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MEDICAID FUNDING FOR SCHOOL-BASED SERVICES

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

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CONTENTS

OPENING STATEMENTS

AGENCY WITNESSES

CONGRESSIONAL WITNESSES

PUBLIC WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL

COMMUNICATIONS

MEDICAID FUNDING FOR SCHOOL-BASED SERVICES

THURSDAY, JUNE 17, 1999

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

The hearing was convened, pursuant to notice, at 2:13 p.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senator Grassley.

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.

Today we are here to discuss Medicaid billing practices for health care services provided in schools. I want to be very clear that we are not here to question whether Medicaid should be paying for school-based services. That decision was made years ago and Medicaid is appropriately responsible for reimbursing the cost of health care services provided in schools to Medicaid-eligible children.

The best way to ensure the continued viability of Medicaid's role in the school is to guarantee that programs are run fairly and responsibly. Unfortunately, there are some very real reasons to be concerned: some of the Medicaid maximization strategies that have been implemented by States and school districts in conjunction with consulting companies.

In too many instances, Medicaid is making payments, but we have no documentation that services are actually being provided. I am also concerned that Federal Medicaid dollars are enriching consulting companies rather than supporting needed services in schools.

More specifically, questions have been raised about two main categories of building practices: the use of bundled billing for services without documentation, and the submission of large claims for administrative costs developed by consulting companies whose payments are tied to the size of the claim they develop.

Additionally, concerns have been identified relating to Medicaid payment for transportation costs. Medicaid payment practices demand our careful attention because of the problems we encountered in the not-so-distant past.

Back in the late 1980's and early 1990's, Medicaid spending on disproportionate share hospitals skyrocketed. Some of that money

did not go to DSH hospitals. We all remember the story of Medicaid dollars ending up building roads, bridges, and stadiums.

Medicaid spending in schools is similarly starting to experience dramatic growth, and much of that is entirely legitimate. HCFA and GAO will tell us that some billing practices currently in use are questionable at best. As Medicaid agencies and school districts develop closer partnerships in order to better serve vulnerable children, let us make sure they get off on the right foot.

Now, we will go ahead with the panelists. We will hear, first, from Sally Richardson, who is director of the Center for Medicaid and State Operations at HCFA. Ms. Richardson?

STATEMENT OF SALLY RICHARDSON, DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Ms. RICHARDSON. Thank you, Mr. Chairman, for giving me the opportunity to speak on Medicaid funding for school-based services.

We agree with you that school-based services play an essential role in making sure that children receive needed health care, things like speech therapies, physical therapies, and other kinds of specialized care for people with disabilities.

We believe that school-based services can also play a powerful role in reaching out and identifying and getting enrolled children who are eligible for Medicaid in the new State Children's Health Insurance Program.

The CHAIRMAN. That can be a very important role, I agree.

Ms. RICHARDSON. Therefore, we strongly support, as you do, Medicaid funding for school-based health services to children who are enrolled in Medicaid.

There has been a real, as you know, surge of State interest in Medicaid reimbursement for school-based health services, mostly for Medicaid-eligible children with special needs, under the IDEA, Individuals with Disabilities Education Act.

We have been very supportive of this goal because we believe it increases the potential, through school-based services, to support mainstreaming these children with disabilities into regular schools, while continuing to get them the care they need.

We have been pleased to work closely with your committee to understand the growth of Medicaid reimbursement in the schools, and we actually recently had the opportunity to sponsor a site visit for key members of your committee staff to see firsthand the essential role that school-based services can play in ensuring Medicaid-eligible children get the services they need without disrupting the education process.

Over the course of this work, your committee, our staff, and now the General Accounting Office, has identified some very serious concerns in a handful of States. These concerns include bundled payments for groups of services to disabled children.

We believe these bundled rates are a problem because most schools do not have the administrative structure to document whether the Medicaid services were actually delivered to Medicaid-eligible children at appropriate payment amounts. We agree with your concern that this creates a real potential for Medicaid to pay for care which has not been provided.

We also are concerned about billing for transportation costs that Medicaid does not cover. Medicaid funding is reserved for specialized transportation to school on a day when a child is receiving a medical service. However, there are several States that have been claiming Federal Medicaid matching funds for transportation that does not fall under this policy.

We also have concerns about billing for administrative activities that Medicaid does not cover. We are acting to eliminate any inappropriate practices and we sent to the State Medicaid directors a letter on May 21 that modifies and clarifies our policy in these areas.

