate that reflects the average cost of a group of services. The bundled rate might, for example, cover the cost of the physical therapy, nursing services, and rehabilitative aide services typically provided to a child with a certain type of disability. The average annual cost of the bundled services for such a child would be translated into a cost per contact or a cost per day. Concern has been expressed that bundled rates may result in payment being made for services that are not necessarily provided. We believe there is nothing inherently wrong with bundled rates, but that rate bundling approaches should have certain characteristics in order to ensure that the payment reflects the cost of services actually delivered.

Medicaid Programs Average Costs In Setting Rates for Many Types of Services

State Medicaid agencies currently pay providers for services through a variety of methodologies. These range from prepaid, capitated payments for HMOs, to per diem payments for hospital care; to per month payments for case management; to per visit payments for clinic services; and to per unit payments for therapy services. All of these forms of payment reflect an averaging of costs to one degree or another in determining what the payment amount should be. This averaging of costs has developed because of the virtual impossibility of identifying and tracking the actual cost of each minute of service provided to a given patient by a given provider on an ongoing basis. The per contact bundled rate that New Jersey and several other states use in billing school services is similar to the per visit or per encounter rates widely used by Medicaid to reimburse health clinics.

Real Issue is the Need for Rigorous Rate Development and Reconciliation Methodologies

We agree that there may be some basis for concern about bundled Medicaid payments for schools as they have been structured in some states, but believe that the problems can be addressed and states still be allowed to use bundled rate methodologies. We have developed four requirements that can be applied to bundled rate methodologies to ensure that payments made reflect proper costs for services actually delivered.

1. The costs included in the service rates and any statistical sampling or other methodology used to establish rates must have been rigorously reviewed and validated.
2. The method for identifying Medicaid-enrolled service recipients must have been reviewed and determined to yield accurate results.
3. Steps must have been taken to ensure that schools maintain adequate documentation regarding the cost of services and the delivery of services over time.
4. The methodology must provide for some type of cost reconciliation to be carried out in order to validate the projections that were made about service cost and service delivery at the time rates were set, and for any appropriate adjustments to payments that may be indicated as a result.

With respect to the fourth criteria, the periodic reconciliation of projected costs and utilization to actual costs and utilization, I would urge that the reconciliation be allowed to be carried out at the school district level, as opposed to the individual child level. If you require reconciliation at the level of the individual student, you will impose a significant administrative burden on each school and the staff of that school. Moreover, there is no precedent of which I am aware for Medicaid to require any other health provider to document the precise, actual cost of delivering each individual service to each individual patient.

CONCERN THAT MEDICAID ADMINISTRATIVE CLAIMS BY SCHOOLS HAVE BEEN INFLATED WITH INAPPROPRIATE COSTS

We understand that the GAO and others have found instances of school districts submitting administrative claims with inappropriate costs. The types of problems identified include:

1. the same staff being counted twice—once in setting direct service reimbursement rates and again in calculating administrative service claims;
2. including the costs of staff for whom Medicaid reimbursability is questionable;
3. including costs already covered by other types of federal funding, and
4. using time sampling methods that may not be generating fair results as to the proportion of staff time being spent on Medicaid administrative activities.

We would add to this list our suspicion that the training of school staff members who provide the information used to develop the administrative claim is inadequate in many instances and not well-maintained over time. Nevertheless, we believe each of these problems can be addressed with reasonable measures.

Best Federal Response is to Address the Individual Problems Rather Than End Administrative Claiming by Schools

There are four specific actions that can be taken to remedy the various shortcomings that have been found in school administrative claiming programs and to ensure that only appropriate claims are paid by Medicaid.

1. First, develop and mandate the use of a rigorous review protocol by state and federal Medicaid staff who evaluate the design and structure of school administrative claiming programs. It should be quite possible to provide for careful assessment of the areas most likely to be structured incorrectly, without dictating the use of one particular program design that may not work well for many states or school districts.
2. Second, enforce federal Office of Management and Budget Circular A–87 standards for time sampling of staff, as a way to ensure fair and accurate results as to the amount of time school staff spend on Medicaid reimbursable activities. HCFA already has proposed that this be done in the draft manual it prepared on school administrative claiming.
3. Third, state Medicaid agencies should require comprehensive and ongoing training for school district personnel who must provide information that drives the amount of the administrative claim. These would include not only school financial officers but all staff who participate in time sampling activities.
4. Fourth, encourage ongoing monitoring by state Medicaid agencies of school administrative claiming programs—including reviews of related training activities and reviews of any changes in staffing levels, accounting structures, or other areas that would affect the amount of an administrative claim.

Manadatory Audits Could Also Be Considered

One other way to ensure that administrative claiming programs operate properly over time would be to require that state Medicaid agencies conduct a detailed audit of any program in which the claim amount grows by more than a specified percentage. An exception could be made for a program in which the growth in the claim

amount can be clearly accounted for by an increase in the number of participating school districts.

We believe that the combined effects of these actions will restore confidence in school administrative claiming and allow schools to continue to devote resources to helping children access needed health services.

CONCERN THAT CONTINGENCY FEES FOR PRIVATE VENDORS CREATES AN UNDESIRABLE INCENTIVE

Many states or school districts have contracted with private firms to help them develop their Medicaid claims system or to assist them in increasing the amount of their claims. A number of the contracts have been done on a contingency fee basis, meaning that the payment to the contractor is a percent of the total additional Medicaid dollars received. There is concern that contingency fees may create an undesirable incentive to improperly increase Medicaid billings or claims, either by false billings or other fraudulent behavior. There are also concerns that the contingency fee rates charged by some firms generate huge "windfall profits."

We understand the concern about excessive rates, but do not believe the solution is to ban contingency fees. It is important to understand that many local school districts do not have the knowledge and other resources necessary to develop a Medicaid claiming system. Contingency fee contracts have been the only way that many school systems can afford to obtain the assistance they need to claim for services that they are mandated to provide. We believe it is possible to safeguard against vendor abuses and allow the continued use of contingency fee contracts to help such school districts.

Banning Contingency Fee Contracts Will Not Prevent Firms From Obtaining High Profits and Will Harm Smaller or Poorer School Districts

We believe that banning contingency fee contracts will not eliminate the potential for vendors to profit from Medicaid billing work. Fixed fee contracts can be set at inappropriate amounts relative to the vendor's cost of doing the work, just as contingency fee contracts can be set at inappropriate rates relative to a vendor's cost and risks.

Banning contingency fee arrangements, though, will unquestionably harm smaller or poorer school districts that do not have the up-front resources to devote to fixed fee contracts. By eliminating the need for such school districts to invest their limited funds in efforts to establish Medicaid billing—which may or may not ultimately be successful—contingency fee contracts provide a way for the schools that most need the additional revenue to participate in the Medicaid program.

Safeguards Can Be Put Into Place to Protect School Districts and Taxpayers from Unscrupulous Vendors

Several steps can be taken to achieve the goal of fair and appropriate vendor payment without banning contingency fee contracting and creating a further disadvantage for small or poor school districts.

1. Require that any contingency fee contract for Medicaid recovery assistance be competitively procured.
2. Require that bidding firms disclose the contingency fees they have charged other school clients for comparable work.
3. Limit the duration of contingency fee contracts to two years, plus a single option year at the same terms and conditions as the original contract.
4. Require that contingency fee vendors commit to providing the necessary software and training to school districts that want to assume responsibility for billing activities at the end of the vendor's contract.
5. Require that all vendors—whether paid by a contingency fee or a fixed fee—provide their school billing clients with full documentation of the billings or claims submitted for Medicaid payment.
6. Require that all vendors—whether paid by a contingency fee or fixed fee—commit to supporting the school billing client in any audit or disallowance action by state or federal Medicaid officials related to the work they performed.

An additional measure to consider would be establishing an upper limit on contingency fee rates. This could harm smaller school districts, though, and should not be necessary if competitive bidding and disclosure of contingency fee rates charged elsewhere are required in procuring school Medicaid billing services.

CONCERN THAT HCFA HAS NOT MET ITS OBLIGATIONS IN THE AREA OF SCHOOL MEDICAID BILLING WELL

There has been some criticism by GAO and others of how HCFA has responded to state and school district interest in Medicaid billing of school health costs. We

have a few observations to offer on this issue, based on our efforts over the last several years to help states establish Medicaid billing for school services.

HCFA's Responses in the Area of School Billing Suggest a Lack of Internal Consensus and Have Resulted in Inequitable Treatment of States

We have experienced two types of problems dealing with HCFA in our efforts to help states establish or revise their school billing programs, both of which suggest that HCFA has not developed an internal consensus on appropriate policies and requirements for school programs.

1. The first problem is where one HCFA regional office has applied Medicaid policies related to service coverage, ratesetting, or other parts of the program differently than those policies have been applied by other HCFA regional offices.

2. The second problem, which has been even more frustrating, is where a HCFA regional office has effectively refused to make a decision at all regarding the acceptability of proposed state practices. Moreover, these regional offices generally have not been able to tell our state clients the steps that could be taken to obtain approval. Our impression is that some regional office staff have not felt empowered to have an opinion, and so have elected to do nothing and leave the states in limbo.

The net effect of these problems is that some states have been able to put comprehensive Medicaid billing programs into place and obtain substantial amounts of federal funding, while others have been stymied in their efforts by an either the inability or unwillingness of a HCFA regional office to respond. This inequitable treatment of states should not be allowed to continue.

There Are Reasonable Ways to Improve Both HCFA's Treatment of States and Its Oversight of Federal Medicaid Funds

We have several suggestions regarding how HCFA can better meet its obligations to states—and strengthen its oversight role, if that is determined to be necessary.

1. HCFA could renew and revamp its efforts to provide comprehensive, workable guidelines for developing and operating Medicaid service billing and administrative claiming programs for schools. To ensure that the resulting guidelines are both fair and reasonable for school districts to live by, it seems critical that HCFA involve school financial officers; consultants who have worked at the detailed level to develop such programs for states; and others with an in-depth understanding of the various ways in which school administration, financing, and service delivery is structured across the country.

2. HCFA should be consistent in its interpretation and application of Medicaid policy across the country. Perhaps requiring that regional offices consult with HCFA Central Office on certain topics for which policy is still evolving would help ensure more consistency from region to region.

3. All HCFA regional offices could be required to grant state requests for informal, "working feedback" as they develop new or expanded school billing programs rather than declining to comment prior to formal submission of a Medicaid state plan amendment. This would save both state and federal time and also help identify areas in which federal policy development may be needed early in the process.

4. HCFA could be required to make decisions on proposed state Medicaid plan amendments in a timely manner, without resorting to denials of amendments simply because it is not sure what the policy in a particular area should be.

5. HCFA could develop specialized audit protocols for state and federal Medicaid staff to use in reviewing service billing and administrative claims for school services.

6. HCFA could conduct a study of school services costs and reimbursement rates across the country with the goal of identifying appropriate upper limits for various types of rates.

SUMMARY REMARKS

In closing, Mr. Chairman, I encourage the Committee to carefully consider the effect of any federal action in this area on school districts' ability to draw down much-needed Medicaid funding. Reasonable measures can be taken to address the various concerns that have been raised about school Medicaid billing and claiming. But it will be important not to impose more restrictions or requirements than are actually necessary, because those requirements could make it impossible for many school districts to participate in Medicaid school billing.

Thank you for your time today. I am happy to respond to any questions that Committee members may have at this time.

PREPARED STATEMENT OF JACQUELINE L. GOLDEN

Mr. Chairman and distinguished members of the Finance Committee, my name is Jackie Golden and it is a pleasure being here today. I wish to share with you, my first hand experience, on how important it is to receive the related, school-based services, paid for by Medicaid, for children with disabilities but first I must share information about my children and myself.

I am a Marylander, and a parent of two children. Both of my children have needed special education. My daughter, Jessica, has attention deficit disorder, and my son Joshua, has Angelman Syndrome. Children with Angleman Syndrome have significant disabilities. Although I do not like to place labels on children I will do so today to help you get a better picture of Joshua. I would say the following labels would best describe my son: significant physical disabilities that include an ataxic gait, profound mental retardation, a complex seizure disorder, non-verbal, and a significant sleep disorder as well as many other labels that would fit. Additional labels I would place on my son are Joshua loves life, he is extremely friendly, and likes nothing better than a good laugh. Joshua is a young man determined to be the most he can be.

Joshua enjoys watching a NASCAR races on TV, enjoys baseball, movies, friends, and school. Our vision for Joshua is to complete his education and assist him in becoming a productive individual in our society, even with his significant disabilities. However, in order for our vision to become a reality the educational system must include related services provided to Joshua in his home school among his peers.

Joshua receives, delivered in his home school, speech pathology services, physical therapy, occupational therapy, assistive technology services, and behavior management services (although I sometimes wonder whose behavior we are managing). The related services needed have been a team decision. What has truly made these related services successful is the delivery of these services among his peers, and including his peers.

Joshua learned to walk at age 14. Some well-educated physicians told us early on that Joshua, my son, would never walk, never sit, talk, or care for himself. Basically, these physicians didn't give us much hope. Yet Joshua had enough sense not listen to these predictions, as I have said many times, Joshua didn't read the medical books. Included in his middle school years, Joshua saw the other children walking, and soon was doing his best to keep us with them. However, he needed the trained eye of a physical therapist to filled with things such a curbs, and small step for your and I, but for Joshua, a mountain.

Yet Joshua did not get discouraged, he kept on trying to be part of those friends that he longed to run with. He achieved his goals with related services such as physical therapy, and an aid to assist him in getting the practice he needed to successful complete his first, independent steps I ask you Mr. Chairman and other members of the Finance Committee; do you remember watching your child's first steps? I waited 14 years to see my child's first steps. It is wonderful to see any child take those first few steps, but seeing my son doing this, well it was nothing short of witnessing a miracle. This came about by not only my son's determination, but by related services, delivered in his school.

As I indicated Joshua is non-verbal, however this does not mean he doesn't have anything to say. We just meant that we needed to find a way for Joshua to be able to communicate his words in a different manner. Through the use of assistive technology make selections and choices. The picture exchange system is not a complex computer, but simply a set of simple pictures that he can exchange for what he wants. A picture of a banana gets Joshua the snack he desires. This came about through Assistive Technology specialist, and speech pathologist working to include Joshua in places like the school lunch line, and classes that Joshua attends. Joshua, probably at this very minute, is in his home school, learning how to use his Big Mac as a job-training tool. A Big Mac is a device, in which you can record a simple phrase, and Joshua can press the button and the phrase will be repeated. Joshua's Big Mac today, say's may I have your movie ticket and thank you. Joshua is learning a job skill within his own high school. You see I do have a vision for my son, and it doesn't include being dependent on a system to totally care for him the rest of his life. I see that with the related services he receives within the school system that he will become independent of the social security system someday. That he will have a job, a life, and contribute to his community. Yes, my son will always need supports, but he does have skills that he can learn. He will learn these skills only if the related Medicaid provides services through related services in the school system.

We must assure that the related services paid by Medicaid, through our school systems, are maintained. Schools must assure that the services, in accordance with

the child's individual education plan (IEP), are delivered. Without related services, we are taking away the opportunity for children with disabilities to become productive, and successful adults. I believe this to be true for every child with disabilities, even with the most significant disabilities such as one Joshua Golden. Thank you.

CONSORTIUM for CITIZENS with DISABILITIES

For additional information, contact
Paul Marchand, (202) 785-3388
Leslie Jackson (301) 652-2682
Libby Kuffner (301) 657-0270
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Principles for Medicaid School-Based Services for Students with Disabilities

The Consortium for Citizens with Disabilities Education Task Force supports increasing the accountability of all school systems who are using the Medicaid program to finance the delivery of eligible services to students with disabilities. CCD applauds the efforts of the Senate Finance Committee and Chairman William Roth to ensure resources are appropriately used to support essential services. CCD believes these activities will contribute to the improvement of education and expansion of services for students with disabilities. As the Congress proceeds with its oversight of the Medicaid program, CCD requests that the following principles be considered.

1. Administrative or legislative changes to the Medicaid program and related changes by schools on how they administer their education programs must not result in any reduction in school-based services to eligible children.

2. There is a need for greater accountability by schools in the delivery of special education and related services, including Medicaid services, for children with disabilities in accordance with their individualized education programs (IEPs). State and local educational agencies should develop an accountability mechanism which includes appropriate written documentation to ensure that every Medicaid eligible or Medicaid enrolled child with an IEP that includes Medicaid services actually receives Medicaid services.

3. Local school districts should receive payment for Medicaid services delivered in accordance with a child's IEP.

4. School districts, especially rural and small school districts, need clear guidance and direct technical assistance from the U.S. Department of Education and the Health Care Financing Administration on how to access Medicaid appropriately, including how to develop interagency agreements.

5. Clear and coordinated guidance from the U.S. Department of Education and the Health Care Financing Administration must be developed that incorporates current IDEA requirements regarding where and how Medicaid services are delivered. For children with disabilities three years and older, services must be delivered along side their non-disabled peers in the least restrictive environment. For infants and toddlers with disabilities, early intervention services must be delivered in the natural environment, usually the child's home or child care placement.

6. The process of billing Medicaid must be simple for schools.

7. Restrictions on the percentage of funds used by schools for administrative costs and for payment to third parties who assist with billing are appropriate. Such restrictions should not prohibit schools from contracting with third parties.

8. Children with disabilities must receive a free, appropriate public education. The U.S. Department of Education and the Health Care Financing Administration must develop joint enforcement activities. Such activities will increase confidence among the tax-paying public that schools are accessing all available public funding streams.

April 1, 2000

Prepared Statement of Susan Sclafani

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

I am here today to speak with you on behalf of Larry Marshall, President of the Board of Trustees and Dr. Rod Paige, Superintendent of Schools of the Houston Independent School District (HISD), and the Council of Great City Schools, a coalition of the 57 largest city and urban school systems in the nation. We appreciate

the opportunity to come before you today to provide testimony about a subject that we have very strong convictions about, the delivery of health and medical services to our children.

The Houston Independent School District is the largest district in Texas and the seventh largest in the United States. It serves 211,000 students who are predominantly minority—53% Hispanic, 35% African American and 12% White and Asian. Seventy-one percent qualify for the Free and Reduced Price Meal Program, and 11% are served in special education programs. The district has participated in the School Health and Related Services (SHARS) Medicaid program since 1992, and the Medicaid Administrative Case Management (MACM) Medicaid program since 1994. These two Medicaid programs have contributed significantly to the delivery of health and related services to our students and particularly to our students with special needs. With the additional Medicaid reimbursement funding, the HISD has been able to enhance, improve, and expand the level and quality of health and related services being delivered to our students.

Our school district serves a vital role in providing outreach services, coordination, medical referral services, and the actual delivery of basic health and medical services to students in general, and more specifically to our students with disabilities and special needs. Our federally mandated and non-mandated school-based health services costs annually exceed $38 million. Our annual expenditures for services to disabled students are approximately $100 million annually or $4,545 per disabled student, while our federal IDEA allocation is only $8 million or $363 per disabled student.

On a daily basis, our school district encounters a significant number of at-risk children in need of health, medical and mental care. The district provides outreach and case-finding services that subsequently initiate the coordination and referral process toward the delivery of clinical or medical intervention. The district understands the Medicaid System's objective of making the Medicaid System more effective and efficient by ensuring Medicaid patients receive covered medical, mental and health care service at the appropriate level of intervention with early illness detection, primary care or wellness care. HISD shares in this vision by providing outreach services and direct Medicaid-covered services. Healthier children are able to achieve greater academic success, because their basic and most fundamental health care needs are met while concurrently receiving a free and unencumbered education.

HISD ESTABLISHES THE MEDICAID FINANCE DEPARTMENT

In October 1992, the Houston Independent School District established the Medicaid Finance Department (MFD) to plan, implement, and manage the district's Medicaid programs and initiatives. The MFD's mission is to pursue, implement and manage the district's Medicaid Programs to enhance, improve and expand the level and quality of health-related services being delivered to our students. The MEDICAID program has reimbursed HISD for approximately 240 health and related clinicians that directly serve students district wide. The HISD has generated approximately $47,982,585 in Medicaid reimbursement revenue between January 1993 and Feb. 2000.

MACM Revenue:	$25,265,345	(May–1994 to Feb. 2000)
SHARS Revenue:	$22,717,241	(Jan.–1993 to Feb. 2000)
Total Medicaid Revenue:	$47,982,586	

Medicaid reimbursement funds generated from the SHARS and MACM programs have been designated to help enhance health-related services for all students with disabilities by providing the HISD funds for additional staff and services. The HISD has been able to fund the following types of positions and services with SHARS and MACM reimbursement revenue:

School Nurses
Educational Diagnostician
Audiologist
Life Skills Coordinators
Speech Therapists
Nurse Consultants
Contracted Physician Services
Computers for Child Study Dept. Adaptive Equipment/Technology
Associate School Psychologists
School-Based Health Clinics

In-home Clinical Training
Speech Therapist (Pathologist)
Behavior Program Teacher
Contracted Physical Therapy Services
Special Transportation Support Staff

As of August, 1995, the district has opened Crossroads, a drug counseling program that is licensed by the Texas Commission for Alcohol and Drug Abuse (TCADA), as a level three outpatient drug counseling provider to serve students with chemical and drug dependency. The HISD currently has approximately 18 school-based or school-linked health clinics within its schools and has partnered with the City of Houston, Texas Department of Health, Baylor College of Medicine, the Harris County Hospital District and other non-profit hospital systems to provide direct care to students. The HISD is also assisting the State with Medicaid managed care by providing direct outreach enrollment services to HISD students and their families who must now select their managed care provider.

SCHOOL HEALTH AND RELATED SERVICES (SHARS)

The Houston Independent School District (HISD) became a SHARS Medicaid provider in November, 1992. The SHARS program enables school districts to be reimbursed for certain health related services rendered to students with disabilities who are Medicaid eligible. HISD's participation in the SHARS program does not preclude a child from receiving additional services by parent choice under another Medicaid program or provider in the private sector.

As a SHARS provider, the HISD has been approved to seek reimbursement for the following School Health and Related Services that are delivered to students as specified and required within their Individual Education Plan (IEP).