Specifically, we will no longer approve Federal Medicaid matching funds for bundled payments to school-based services. We will only pay transportation costs for children with special transportation needs on days when they receive a medical service.

We plan to issue clear written guidance this summer that will definitively address such areas as what is covered, what is not, how do you calculate staff time, the documentation that is required, and all of those kinds of issues that we think are important in administrative claiming.

We also want to continue to work with you and your staff, the Department of Education, and the States to make sure that Medicaid dollars are only used for Medicaid-covered school-based services delivered to Medicaid-eligible children, and that it is done effectively and efficiently.

Again, I want to express my appreciation for you having this hearing, and will be, of course, happy to answer any questions.

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

The CHAIRMAN. Thank you, Ms. Richardson.

We will now turn to you, Dr. Scanlon. Back again.

STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR, PUBLIC HEALTH AND FINANCING ISSUES, EDUCATION AND HUMAN SERVICES SECTION, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Dr. SCANLON. Thank you very much, Mr. Chairman. It is unusual to be here in the afternoon, though.

I am very pleased to be here today as you explore the potential improprieties involving Medicaid claims for school-based services. The multi-million dollar spikes in Medicaid spending for these services in a few States has started to raise some eyebrows.

We see practices, as you have indicated, emerging that are disturbingly similar to the financing gimmicks that some States adopted in the late 1980's. The best known of those schemes, as you have mentioned, was the disproportionate share hospital payments, or popularly known as DSH.

DSH payments were intended for hospitals to serve a higher proportion of uninsured patients. However, under various DSH schemes, Federal matching payments, instead of going to hospitals to finance services, made a round trip to the hospital and back to the State treasury. In just three short years, DSH payments exploded from less than $1 billion to almost $17 billion.

As the nature and the magnitude of inappropriate DSH payments and other financing gimmicks became apparent, Congress acted swiftly to make these practices cease. Given this history, the importance of the committee in appropriately focusing attention now on the growing claims for school administrative services is significant. My comments today are based on information that we gathered for you over the last 2 months from over a dozen States.

Since close to one-half of Medicaid's eligible individuals are children, schools do serve an important arena for Medicaid services. Even for schools that do not directly provide Medicaid health services, administrative activities can help identify and enroll eligible children, as well as screen and refer children for needed services.

In submitting claims for administrative activities, however, some school districts' and States' practices appear intent on maximizing their receipt of Medicaid funds through suspect practices.

As you can see from the graphic to my left, and which is also on page 6 of my written statement, over the past 4 years, claims for the costs associated with school-based administrative health services grew five-fold in just 10 States that had readily available data, from $82 million to $469 million.

Michigan and Illinois account for most of the increase, the former because an increasing number of school districts have begun submitting claims, and the latter because claims per school have grown significantly.

Soon, as other States, too, begin filing administrative claims, these expenditures could increase dramatically, for HCFA indicates today that only 18 States are submitting administrative claims.

Appropriate payment for appropriate service is not the real concern. The concerns are that Federal dollars, rather than supporting appropriate services, are being diverted to other uses and that efforts to maximize Federal revenues are potentially inflating claims to include inappropriate costs.

In a moment, you will see the other graphic to my left, which is on page 8 of my written statement, and shows how some States are diverting Federal dollars intended for schools to their own treasuries, while other States return the entire Federal share directly to the school districts. We found that at least four States of the dozen that we contacted retain a portion of the Federal funds obtained.

Additional dollars are being diverted because many school districts employ consulting firms to help them with the complexities of claiming Medicaid reimbursement. As compensation, these firms typically receive a share of the revenues generated by the claims. Fees paid by some school districts ranged from 3 to 25 percent of the Federal reimbursements.

The net effect, after the State takes its share and the private firm is paid, is that some school districts in one State are getting only $4 out of every $10 of Federal Medicaid reimbursement for administrative costs.

Concerns that the school district administrative claims may exceed reasonable or allowable costs emanates from the acknowledged objective of maximizing Federal revenues. The contingent fee arrangements between consulting firms and school districts create

an incentive for the consultants to push the envelope on claimed costs.

Further, their own words indicate that they do so. As a selling point in marketing materials that we reviewed from two consulting firms, they touted their ability to maximize Medicaid revenue for schools. These firms design the methods to claim administrative costs and train the school personnel to apply them.