Comprehensive Assessments
School Health
Counseling Services
Medical (Physician) Services
Social Services (Social Workers)
School health Services (Nurses)
Occupational Therapy
Physical Therapy
Psychological Services
Special Transportation Services

The HISD has billed and received the following Medicaid reimbursement revenues for direct SHARS delivered to Medicaid eligible students.

SHARS Revenue:	$22,717,241	(Jan.-1993 to Feb. 2000)

It is important to note that the district has worked with the state Medicaid Office in establishing our program, and we have cooperated with that office in designing our program to meet all of the Medicaid requirements. The HISD has also assisted the state and federal Medicaid agencies with developing SHARS rate studies and clinical cost analyses to establish reimbursement rates that eventually affect all Texas school districts.

HISD is currently petitioning the Texas Department of Human Service (TDHS) for adaptive equipment and additional health or medical services to be covered with Medicaid reimbursement. Currently, students who qualify for adaptive devices must bring those devices with them each day on the school bus and return home with them each evening. Having the devices at home and school would make it far easier for their families and their teachers.

MEDICAID ADMINISTRATIVE CASE MANAGEMENT (MACM)

The HISD has participated in the MACM program since May 1994. Under this program, the district can be reimbursed for administrative case management activities that are rendered to all students within the district. MACM differs from the SHARS program, because SHARS will reimburse school districts for direct services delivered to students with IEP's, and MACM only reimburses districts for medical case management and Medicaid covered outreach activities. On a quarterly basis for a period of three days, over 300 clinicians who provide services participate in a comprehensive time study which includes notations of activities for every 15 minutes of their daily work schedule. These clinicians have been trained to complete these

tasks, and they understand their value in providing the necessary resources to serve their students.

The MACM program has been designed to comply with the state Medicaid plan with established regulations and guidelines. In annual state Medicaid audits and in the two Health Care Financing Administration (HCFA) audits, the district was found to be in full compliance. The HISD generates between $4.5 to $5.5 million in MACM reimbursement annually. Between May 1994 and Feb. 2000, HISD generated approximately $25,265,345 in MACM Medicaid reimbursement revenue for allowable MACM activities.

MACM Revenue:	$25,265,345	(May–1994 to Feb. 2000)

The MACM program is currently being implemented by the Texas Department of Human Services. In August, 1995 the Health Care Finance Administration (HCFA), approved the MACM program for Texas.

HISD shares in the Health Care Finance Administration's (HCFA) programmatic objective that these Medicaid programs will eventually reduce the cost of delivering Medicaid-covered health care, if children receive care at the appropriate level of intervention with primary health care or wellness care through outreach and improved interagency coordination of delivered services.

The HISD has been through annual Medicaid audits by both state and federal Medicaid agencies, and it has successfully met compliance with all regulatory and audit standards required by Medicaid and HCFA.

FISCAL IMPLICATIONS FOR SCHOOL DISTRICTS

In 1975, the United States Congress passed the Individuals with Disabilities Education Act (IDEA) that requires school districts to provide education related health and medical services to students with disabilities and to develop individual education plans (IEP) for service delivery. Congress passed IDEA without providing adequate special education funding, this consequently left school districts ill-equipped to meet the clinical demands of IDEA requirements. Even the major expansions of IDEA funding in the 105th and 106th Congress have yet to reach 20% of the original congressional funding promise for this special group of schoolchildren. To meet the regulatory requirements of IDEA, school districts find that they have to employ or contract for speech therapists, speech pathologists, nurses, audiologists, diagnosticians, psychologists, physical therapists, occupational therapists, and other clinicians as required for students enrolled with special needs. In many cases, parents have taken school districts to court and sued under the provisions of IDEA and the Americans with Disabilities Act (ADA) to provide additional or more comprehensive clinical services to their disabled children.

Medicaid reimbursement funding is increasingly becoming a significant funding source for the costs of providing health and medical services to students. Once received, these funds have been utilized to improve and expand the level and quality of health and medical services being delivered to students. With increased enforcement of court decrees to comply with IDEA criteria via the recent Supreme Court decision of *Garret* F. vs. *Cedar Rapids School District*, school districts are required to accommodate the extensive and costly health and medical services needed by profoundly disabled students. The fiscal impact of providing such services places school districts on a critical funding path. Districts have great difficulty in absorbing the extra costs of providing mandated IDEA health and medical services to disabled students without assistance from the federal government. Unfortunately, the existing public health system has been unable to provide adequate health services to Houston's at-risk populations, particularly our low-income and disabled children.

In view of IDEA regulations, it is HISD's recommendation that federal guidelines and requirements for state Medicaid programs be revised to include specific mandates that include school districts in state Medicaid programs for reimbursement of health and Medicaid services delivered. This would guarantee that sufficient levels of funding would be available to address the direct needs of students with disabilities per IDEA compliance. Without this alternative funding mechanism, school districts may not be in a position to maintain high levels of quality health and medical care for their students. The main reason for this quality assurance concern is that health care professionals who must be clinically competent to provide health and medical services are very costly to recruit and employ within a school district.

IMPLICATIONS AND RECOMMENDATIONS

School districts serve a vital role in providing outreach, coordinating, referral services, and, in some cases, the delivery of basic health and medical services to students with disabilities and other special needs. On a daily basis, school districts, especially large urban districts, encounter large numbers of at-risk children in need of health, medical and mental care. For many of our students, the school nurse is the only health professional the child sees. School districts can be utilized as an outreach and case finding agent to initiate the referral process toward medical intervention. State and federal health and human services agencies should partner with school districts to provide early illness detection, preventative and wellness care to at-risk children. With sufficient funding, school districts could enhance their efforts to establish either school-based or school-linked clinics available at the campus to provide basic medical screenings and care. HCFA has always taken the position of trying to contain rising costs of health care by engaging in dialogue with the health care sector; it would be advantageous for more efforts to be taken to incorporate school districts in acculturating children and families as to the importance of becoming their own health care advocates and wiser health care consumers. These grassroots efforts will equate to reducing the fundamental cost of delivering health care to not only Medicaid recipients, but for "insured" recipients as well.

School districts can make a significant difference in the delivery of health, medical and mental care, and they should be given the opportunity to be a part of the Medicaid system to acculturate children and families in being better health care consumers. School districts currently participate in the health care advocacy of children. Such efforts will lead to the effective and efficient utilization of our Medicaid system with the appropriate level of medical intervention, which leads to healthier children with our society.

PROGRAM RECOMMENDATIONS TO STABILIZE SCHOOL-BASED MEDICAID PROGRAMS AND INIATIVES

While states and school districts implement school-based MEDICAID services in a variety of different approaches, HISD suggests that the SHARS AND MACM programs may serve as a useful example for other states and school districts. The Texas implementation of SHARS and MACM has been audited by the HCFA and meets the regulatory requirements of the Code of Federal Regulations (CFR).

As it is designed in Texas, the SHARS program is a traditional fee-for-service Medicaid program that is self-adjusting based from a reimbursement perspective that is tied into direct utilization of services delivered to students. School districts will only be reimbursed for the SHARS services that they deliver based on the health and medical needs of IDEA students. This means that Medicaid reimbursement to school districts will automatically increase or decrease based on SHARS services delivered. It is this fee-for-service model with its self-adjusting utilization component that will meet the regulatory and fiscal requirements of HCFA and the program expectations of the U.S. Congress.

The Texas version of the MACM program has been reviewed, audited and approved by the HCFA Dallas (Region VI) office with coordinated approval of HCFA Baltimore, the headquarters for HCFA. This MACM program is also self-adjusting from a Medicaid reimbursement perspective that is tied into direct utilization of services delivered to the Medicaid population for Medicaid covered administrative case management services.

CONCLUSION

Participation in the school-based Medicaid program is a complex undertaking for a school district. The Houston program has evolved from eight years of intense effort and attention, and the resources to match. Other school districts have not had the expertise or the opportunity to develop their school-based Medicaid programs in an analogous manner. Federal technical assistance to school districts to implement Medicaid has generally not been available, forcing many schools to rely on expensive external contractors to meet the complex requirements of the Medicaid program. HISD recommends that the comments of the Council Of The Great City Schools regarding improvements in school-based Medicaid services be seriously reviewed by The Department Of Health And Human Services. HISD further suggests that the dialogue and process begun at the March 21 ST meeting between the national education groups, and the Departments Of Health And Human Services and Education serve as the collaborative basis for correcting any improper school-based claiming practices and for improving Medicaid services to eligible children through the very realistic opportunities presented in school settings.

We must put children first, and we must collectively participate in their health care advocacy with more outreach, which will lead to the effective and efficient utilization of our Medicaid System with the appropriate level of medical intervention which leads to healthier educated children within our society.

PREPARED STATEMENT OF TIM WESTMORELAND

Chairman Roth, Senator Moynihan, distinguished Committee members, thank you for inviting me to discuss Medicaid funding for school-based services. I would also like to thank the General Accounting Office for helping us to ensure that these payments are appropriate.

School-based health services play an important role in making access to certain health care services available to children who otherwise might go without needed services. We believe that these services play an important role in supporting and enhancing children's progress in schools. Schools also offer unique advantages and opportunities to reach children and encourage their families to enroll in the Medicaid and State Children's Health Insurance Programs. We strongly encourage schools to provide services and conduct outreach, and we are committed to ensuring that all eligible children are enrolled in these programs and receive the services they need.

States have been leading the way in developing and implementing programs that effectively utilize schools to increase access to services for children. However, in some instances, there has been confusion and possible disregard of the restrictions on claiming federal funds for school-based services. Problems identified include:

- Abundled *payment for groups of services to children with disabilities without documentation of the actual delivery of services or their costs;*
- payment for services to children who are not eligible for Medicaid;
- billing for transportation costs that Medicaid does not cover; and
- billing for administrative activities that Medicaid does not cover.

We are taking action to address these concerns and prevent improper claims for federal Medicaid funds.

- We are no longer approving proposals to use bundling methodologies and identified key issues that need to be addressed.
- We have clarified transportation issues and will provide further clarification where needed.
- We are circulating a draftT3Medicaid School-Based Administrative Claiming Guide intended to help schools correctly bill for the Medicaid services they provide by consolidating and providing a consistent national statement of existing requirements.
- We will provide training and technical assistance to schools and school districts on how to use existing guidance to claim for administrative services and how to use the guide once it is final.
- We also have taken action to defer inappropriate claims.

We agree with the GAO that payment methodologies should balance the need to ensure the proper expenditure of Federal Medicaid funds and the flexibility of States to expend such funds without being unduly burdened. This, however, has not proven to be easy. As the GAO observed in their testimony last year, AStriking 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.

We are working to improve the collection and analysis of data on State Medicaid school-based program expenditures so we will have a clearer picture of the needs and challenges before us. We are also reviewing our oversight and monitoring in this area. We are committed to working with States and school districts to overcome remaining challenges and ensure that all parties understand their opportunities and obligations with regard to the provision of school-based Medicaid services.

BACKGROUND

Medicaid covers school-based services when they are primarily medical and not educational in nature. They must be provided by a qualified Medicaid provider to Medicaid-eligible children, and cannot be provided free to all students. For services included under the Individuals with Disabilities Education Act, they must be considered medically necessary for the Medicaid-eligible child and they must be listed in the child's Individualized Education Program. The services provided in schools can include:

- routine and preventive screenings and examinations;
- diagnosis and treatment of problems found;
- monitoring and treatment of chronic medical conditions; and

- speech, occupational, or physical therapy, or other services provided to children under the Individuals with Disabilities Education Act.

Medicaid funding for school-based services was limited to coverage for routine screenings and treatment of acute, uncomplicated problems until 1988. Then, Medicaid's role in supporting school-based health care was expanded under the Medicare Catastrophic Coverage Act. That law stipulates that Medicaid—not the Department of Education or local school districts—pays for services provided to Medicaid-eligible children with disabilities. In order for Medicaid to pay for their school-based care, such children must have an Individualized Education Program, in accordance with the Individuals with Disabilities Education Act.

There has been a surge of State interest in Medicaid reimbursement for school-based health services, mostly for Medicaid-eligible children with special needs under the Individuals with Disabilities Education Act. We have encouraged this because of the potential for school-based services to contribute to the growth and development of school age children, allowing them to progress better in school and participate with their non-disabled peers.

Because of concerns about potential improper claiming, we issued a letter to State Medicaid Directors last May clarifying existing policy and halting certain practices. Underlying the May 1999 letter is a very simple, but critical, principle—Medicaid funds must only be used to provide Medicaid covered services to Medicaid-eligible children at a reasonable cost. There are key additional activities of Medicaid, such as outreach and enrollment assistance, but the general rule for services is clear.

However, it has not been easy to balance our program integrity goals with the need to ensure that children receive necessary services. While we have taken several important steps toward clarifying our policy and implementing additional monitoring efforts, we also recognize that additional measures are needed. We are committed to working with States, schools, the Department of Education, the IG, GAO and Congress to determine and achieve the right balance so children receive the care they need and Medicaid funds are spent appropriately in accordance with the law.

BUNDLING

Under a bundling system, States make weekly or monthly payments to schools based on a package of services that are needed by children within various categories of disabilities, rather than paying separately for individual services. Rates for these payments are usually based on a survey of the service needs of children in various disability categories. Many services may be included in the bundled rate, such as physical therapy and speech therapy. Often, the payment is the same regardless of the number of services actually provided or the specific costs of the services involved.

HCFA initially approved some bundling methodologies because they seemed an efficient way to give States and schools both the funding and the flexibility they need. However, schools have not had the types of data readily available that are necessary to support bundling. We agree with GAO that existing bundling methodologies may have placed Medicaid at risk for improper claims because they do not ensure that services have been provided or are eligible for coverage. That is why, in our May 1999 letter, we informed States we would no longer approve bundling methodologies. This suspension has allowed time to explore ways to balance the need for flexibility with our obligation to protect Medicaid program integrity.

With our partners, we have identified several outstanding challenges. Key among these is finding the appropriate balance between the need for, and the burden of, using and maintaining appropriate documentation. As noted by the GAO report, school-based providers usually do not use such documentation of the services actually provided in developing bundled billing methodologies. They may not maintain adequate or readily available documentation of the services actually provided for bundled payments. They may not have the administrative infrastructure needed to do so. Also, all States do not conduct periodic reviews to reconcile claims for services delivered and costs for those services.

Without proper documentation, there is no reliable basis for determining whether the needed service was delivered at a reasonable rate. States could obtain Federal matching funds for services that have not been provided. And it is possible that States could claim funds for services that are not covered by Medicaid. This could violate the Social Security Act, which requires that States have methods and procedures to assure that Medicaid payments are consistent with efficiency, economy, and quality of care.

We believe the processes that have been used for developing bundled rates have been inconsistent with economy, since the rates were not designed to accurately re-

flect true costs or reasonable fee-for-service rates. The processes were not consistent with the efficiency requirement, since they would require substantial Federal oversight to establish the accuracy and reasonableness of State expenditures. As a result, there is no reliable basis for determining that the bundled payment rate is related to the actual cost.

To help us address these issues, we created a workgroup in July 1999 with representatives of State Medicaid Agencies, the Department of Education, local education agencies and the Office of Management and Budget. The workgroup heard a variety of perspectives, and played a key role in helping us to define several issues that should be considered in bundled payment methodologies for school based services. These issues include:

- **Documentation** that goes beyond requiring simple Assurances. *States need to provide detailed information at the provider or school level to establish auditible records and develop methods for the maintenance of documentation.*
- **Retrospective reconciliation** or other safeguards to assure that the bundled payment methodology continues to reflect the services that are delivered.
- **Reasonable payment** rates derived from identification of reasonable costs for specific services included in bundled payments, and recognizing varying levels of services needed by children with different needs.
- **Statistically valid sampling methodologies** to accurately identify services provided to Medicaid-eligible children with disabilities who have an Individualized Education Program. The sampling methodology should take into account the medical needs of children with varying disabilities and geographic distribution of children with disabilities.

Any methodology that does not address these issues could place the Federal government at risk for expenditures not permitted by law. We are now testing statistical sampling methodologies and working with Department of Education colleagues and others to better identify what documentation schools have or could reasonably maintain. We also are considering use of outside expert contractors to help us develop appropriate reimbursement methodologies and requirements, as we have done for other prospective payment systems.

TRANSPORTATION

Schools can be reimbursed for a variety of transportation costs that are related to provision of Medicaid services. We agree with the GAO that policies for reimbursement of transportation costs should offer equitable treatment for children with different types of disabilities.

We issued a letter to State Medicaid Directors in May 1999 to clarify several issues:

- Transportation to and from school may be claimed when the child receives a medical service in school on a particular day and when the need for medically necessary specialized transportation is specifically listed in a student's Individual Education Plan.
- If a child requires transportation in a specially adapted vehicle, including a specially adapted school bus, that transportation may be billed to Medicaid only on days when the child receives a Medicaid-covered service.
- Transportation from school to a provider in the community may be billed to Medicaid.
- States must provide documentation of transportation service, usually in the form of a trip log maintained by the provider of the specialized transportation service.
- States must describe the methodology used to establish the transportation rate in the State Medicaid plan.
- States must develop a cost allocation methodology to ensure that Medicaid only pays for that portion of the specialized transportation (and regular bus transportation with an aide) attributable to Medicaid beneficiaries.

We agree with the GAO that the May 1999 letter has not eliminated all confusion on transportation matters. We will issue additional guidance on coverage of transportation when an aide or other medical professional accompanies a child. We also plan to further clarify transportation services, including the specific types of vehicles, staff, characteristics, and purposes of service that may be claimed for children with Individualized Education Programs. And we will work with our regional offices to assure that there is a uniform understanding and application of these policies.

ADMINISTRATIVE CLAIMING

Schools are allowed to bill Medicaid for administrative costs related to outreach, enrollment, and provision of Medicaid services. However, there has been confusion

regarding precisely which administrative services qualify for reimbursement and how to calculate such things as the share and value of professional staff time. We agree that there must be a uniform national statement of requirements for claiming the costs of school-based administrative activities. That is why we developed the draft Medicaid School-Based Administrative Claiming Guide.

The Guide is intended to help schools provide Medicaid services by consolidating and clarifying existing requirements for claiming related administrative costs. When final, it will provide a consistent national statement of these requirements. It will not establish new policies. It will serve as a reference on all aspects of school-based administrative claiming, and allow States to feel comfortable that they are submitting claims in compliance with the law.

For example, it includes a thorough discussion of claiming for administrative activities performed by skilled professional medical personnel. It addresses time study sampling methodologies, which are the primary mechanism for identifying and categorizing administrative activities performed by school employees that may be properly reimbursed under Medicaid. And it provides standard activity codes that may be further tailored to reflect local differences and other appropriate accounting methods allowed. Such an approach addresses the need for a balance between State/local flexibility and consistency within and across States.

We released a draft of the Guide in February to solicit comments from States, schools, and other interested parties. We have asked interested parties to give us feedback by April 3. The draft is available on the HCFA web site at www.hcfa.gov. Once we have reviewed the feedback we expect to make changes before issuing a final Guide. At that time, we will work to help all relevant parties understand how to use it, particularly small school districts that would otherwise have difficulty claiming. This will include technical assistance, regional conference calls, and a national training session in Baltimore. Schools and school districts will be a critical part of our training effort. We have already begun working with school districts to foster an understanding of related policy.

We also will incorporate the Guide into formal financial management tools, procedures, review guides, and manuals on the oversight of school-based services and administrative activities. We will review existing Medicaid expenditure reporting and work with States to identify additional data that should be gathered. We will work prospectively as partners with States to ensure that proper claiming methodologies are used and to ensure that any future changes in claiming procedures by States will be part of a formal review and approval process. And, consistent with our legal authority and responsibility, we will recoup funds inappropriately claimed by States.

We share the concerns expressed by the GAO and several members of Congress that private firms who receive a percentage of reimbursement as payment for consulting and billing services, rather than a fixed fee, have an incentive to maximize the amount of reimbursement claimed, and we will further review claims to ensure that no consultant's contingency fees are included. We also share GAO concerns about States retaining a share of Federal funds related to schools' claims. However, this practice is allowable under current law and can only be changed by the Congress.

CONCLUSION

We recognize that many challenges remain in striking the balance between ensuring fiscal integrity and providing appropriate school-based Medicaid services. We are committed to taking all necessary steps to ensure proper and efficient operation of school-based programs. We will work with our Federal, state, and local partners to continue to address these issues. I thank you again for holding this hearing, and I am happy to answer your questions.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

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

April 7, 2000

Dear State Medicaid Director.

Over the past few years, States have made enormous progress increasing access to health care coverage for low-income, working families As a result of eligibility expansions, simplified enrollment procedures, and creative outreach campaigns, millions more low-income children and parents are eligible for health care coverage through Medicaid or through separate State Children's Health Insurance Programs (SCHIP). And yet, at the same time that States have made expansions of coverage a priority, instances in which eligible children and parents have lost out on coverage have come to light

The delinkage of Medicaid from cash assistance has made it possible for States to offer low-income families health care coverage regardless of whether the family is receiving welfare, but it has created challenges as well as opportunities for States Last August, President Clinton spoke to the National Governors' Association (NGA) about the importance of ensuring that everyone who is eligible for Medicaid is enrolled, and directed the Department of Health and Human Services (HHS) to take several actions to improve the health care available to low-income families

Today, I am writing to provide guidance and information that will build on our joint efforts to improve eligible, low-income families' ability to enroll and stay enrolled in Medicaid. We are concerned that some families who left the Temporary Assistance for Needy Families (TANF) program and who remain eligible for Medicaid or Transitional Medical Assistance (TMA) benefits may have lost coverage. In addition, it appears that some children who became ineligible for Supplemental Security Income (SSI) benefits due to a change in the SSI disability rules may not have been continued on Medicaid despite Congressionally mandated requirements.

This letter covers three related topics. First, it outlines a series of actions that all States must take to identify individuals and families who have been terminated improperly and to reinstate them to Medicaid. Second, it clarifies guidance on Federal requirements relating to the process for redetermining Medicaid eligibility. Third, it reviews the obligations imposed by Federal law with regard to the operation of computerized eligibility systems. We have also enclosed a set of questions and answers to help States implement the guidance. We will continue to issue written answers to questions that arise and make those questions and answers available to States on an ongoing basis.

Reinstatement for Improper Medicaid Terminations

Over the past several years, cash assistance rules have changed at both the Federal and State levels. As a result of these changes to promote work and responsibility, and a strengthened economy, many fewer families are receiving cash assistance. When eligibility for cash assistance and Medicaid were delinked, Congress and the Administration took specific actions to assure that Federal law continued to guarantee Medicaid eligibility for children and families who formerly qualified for Medicaid through their receipt of cash assistance.

These changes required a significant retooling of Medicaid eligibility rules and procedures at the State and local level. In some cases, it appears that necessary adjustments to State and/or local policies, systems and procedures have not been made.

Several States have taken action to reinstate coverage for families and children who have been terminated improperly from Medicaid. Reinstatement is compelled by Federal regulations and prior court decisions. Under Federal regulation 42 CFR 435.930, States have a continuing obligation to provide Medicaid to all persons who have not been properly determined ineligible for Medicaid. This includes individuals whose Medicaid has been terminated through computer error or without a proper redetermination of eligibility. Therefore, all States must take steps to identify individuals who have been terminated improperly from Medicaid and reinstate them, as described below.

Identifying Improper Actions

A. Requirements for TANF-related terminations

States must determine whether individuals and families lost Medicaid coverage when their TANF case was closed, or when their TMA coverage period ended without a proper notice or without a proper Medicaid redetermination, including an ex parte review consistent with previous guidance. For example, States should review whether their computer system improperly terminated Medicaid coverage when TANF benefits were terminated, and they should consider whether families whose TANF termination was due to earnings were evaluated with respect to ongoing Medicaid eligibility, including TMA. In addition, if a State did not implement its Section 1931 category until some time after its TANF program went into effect, the State must review Medicaid/TANF terminations that occurred before the State had an operative Section 1931 category.

B. Requirements for terminations of disabled children eligible for Medicaid under Section 4913 of the Balanced Budget Act of 1997

Children who became ineligible for SSI due to the 1996 change in the SSI disability rules and then were terminated from Medicaid either without adequate consideration of their eligibility

under Section 4913 of the BBA, or without a proper redetermination, including an ex parte review consistent with previous guidance, must be identified and reinstated. States must compare the Social Security Administration (SSA) list of children whose Medicaid eligibility was protected by Section 4913 and determine which, if any, of those children are not currently receiving Medicaid or are receiving Medicaid but are not identified as a Section 4913 child. The Health Care Financing Administration (HCFA) and SSA will work with States to ensure that States have the information that they need to identify Section 4913 children. The results of these cross-matches should be promptly reported to the HCFA Regional Office.

C. Improper Denials of Eligibility

In some States, eligible individuals applying for both Medicaid and TANF may have been denied Medicaid improperly because eligibility determinations continued to be linked. While HCFA is not requiring States to identify and enroll these applicants, we encourage you to do so.

Reinstatement

If, after a State-wide examination of enrollment policies and practices, it appears that there have been improper terminations since their TANF plan went into effect, States must develop a timetable for reinstating coverage and conducting follow-up eligibility reviews as appropriate. Action to reinstate coverage should be taken as quickly as possible, and States should keep their HCFA regional office informed as they review their policies and practices and develop their plans. This guidance should not delay State actions to reinstate individuals that are already under way.

Because it may not always be clear or easy for the State to determine whether a particular individual was terminated properly, States that determine that problems in policy or practice did cause individuals to lose Medicaid improperly may reinstate coverage without making a specific finding that an individual termination was in fact improper. Such action is consistent with Federal regulations that require that eligibility be determined in a manner consistent with simplicity of administration and the best interests of the applicant or recipient (42 CFR 435.902).

Federal Financial Participation (FFP) will be available for up to 120 days of coverage after reinstatement, pending a redetermination of ongoing eligibility, regardless of the outcome of the redetermination process. States that have developed reinstatement procedures have typically reinstated individuals and families for a period of 60 or 90 days. Coverage provided during this time period will not be considered for any Medicaid Eligibility Quality Control (MEQC) purpose.

If a State determines that there have been no instances of improper terminations, it should inform the Regional Office of the review undertaken and the basis for its conclusions. HCFA will provide assistance to States throughout this process.

Contacting Individuals and Families

States may have to reinstate individuals and families who have not been in contact with the Medicaid agency for some time, and should take all reasonable steps to identify the individual or family's current address. For example, States could check Food Stamp program records for a more up-to-date address and alert caseworkers to the list of affected individuals so that these individuals are identified if they contact the agency for other reasons. Other outreach efforts might include notices to families receiving child care services and television and radio spots

Redetermining Eligibility Once Reinstatement is Accomplished

In most situations, States will need to redetermine eligibility after reinstatement to assess whether the family or individual is currently eligible for Medicaid. To ensure that families understand the process and have adequate time to respond to requests for further information, States should allow a reasonable time for the review process. As noted above, FFP will be available for up to 120 days after reinstatement to allow States adequate time to review ongoing eligibility.

Individuals and families whose most recent Medicaid eligibility determination or redetermination occurred less than 12 months before reinstatement may be continued on Medicaid until 12 months from the date of that last eligibility review, without any new redetermination of eligibility. In these situations FFP will not be limited to 120 days. Individuals and families who have earnings may be covered under TMA and therefore would be subject to the State's TMA reporting and review procedures

When States redetermine the eligibility of children identified by SSA as a Section 4913 child, the child does not lose protection under Section 4913 because of a prior break in eligibility. Continuous eligibility is not a requirement of Section 4913.

Covering Services Provided Prior to Reinstatement

Many of the individuals and families who were terminated improperly will have incurred medical expenses that would have been covered under Medicaid. States have the option to provide payment to providers and individuals for the cost of services covered under the State's Medicaid plan provided between the time the individual was terminated from Medicaid and reinstatement. FFP will be available to States that provide such retroactive payments, including direct payments by the State to individuals who had out-of-pocket costs for services that would have been covered by Medicaid had the individual not been terminated from the program. FFP in direct payments will be based on the full payment amount. FFP in payments to participating Medicaid providers will be at the Medicaid rate.

Review of Federal Requirements for Eligibility Redeterminations

Over the past few years, HCFA has issued guidance on the redetermination process (see letters issued February 6, 1997, April 22, 1997, November 13, 1997, June 5, 1998 and March 22, 1999). This guidance instructs States that individuals must not be terminated from Medicaid unless the State has affirmatively explored and exhausted all possible avenues to eligibility. It also outlines requirements for ex parte reviews. However, recent reports indicate that inadequate redetermination procedures have caused some eligible individuals and families to lose coverage, and some States have asked for more guidance in this area. As such, this letter restates and clarifies the previous guidance on (1) information that can be required at redeterminations, (2) ex parte reviews; and (3) exhausting all possible avenues of eligibility.

Information Required at Redeterminations

Pursuant to Federal regulations (42 CFR 435.902 and 435.916), States must limit the scope of redeterminations to information that is necessary to determine ongoing eligibility and that relates to circumstances that are subject to change, such as income and residency. States cannot require individuals to provide information that is not relevant to their ongoing eligibility, or that has already been provided with respect to an eligibility factor that is not subject to change, such as date of birth or United States citizenship.

Questions about the proper scope of a redetermination also arise when an individual reports a change in circumstances before the next regularly scheduled redetermination. Federal regulations require a prompt redetermination in such cases, but States may limit their review to eligibility factors affected by the changed circumstances and wait until the next redetermination to consider other factors. For example, if a State generally conducts a redetermination every 12 months and a parent reports new earnings three months after the family's most recent redetermination, the State must assess whether the individuals in the family continue to be eligible for Medicaid in light of the new earnings. However, it may wait until the next regularly scheduled redetermination to consider other eligibility factors.

Ex Parte Reviews

States are required to conduct ex parte reviews of ongoing eligibility to the extent possible, as stated in HCFA's previous guidance. By relying on information available to the State Medicaid agency, States can avoid unnecessary and repetitive requests for information from families that can add to administrative burdens, make it difficult for individuals and families to retain coverage, and cause eligible individuals and families to lose coverage. States should use the following guidelines and enclosed questions and answers in conducting redeterminations.

Program records. States must make all reasonable efforts to obtain relevant information from Medicaid files and other sources (subject to confidentiality requirements) in order to conduct ex

parte reviews States generally have ready access to Food Stamp and TANF records, wage and payment information, information from SSA through the SDX or BENDEX systems, or State child care or child support files

Family records. States must consider records in the individual's name as well as records of immediate family members who live with that individual if their names are known to the State Again, this should be done in compliance with privacy laws and regulations.

Accuracy of information. States must rely on information that is available and that the State considers to be accurate Information that the State or Federal government currently relies on to provide benefits under other programs, such as TANF, Food Stamps or SSI, should be considered accurate to the extent that those programs require regular redeterminations of eligibility and prompt reporting of changes in circumstances Even if benefits are no longer being provided under another program, information from that program should be relied on for purposes of Medicaid ex parte reviews as long as the information was obtained within the State's time period for conducting Medicaid redeterminations unless the State has reason to believe the information is no longer accurate

Timing of redetermination States have the option to schedule the next Medicaid redetermination based on either the date of the ex parte review or the date of the last eligibility review by the program whose information the State relied on for the ex parte review Since the date of the ex parte review will be the later of the two dates, States could reduce their administrative burden by scheduling the next redetermination based on the ex parte review date

Use of eligibility determinations in other programs. The responsibility for making Medicaid eligibility determinations is generally limited to the State Medicaid agency or the State agency administering the TANF program However, the State may accept the determination of other programs about particular eligibility requirements and decide eligibility in light of all relevant eligibility requirements.

Obtaining information from individuals. If ongoing eligibility cannot be established through ex parte review, or the ex parte review suggests that the individual may no longer be eligible for Medicaid, the State must provide the individual a reasonable opportunity to present additional or new information before issuing a notice of termination.

Exhausting All Possible Avenues of Eligibility

The Medicaid program has numerous and sometimes overlapping eligibility categories. For eligibility redeterminations, States must have systems and processes in place that explore and exhaust all possible avenues of eligibility. These systems and processes must first consider whether the individual continues to be eligible under the current category of eligibility and, in the case of a negative finding, explore eligibility under other possible eligibility categories.

The extent to which and the manner in which other possible categories must be explored will depend on the circumstances of the case and the information available to the State. If the ex parte review does not suggest eligibility under another category, the State must provide the individual a reasonable opportunity to provide information to establish continued eligibility. As part of this process, the State will need to explain the potential bases for Medicaid eligibility (such as disability or pregnancy).

In addition, in States with separate SCHIP programs, children who become ineligible for Medicaid are likely to be eligible for coverage in SCHIP. States should develop systems for ensuring that these children are evaluated and enrolled in SCHIP, as appropriate. As is consistent with the statutory requirements, States must coordinate Medicaid and SCHIP coverage.

Computerized Eligibility Systems

Changes in eligibility rules affecting cash assistance and Medicaid have required States with computerized eligibility systems to modify their computer-based systems. If a State has not modified its system properly, some applicants may be erroneously denied enrollment in Medicaid. In addition, some beneficiaries may lose coverage even though they still may be eligible.

States have an obligation under Federal law to ensure that their computer systems are not improperly denying enrollment in, or terminating persons from, Medicaid. The attached questions and answers explain this obligation and present some practical suggestions on how States might meet their responsibilities under the law.

Conclusion

Most States are addressing the challenges associated with changing eligibility rules and systems, and many have developed promising new strategies for ensuring that children and families who are not receiving cash assistance are properly evaluated for Medicaid. HCFA will work with States as they assess the need for reinstatement, provide technical assistance to States implementing reinstatements, and facilitate exchanges among States to promote best practices to improve and streamline redetermination procedures. We anticipate that there will be many questions about the reinstatement process and the redetermination guidelines. We will make every effort to address your questions promptly, and to post and maintain a set of questions and answers on HCFA's website so that all States will be aware of how particular situations should be handled.

As important as it is to correct problems that have led eligible children and families to lose coverage, it is equally important that we improve eligibility redetermination processes and computer systems to prevent problems in the future. We are committed to working with you to implement this guidance to help achieve our mutual goal of an efficient, effective Medicaid program that helps all eligible families. If you have any questions concerning this letter, please contact your regional office.

Sincerely,

Timothy M. Westmoreland
Director

Attachment

cc:
All HCFA Regional Administrators

All HCFA Associate Regional Administrators
For Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors' Association Director

QUESTIONS AND ANSWERS

Redeterminations

Q. When should a State rely on information available through other program records?

A. States must rely on all information that is reasonably available and that the State considers to be accurate. Information that the State or Federal government is relying on to provide benefits under other programs, such as TANF, Food Stamps or SSI, should be considered accurate to the extent that those programs require regular redeterminations of eligibility and prompt reporting of changes in circumstances. For example, in the Food Stamp program, Federal law requires States to recertify eligibility on a regular basis, and individuals receiving food stamps are required to report promptly any change in their circumstances that would affect eligibility. Thus, information in Food Stamp files of individuals currently receiving food stamp benefits should be considered accurate for purposes of Medicaid ex parte reviews

Q. If benefits are no longer being paid under another program, can information from that program be relied on for purposes of Medicaid ex parte reviews?

A. It can be relied on if the information was obtained within the time period established by the State for conducting Medicaid redeterminations unless the State has reason to believe the information is no longer accurate. For example, take the case of a State that normally schedules Medicaid redeterminations every 12 months. If a child was determined financially eligible for SSI in January, 2000 and then loses SSI on disability-related grounds in March, 2000, the SSA financial information should still be considered accurate when the State redetermines Medicaid eligibility in March, 2000.

Q. When can the State schedule the next Medicaid redetermination if it relies on information from another program for its ex parte review?

A. The State may schedule the next Medicaid redetermination based on the date of the ex parte review or the date when the last review of eligibility was conducted in the other program. For example, consider a State that normally schedules Medicaid redeterminations every six months and that determines, based on a Medicaid ex parte review in March, that the family continues to be eligible for Medicaid. If the ex parte review relies on Food Stamp program information, and the last Food Stamp review took

place in January, the State may wait until September (six months from March) to schedule its next Medicaid redetermination review, or it may schedule the next redetermination in June (six months after the last Food Stamp recertification).

Q. When can Medicaid accept another program's eligibility requirement determination?

A. When an eligibility requirement under another program applies equally to the Medicaid program, the State may accept the other program's determination with respect to this particular eligibility requirement. For example, if the resource standard and method for determining countable assets under the State's TANF program were the same or more restrictive than the asset rules in the Medicaid program, the Medicaid agency may accept TANF agency's determination that a family's assets fall below the Medicaid asset standard without any further assessment on it own part regarding this requirement. The Medicaid agency would then proceed to make a final determination of eligibility in light of all relevant eligibility requirements.

Q. When an individual reports a change in circumstances before the next regularly scheduled redetermination, must the State conduct a full redetermination at that time?

A. No. The State may limit this redetermination to those eligibility factors that are affected by the changed circumstances and wait until the next regularly scheduled redetermination to consider other eligibility factors. For example, if a State generally conducts a redetermination every 12 months and a parent reports new earnings three months after the family's most recent redetermination, the State must assess whether the individuals in the family continue to be eligible for Medicaid in light of the new earnings. However, it may wait until the next regularly scheduled redetermination to consider other eligibility factors.

Whether the State conducts a full or limited redetermination when an individual reports a change in circumstance, Federal regulations require that the redetermination must be done promptly.

Q. How must the State proceed to consider all possible avenues of eligibility before terminating (or denying) eligibility?

A. The systems and processes used by the State must first consider whether the individual continues to be eligible under the current category of eligibility and, if not, explore

eligibility under other possible categories The extent to which and manner in which other possible categories must be explored will depend on the circumstances of the case and the information available to the State.

For example, if the State has information in its Medicaid files (or other available program files) suggesting an individual is no longer eligible under the poverty-level category but potentially may be eligible on some other basis (e g , under the disability or pregnancy category), the State should consider eligibility under that category on an ex parte basis. If the ex parte review does not suggest eligibility under another category, the State must provide the individual a reasonable opportunity to provide information to establish continued eligibility. As part of this process, the State will need to explain the potential bases for Medicaid eligibility (such as disability or pregnancy).

Q. If a State has determined that an individual is no longer eligible under the original category of coverage, does the State have the option to terminate coverage and advise the individual that he or she may be eligible under other categories and could reapply for Medicaid?

A. No. States must affirmatively explore all categories of eligibility *before* it acts to terminate Medicaid coverage

Q. Does this requirement to explore all categories of coverage apply to Transitional Medical Assistance? When the TMA period is over, can the State terminate coverage and advise the family to reapply for Medicaid?

A. No. TMA is like any other Medicaid eligibility category. Eligibility under other categories of coverage must be explored before coverage is terminated. In light of expansions in coverage, particularly for children, many children in families receiving TMA will continue to be eligible under other eligibility categories.

Computer Systems

Q. My State's computer system may be erroneously terminating Medicaid coverage when families leave cash assistance. Because of Y2K, programming on a number of priorities has been backed up. The delinking reprogramming is scheduled to take place this fall. Is this an acceptable corrective action?

A No HCFA recognizes that Y2K delayed other priorities, and we know that it takes time to make computer changes However, States have an obligation to move expeditiously to correct computer programming problems that are leading to erroneous Medicaid denials and terminations HCFA will be working with States to correct computer problems and will provide whatever assistance we can to help resolve the problem

In the meantime, no person should be denied Medicaid inappropriately due to computer error, and no person should have his/her Medicaid coverage terminated erroneously due to computer error. Once a problem with a State's computerized eligibility system has been identified, the State must take immediate action to correct the problem If programming changes cannot be made immediately, an interim system to override computer errors must be put in place to ensure that eligible individuals are not denied or losing Medicaid HCFA will review State procedures and State plans to adopt new procedures as follow-up to the Medicaid/TANF State reviews.

Q. Have other States experienced these problems? How have they corrected the problems?

A. Each State's issues and processes are unique The measures that will be effective to remedy computer-based problems will vary from State to State There are a number of ways States can address these issues

Correct the Computer Error - The most direct way to remedy the problem is by making the necessary changes to the computer system. This should occur expeditiously.

Implement an Effective Back-Up System to Prevent Erroneous Actions- While corrections to the computer system are being made, States must ensure that erroneous actions do not occur. States that have identified computer-based problems in their systems have adopted different approaches; four different approaches are described below. In each case, the State adopted a formal and systematic approach to correcting computer-based errors. A simple instruction to workers to override or work around computer errors is insufficient to ensure that erroneous denials and terminations will not occur.

Supervisory review. To stop erroneous terminations from occurring due to Medicaid/TANF delinking problems, Pennsylvania required supervisors to review all TANF case closures before any Medicaid termination could proceed. Having trained supervisors review terminations (and denials) can prevent wrongful terminations (and denials) from occurring.

Centralized review. Maryland instituted a system in which local supervisors and a State-level task force review all Medicaid denials and terminations that coincide with a TANF denial or termination. This system has been instrumental in ensuring that thousands of eligible families were not denied or terminated from Medicaid while computer fixes were finalized.

"Peremptory" reinstatement. The State of Washington devised a system in which cases to be terminated were given a next-day audit by caseworkers and managers. Cases that continue to be eligible for Medicaid are 'reinstated' before the case is scheduled to be closed.

Interim hold on case actions. A short-term moratorium on Medicaid case closings based on certain computer codes pending implementation of other solutions might be an option for some States. Medicaid case closings could be held as long as Federal requirements on the frequency of redeterminations are met.

Q. Are there any actions that States must take before they alter their computer systems?

A. Yes. In general, prior authorization from HCFA must be obtained in order for a State to receive federal matching funds for changes it makes to its computer systems. HCFA will work with States and provide technical assistance as early in the planning process as possible in an effort to help States accomplish their objective.

Q. Is there additional funding available to help with the changes in the computer system?

A. Yes. Per our letter of January 6, 2000 concerning the $500 million federal fund established in 1996, there is federal funding available for computer modifications related to delinking. We encourage you to review that letter and the amount your State has available from the enhanced matching funds to make changes needed as a result of the enactment of Section 1931 (the delinking provision). MMIS enhanced funding may also be available for some MMIS changes; please consult with your regional office.

RESPONSES TO QUESTIONS FROM SENATOR MOYNIHAN DURING HEARING

Question: I wonder if Mr. Westmoreland could not look into that for us [why states like Minnesota are not spending Medicaid dollars on school-based health services]. Minnesota is not in the habit of depriving people of education or health care. You could always call them up and ask [the reasons].

Answer: The lack of Medicaid school-based billing reported to GAO by the State of Minnesota does not necessarily mean that the State is not providing school-based health services to their children, only that they are not billing Medicaid. Under the Individuals with Disabilities Education Act (IDEA), all disabled children must be provided with the services they need to access a free and appropriate public education. This is true regardless of whether or not schools choose to bill Medicaid for covered services provided to eligible children at school.

There are a number of reasons for State variation in Medicaid claiming for school-based health services. State Medicaid claiming for school services normally begins with participation from only a few school districts. The experience gained by those schools in submitting correct, approvable Medicaid claims is then used to expand to more and more school districts. Also, school-based claiming begins with a few different school-based providers submitting claims (e.g., speech therapists, occupational therapists). As the program matures, more and different types of providers begin

billing Medicaid. The variation in claiming depends largely on how prepared school districts and providers are to develop systems or methods for billing Medicaid and on how prepared the State Medicaid agency is to accept, process and approve claims.

In Minnesota, where the school-based claims are relatively low, around $2 per Medicaid-eligible child, the State Medicaid agency just received our approval to begin, in July 2000, paying school-based claims for all schools in the State for the services of seven different provider types. The provider types are: 1) physical therapist, 2) occupational therapist, 3) speech language pathologist or audiologist, 4) psychologist, clinical psychologist and social worker, 5) paraprofessional, such as management aid, 6) nurse, and 7) assistive technology specialist. For each encounter with a Medicaid-eligible child by these school-based providers, Medicaid will pay a rate based on the actual costs of providing the service rather than the lower community provider rate that was being paid by Medicaid. Since Medicaid claiming for school-based services is being expanded to more schools and payment rates for the services provided are being increased, we expect Minnesota's school-based service claims to Medicaid to rise dramatically.

Question: [Speaking of children losing Medicaid due to Temporary Assistance for Needy Families (TANF) legislation] Please keep the Committee in touch with what happens.

Answer: Within the next few days, we will send a letter to all State Medicaid Directors which will address the issue of reinstatement of people improperly terminated from Medicaid as a result of TANF. This letter will outline a series of actions that all States must take to identify individuals and families who have been terminated improperly and to reinstate them to Medicaid; clarify guidance on Federal requirements relating to the process for redetermining Medicaid eligibility; and review the obligations imposed by Federal law with regard to the operation of computerized eligibility systems.

We will brief your staff on this letter when we send it and will keep you and your staff informed on the efforts made by States to address these requirements. We also will provide a copy of this letter to the Committee.

Question: Do you have a variation in the number of disabled children eligible from State-to-State? And within the variation are there specific physical disabilities?

Answer: There are a number of different ways to count disabled children eligible for public services. Children with disabilities are served in schools under the guidelines of the Individuals with Disabilities Education Act or IDEA. The Health Care Financing Administration does not keep track of the number of children served under this program, but the Department of Education does. A copy of Department of Education's 21st Annual Report to Congress is posted on their web site at www.ed.gov. Table AA2 of the appendix to that report provides a State-by-State breakdown of the number of school-aged disabled children with Individual Education Plans or IEPs by disability (Attachment A). It is important to note that although all of these children are served under IDEA, have IEP's and are receiving services in school, most of the services provided to the children are educational rather than medical services. Not all of these children are eligible for Medicaid.

Medicaid data on disabled children comes from the "HCFA–2082" statistical reports that States must submit annually. From those reports, we can compile data on the total number of individuals enrolled in Medicaid in the "blind or disabled" category and the total number and percentage of children aged 0 to 20 enrolled in that category at any point during fiscal year 1998 (Attachment B). The usefulness of this data is limited in that many States only place beneficiaries that do not fall into any other eligibility category in the "blind or disabled" category. This is especially true in States that do not rely on Supplemental Security Income (SSI) to make Medicaid eligibility determinations, the so-called 209(b) States. Therefore, the counts may be low because many blind or disabled children were placed in other eligibility categories and so do not appear as blind or disabled. It is also important to note that the 2082 data contains no information on how many of these disabled children attend school.

Another set of data that provides some information on the number of disabled children belongs to the Social Security Administration (SSA. Social Security data comes from the 10-percent sample file of the Supplemental Security Record (SSR) (Attachment C). We can compile data to show the total number of children age 0–18 who received SSI payments in December 1999. All children who receive these payments are eligible for Medicaid.

In comparing the Department of Education, HCFA and SSA data, it is important to note that the Department of Education data counts the number of children served under Part B of IDEA during the 1997–98 school year, the SSA data counts the number of individuals who received benefits in a single month, and the HCFA data counts all individuals enrolled in Medicaid at any time during the year. In addition,

since the SSA data is based on a sample of the total population, it is subject to sampling error.

Question: [Speaking of legislation that involved a cube root] Would you let us know about that? Send a letter.

Answer: The citation that I was referring to was the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, P.L. 101–381.

ATTACHMENT A

TO ASSURE THE FREE APPROPRIATE PUBLIC EDUCATION OF ALL CHILDREN WITH DISABILITIES

Individuals with Disabilities Education Act, Section 618

Twenty-first Annual Report to Congress
on the
Implementation of the
Individuals with Disabilities Education Act

U.S. Department of Education

1999

Table AA2

Number of Children Ages 6-21 Served Under IDEA, Part B by Disability

During the 1997-98 School Year

STATE	ALL DISABILITIES	SPECIFIC LEARNING DISABILITIES	SPEECH OR LANGUAGE IMPAIRMENTS	MENTAL RETARDATION	EMOTIONAL DISTURBANCE
ALABAMA	91,025	39,379	16,812	22,621	5,618
ALASKA	16,005	9,586	3,357	755	827
ARIZONA	75,240	44,163	13,634	6,480	5,071
ARKANSAS	48,870	21,841	8,332	12,226	400
CALIFORNIA	547,309	329,881	117,880	31,118	19,840
COLORADO	65,734	33,764	11,921	3,220	8,497
CONNECTICUT	69,532	34,930	12,201	4,101	9,752
DELAWARE	14,559	9,191	1,572	1,908	718
DISTRICT OF COLUMBIA	7,292	4,210	366	1,184	1,079
FLORIDA	307,149	167,557	72,270	36,935	35,608
GEORGIA	133,367	42,225	28,819	28,583	22,340
HAWAII	16,930	8,292	2,539	2,499	2,048
IDAHO	22,824	13,566	3,550	2,709	627
ILLINOIS	250,193	126,222	54,079	26,067	29,722
INDIANA	129,584	55,129	35,370	21,216	9,857
IOWA	63,820	30,834	6,998	14,095	8,873
KANSAS	50,027	21,560	11,128	5,697	4,766
KENTUCKY	71,242	21,954	18,515	18,120	9,285
LOUISIANA	84,690	37,715	16,751	12,927	8,914
MAINE	30,686	13,100	7,067	1,211	4,256
MARYLAND	99,438	45,130	26,619	6,301	7,668
MASSACHUSETTS	148,364	90,785	22,676	14,435	12,733
MICHIGAN	181,578	86,543	37,392	21,401	17,562
MINNESOTA	92,966	39,456	15,605	10,316	17,568
MISSISSIPPI	57,598	29,399	17,615	7,260	775
MISSOURI	119,565	64,154	24,620	12,747	9,540
MONTANA	17,016	9,574	3,396	1,165	1,105
NEBRASKA	37,691	15,965	9,101	5,944	2,873
NEVADA	28,414	18,263	4,688	1,672	1,549
NEW HAMPSHIRE	24,676	12,530	5,169	983	2,148
NEW JERSEY	189,219	105,557	47,657	4,631	12,499
NEW MEXICO	45,349	27,368	8,544	2,142	3,454
NEW YORK	373,002	210,348	51,271	16,703	45,149
NORTH CAROLINA	162,628	61,465	27,277	27,466	9,710
NORTH DAKOTA	11,738	5,692	3,212	1,250	808
OHIO	208,954	79,852	43,845	49,767	12,950
OKLAHOMA	71,735	39,555	14,109	9,598	3,278
OREGON	61,346	32,446	13,993	3,956	3,880
PENNSYLVANIA	202,665	106,908	38,590	27,496	18,702
PUERTO RICO	45,466	21,567	5,033	13,467	810
RHODE ISLAND	24,971	14,843	4,515	1,132	2,222
SOUTH CAROLINA	84,223	37,011	19,172	17,428	5,701
SOUTH DAKOTA	13,245	6,747	3,233	1,478	517
TENNESSEE	119,077	58,481	25,353	16,099	3,457
TEXAS	443,341	265,049	67,693	24,688	35,480
UTAH	49,326	28,737	8,480	3,411	4,470
VERMONT	11,000	4,522	1,769	1,320	1,710
VIRGINIA	134,902	66,423	24,595	14,434	12,206
WASHINGTON	98,535	46,861	16,374	7,587	5,126
WEST VIRGINIA	43,482	19,613	10,744	8,365	2,082
WISCONSIN	100,027	46,651	17,261	12,917	16,004
WYOMING	11,508	5,903	2,832	674	917
AMERICAN SAMOA	394	303	17	38	3
GUAM	1,808	1,180	150	102	11
NORTHERN MARIANAS	330	202	9	39	6
PALAU	96	75	4	6	2
VIRGIN ISLANDS	1,833	739	281	589	54
BUR. OF INDIAN AFFAIRS	8,348	4,850	1,646	526	755
U.S. AND OUTLYING AREAS	5,401,292	2,756,046	1,067,181	603,408	455,194
50 STATES, D.C. & P.R.	5,388,483	2,748,497	1,065,074	602,111	454,363

Please see data notes for an explanation of individual State differences.

Developmental Delay is applicable only to children 3 through 9.

Data based on the December 1, 1997 count, updated as of September 1, 1998.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Table AA2

Number of Children Ages 6-21 Served Under IDEA, Part B by Disability

During the 1997-98 School Year

STATE	MULTIPLE DISABILITIES	HEARING IMPAIRMENTS	ORTHOPEDIC IMPAIRMENTS	OTHER HEALTH IMPAIRMENTS	VISUAL IMPAIRMENTS
ALABAMA	1,355	916	612	2,338	611
ALASKA	486	239	66	468	49
ARIZONA	1,344	1,333	1,004	964	511
ARKANSAS	1,026	579	172	3,595	213
CALIFORNIA	5,261	9,050	10,595	13,739	3,795
COLORADO	2,847	1,076	4,034	0	304
CONNECTICUT	1,972	769	235	5,321	421
DELAWARE	0	224	654	0	60
DISTRICT OF COLUMBIA	70	24	149	100	18
FLORIDA	0	2,805	4,621	3,959	1,040
GEORGIA	0	1,353	868	7,336	555
HAWAII	244	246	143	572	61
IDAHO	448	304	127	805	106
ILLINOIS	0	3,144	2,660	4,733	1,100
INDIANA	941	1,557	1,183	1,840	750
IOWA	460	696	1,025	63	163
KANSAS	1,668	592	455	3,573	223
KENTUCKY	1,728	743	459	3,406	431
LOUISIANA	978	1,429	1,336	6,114	468
MAINE	2,224	273	83	1,438	97
MARYLAND	5,605	1,240	496	4,665	489
MASSACHUSETTS	2,701	1,396	897	1,196	521
MICHIGAN	2,515	2,811	10,002	0	819
MINNESOTA	0	1,736	1,435	5,095	374
MISSISSIPPI	421	581	1,380	0	218
MISSOURI	762	1,151	750	4,192	425
MONTANA	536	205	84	705	57
NEBRASKA	406	583	490	1,674	229
NEVADA	509	333	272	793	118
NEW HAMPSHIRE	356	275	171	2,717	130
NEW JERSEY	14,651	1,353	597	727	304
NEW MEXICO	960	462	436	1,351	179
NEW YORK	18,827	5,502	2,831	16,206	1,675
NORTH CAROLINA	1,587	2,026	954	9,460	638
NORTH DAKOTA	0	92	139	349	53
OHIO	12,602	2,335	2,318	3,481	1,004
OKLAHOMA	1,522	767	429	1,555	317
OREGON	0	1,009	786	3,029	374
PENNSYLVANIA	1,484	2,762	1,330	830	1,281
PUERTO RICO	1,225	879	492	1,056	504
RHODE ISLAND	239	204	139	1,430	68
SOUTH CAROLINA	281	939	752	2,023	356
SOUTH DAKOTA	562	130	93	274	66
TENNESSEE	1,740	1,386	1,163	8,951	844
TEXAS	4,281	5,700	4,713	29,250	2,258
UTAH	1,372	880	187	801	367
VERMONT	75	152	75	811	38
VIRGINIA	5,486	1,321	798	7,713	455
WASHINGTON	3,025	1,950	915	15,431	326
WEST VIRGINIA	0	392	206	1,353	198
WISCONSIN	0	1,375	1,496	2,814	389
WYOMING	0	178	137	675	53
AMERICAN SAMOA	18	8	0	2	5
GUAM	61	32	9	45	10
NORTHERN MARIANAS	38	12	11	3	4
PALAU	3	1	3	0	1
VIRGIN ISLANDS	31	21	34	39	26
BUR. OF INDIAN AFFAIRS	325	61	23	129	9
U.S. AND OUTLYING AREAS	107,234	69,672	67,502	191,153	26,070
50 STATES, D.C. & P.R.	106,758	69,537	67,422	190,935	26,015

Please see data notes for an explanation of individual State differences.

Developmental Delay is applicable only to children 3 through 9.

Data based on the December 1, 1997 count, updated as of September 1, 1998.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Table AA2

Number of Children Ages 6-21 Served Under IDEA, Part B by Disability During the 1997-98 School Year

STATE	AUTISM	DEAF-BLINDNESS	TRAUMATIC BRAIN INJURY	DEVELOPMENTAL DELAY
ALABAMA	446	16	196	289
ALASKA	100	7	67	8
ARIZONA	564	105	65	0
ARKANSAS	338	17	133	0
CALIFORNIA	5,095	142	913	0
COLORADO	187	81	205	0
CONNECTICUT	684	61	85	0
DELAWARE	183	45	6	0
DISTRICT OF COLUMBIA	67	11	14	0
FLORIDA	2,066	32	256	0
GEORGIA	997	11	270	0
HAWAII	133	100	53	0
IDAHO	167	13	144	258
ILLINOIS	1,844	56	586	C
INDIANA	1,337	41	363	0
IOWA	452	1	188	0
KANSAS	242	12	111	0
KENTUCKY	426	14	163	0
LOUISIANA	796	11	251	0
MAINE	231	9	95	0
MARYLAND	944	23	278	0
MASSACHUSETTS	581	48	297	0
MICHIGAN	2,383	0	0	130
MINNESOTA	1,112	23	246	0
MISSISSIPPI	253	13	83	0
MISSOURI	862	59	283	0
MONTANA	101	24	64	0
NEBRASKA	188	4	154	0
NEVADA	146	1	78	0
NEW HAMPSHIRE	169	4	44	0
NEW JERSEY	1,382	21	40	0
NEW MEXICO	148	8	190	107
NEW YORK	3,466	33	993	0
NORTH CAROLINA	1,708	22	315	0
NORTH DAKOTA	72	46	25	0
OHIO	507	17	276	0
OKLAHOMA	364	28	213	0
OREGON	1,595	10	268	0
PENNSYLVANIA	1,719	19	1,544	0
PUERTO RICO	367	27	31	0
RHODE ISLAND	134	2	43	0
SOUTH CAROLINA	422	19	59	0
SOUTH DAKOTA	107	6	52	0
TENNESSEE	611	7	227	758
TEXAS	3,506	69	654	0
UTAH	270	68	283	0
VERMONT	92	2	33	393
VIRGINIA	1,188	5	280	0
WASHINGTON	689	28	223	0
WEST VIRGINIA	185	25	121	0
WISCONSIN	831	7	260	0
WYOMING	52	1	86	0
AMERICAN SAMOA	2	1	0	0
GUAM	4	2	2	0
NORTHERN MARIANAS	2	0	0	4
PALAU	0	1	0	0
VIRGIN ISLANDS	5	1	6	5
BUR. OF INDIAN AFFAIRS	11	2	11	0
U.S. AND OUTLYING AREAS	42,511	1,463	11,914	1,944
50 STATES, D.C. & P.R.	42,487	1,454	11,895	1,935

Please see data notes for an explanation of individual State differences.

Developmental Delay is applicable only to children 3 through 9.

Data based on the December 1, 1997 count, updated as of September 1, 1998.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

ATTACHMENT B

Table 1
Health Care Financing Administration
Medicaid Eligibles with disabled basis of eligibility by age grouping and by state, FY 1998

State	Disabled Eligibles 2_/ Total	Ages 0 to 20	Children as a % of the disabled
TOTAL 1_/	6,941,704	1,261,608	18%
ALABAMA	165,972	36,322	22%
ALASKA	9,586	1,493	16%
ARIZONA	89,642	19,828	22%
ARKANSAS	102,277	23,799	23%
CALIFORNIA	892,277	109,974	12%
COLORADO	64,153	12,818	20%
CONNECTICUT	54,802	684	1%
DELAWARE	14,956	4,748	32%
DISTRICT OF COLUMBIA	28,890	4,543	16%
FLORIDA	412,175	86,106	21%
GEORGIA	226,999	39,223	17%
HAWAII	NA	NA	
IDAHO	18,468	5,290	29%
ILLINOIS	269,618	41,137	14%
INDIANA	93,879	11,136	12%
IOWA	52,661	9,842	18%
KANSAS	46,314	8,099	17%
KENTUCKY	187,148	31,905	17%
LOUISIANA	164,758	51,063	31%
MAINE	40,114	5,065	13%
MARYLAND	113,836	18,260	16%
MASSACHUSETTS	198,747	38,264	19%
MICHIGAN	273,214	52,110	19%
MINNESOTA	76,969	14,804	19%
MISSISSIPPI	142,423	31,152	22%
MISSOURI	119,232	8,784	7%
MONTANA	16,262	2,864	18%
NEBRASKA	27,463	4,801	17%
NEVADA	21,799	4,078	19%
NEW HAMPSHIRE	11,980	380	3%
NEW JERSEY	165,497	29,421	18%
NEW MEXICO	46,502	8,267	18%
NEW YORK	625,843	115,180	18%
NORTH CAROLINA	210,064	40,562	19%
NORTH DAKOTA	9,219	1,155	13%
OHIO	231,324	41,518	18%
OKLAHOMA	NA	NA	
OREGON 3_/	112,407	53,844	48%
PENNSYLVANIA	299,438	58,042	19%
RHODE ISLAND	30,002	4,939	16%
SOUTH CAROLINA	110,839	24,091	22%
SOUTH DAKOTA	14,899	3,419	23%
TENNESSEE	306,344	43,712	14%
TEXAS	320,882	70,631	22%
UTAH	21,507	2,794	13%
VERMONT	16,360	2,035	12%
VIRGINIA	127,524	25,991	20%
WASHINGTON	120,040	15,926	13%
WEST VIRGINIA	81,681	11,606	14%
WISCONSIN	126,166	29,592	23%

WYOMING	7,660	1,707	22%

1_/ Excludes Hawaii and Oklahoma, who did not report detailed data on basis of eligibility
2_/ Many disabled eligibles are categorized as having other bases for eligibility,
especially in 209(b) States that do not use SSI's eligibility determination (e.g., Ct., In., Mo., Nh., and Ut.)
3_/ Oregon counts of disabled children appear to be high, and may reflect miscounting of children in waiver programs
Source: HCFA, CMSO, Data and Systems Group
Data from Division of Information Analysis and Technical Assistance
14-Apr-00

ATTACHMENT C

Table 2
Social Security Administration
Number of children receiving federally administered SSI payments, by region and state, December 1999

State	Ages 0-18
ALABAMA	23,630
ALASKA	880
ARIZONA	11,980
ARKANSAS	14,950
CALIFORNIA	79,550
COLORADO	7,010
CONNECTICUT	5,550
D.C.	3,130
DELAWARE	2,850
FLORIDA	60,580
GEORGIA	26,090
HAWAII	1,370
IDAHO	3,000
ILLINOIS	39,920
INDIANA	16,690
IOWA	5,550
KANSAS	6,030
KENTUCKY	22,220
LOUISIANA	27,570
MAINE	2,890
MARYLAND	13,130
MASSACHUSETTS	15,410
MICHIGAN	34,250
MINNESOTA	7,350
MISSISSIPPI	18,590
MISSOURI	16,280
MONTANA	1,930
NEBRASKA	3,370
NEVADA	3,400
NEW HAMPSHIRE	1,630
NEW JERSEY	19,530
NEW MEXICO	5,610
NEW YORK	65,950
NORTH CAROLINA	30,190
NORTH DAKOTA	1,050
NORTHERN MARIANAS	200
OHIO	40,280
OKLAHOMA	10,300
OREGON	5,830
PENNSYLVANIA	39,030
RHODE ISLAND	3,000
SOUTH CAROLINA	16,800
SOUTH DAKOTA	2,010
TENNESSEE	20,800
TEXAS	47,350
UTAH	3,360
VERMONT	1,080
VIRGINIA	20,140
WEST VIRGINIA	7,220
WASHINGTON	10,500
WISCONSIN	15,050
WYOMING	1,010

Source: SSA Office of Policy
http://www.ssa.gov/policy/pubs/index.html?main=/statistics/children_recving_ssi/121999/

COMMUNICATIONS

STATEMENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

On behalf of the 70,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit this statement for your consideration as you examine Medicaid payments to schools. APTA appreciates having the opportunity to comment.

The Individuals with Disabilities Education Act (IDEA) requires that all children with disabilities receive a free and appropriate public education, and "related services" necessary to benefit from their educational program. As a designated "related service," physical therapy must be provided at no cost to the child or family. The cost of providing special education and related services has given rise to financial concerns for school districts. To finance and deliver services, IDEA's authorizing legislation and regulations require that it coordinate with other federal programs, such as Medicaid. However, the interaction between the financial responsibilities of these two entities has not been well defined, and efforts to coordinate Medicaid and IDEA have been affected by the lack of clear and consistent federal guidelines. There is confusion over proper billing procedures which is coupled with the lack of clear and consistent federal guidance about services appropriately provided under Medicaid.

A further challenge involves third-party liability (TPL) under the Medicaid statute. Third-party liability refers to the legal obligation of certain health care payors (including private health insurance) to pay the medical claims of Medicaid beneficiaries before Medicaid pays these claims. Medicaid rules require that Medicaid pay only after TPL sources have met their legal obligation to pay, whereas IDEA requires that parents not be charged for services provided through an IEP. Of considerable concern is the possibility of limitation, or loss, of lifetime insurability and benefits for these children. In addition, the increasing number of states choosing to utilize a managed care plan for Medicaid services creates a life-time cap where none had previously existed.

Physical therapists are integrally involved in the provision of services for children with disabilities in educational environments. Physical therapists trained in pediatrics provide essential early intervention and school-based services for children with disabilities. Physical therapy helps children overcome the mobility and other functional obstacles to learning and daily living that most of us take for granted.

Access to physical therapy in their own schools and communities gives children with disabilities the educational opportunities we all need in order to enhance our lives, to live independently, to become gainfully employed, and to be positive contributors to society. These are just some of the important achievements that the IDEA program has made possible.

APTA strongly supports IDEA and its goals of providing a free appropriate public education to all children. Unfortunately, the challenges faced by providers and schools who are charged with carrying out IDEA are further exacerbated by the limited funding that is provided to the schools under IDEA. Although Congress has taken steps to increase funding for IDEA in the past few years, much work remains. Full funding of the Federal share of IDEA is crucial to the program's success. APTA urges Congress to address the critical need for fulfilling the Federal government's promise under IDEA.

Fully funding the Federal share of IDEA is the best way Congress can assure that children with disabilities will receive the necessary services and to prevent the inappropriate use of Medicaid funds. We urge you to continue your work toward providing full Federal funding of IDEA.

We also would ask you urge HCFA to establish a panel of expert stakeholders, including related service providers, to assist them in their development of guidelines and clarification regarding the use of Medicaid dollars to serve children in the

schools. This expert panel could provide invaluable information to HCFA in their efforts to address the issues that families, providers, and schools face each day in their efforts to properly implement IDEA.

Thank you again for allowing us to provide this statement for the record. We look forward to working with you on this very important issue.

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