As an example of how such efforts can inflate Medicaid spending, HCFA has found instances in which school personnel charged 100 percent of their activities to Medicaid, when only a portion was Medicaid-related.

These inappropriate claims totaled over $33 million. Our evidence suggested that this is only the tip of the iceberg. Spotty oversight and guidance by HCFA is failing to adequately safeguard Medicaid dollars. What claims submitted by States are approved or denied by different HCFA regions as allowable administrative costs vary widely.

Practices that HCFA has allowed in one State have been disallowed in others. The resulting confusion creates an environment in which opportunism can flourish because claimants are not consistently discouraged from testing questionable billing practices.

In conclusion, while the problems of claims administration for administrative services is not yet out of control, the DSH experience shows that inappropriate claims can add substantially to Medicaid spending in a very short period of time.

What is needed from HCFA is clear and consistent guidance to its regional offices, specifying criteria to help them review and approve administrative claims. In addition, HCFA needs to be vigilant to ensure that its guidance is uniformly and appropriately applied nationwide.

However, claiming administrative costs is a complex activity and there will continue to be gray areas that need further explanation. HCFA is in a position to explore these areas in partnership with the States and should take concrete steps to do so, since HCFA and the States share the fiduciary responsibility to administer Medicare efficiently and effectively.

Thank you very much, Mr. Chairman. This concludes my statement.

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

The CHAIRMAN. Thank you, Dr. Scanlon.

Dr. Smith?

STATEMENT OF VERNON K. SMITH, PH.D., PRINCIPAL, HEALTH MANAGEMENT ASSOCIATES, LANSING, MI

Dr. SMITH. Mr. Chairman, members of the committee, I, too, am very pleased to be here to talk with you about some important issues that have emerged relating to Medicaid financing of——

The CHAIRMAN. Let me point out, first, that you are a principal with Health Management Associates and former Medicaid director for the State of Michigan.

Dr. SMITH. I am, indeed. Thank you very much, Mr. Chairman.

The CHAIRMAN. Please proceed.

Dr. SMITH. At the outset, I would like to second the statement that you made at the outset. It is important for me also to say that I would not want anything that I would say to be considered as negative toward the ability of schools and States to obtain Medicaid reimbursement for these very, very important services.

But, as States have implemented their programs for Medicaid reimbursement, a number of important issues have arisen, several of which Dr. Scanlon has identified just previous to my testimony.

One of the things that struck me as I was dealing with this issue as a Medicaid director was the role of billing agents in advocating for the development of Medicaid policy in this area.

It certainly has not been unusual for billing companies to advocate with State legislatures, budget and Medicaid agencies, for the adoption of Medicaid coverage of these services and the enrollment of schools as Medicaid providers.

Now, there is nothing wrong with schools using billing agents. Among medical providers, it is very common to use billing companies to prepare claims for services provided.

However, it is unusual that those who prepare the claims for reimbursement sometimes have seemingly played a greater role in policy making than those who actually provide the services.

Now, schools should not seek to avoid billing companies. Billing companies provide an essential service. Schools are in no position to know how to prepare a claim that would meet the demanding requirements to be paid by Medicaid through the Medicaid claims process system. So, that is not the issue.

But how billers are selected and paid, in that area, there are some issues. Let me just mention a couple of those issues. School districts often select a billing agent to prepare Medicaid claims without any competitive procurement. It is my belief that public providers, in particular, such as schools, should select billing agents through a competitive process and that this should be a condition of qualifying for Medicaid reimbursement.

Second, school districts often do pay commissions based on the amount of revenue generated, often on the order of 10 to 20 percent. In my view, inappropriate incentives are created when the billing agent earns more by claiming more.

What happens, is that the company with the highest average billing amount per pupil markets itself as the one that can generate the most revenue. These billing agents, with lesser reimbursement per pupil, are left to try to explain why and may find themselves under pressure to bill for services that they may actually believe would not be appropriate.

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

A third issue has to do with bundling of services, an issue which was raised recently in a letter from HCFA to Medicaid directors. Even though Michigan does not, and has not, paid claims on the basis of bundled services, it my belief that the key issue here should not be bundled services and reimbursement, the issue should be the definition and documentation of what is included in

the package of services and the actuarial soundness of the payment.

From a technical standpoint, a bundled rate is no different from a capitation rate paid to an HMO or a DRG payment to a hospital. It is a simplified system that minimizes administrative costs to those providing billing for the services. I believe that financial integrity of the system can be achieved without outlying bundled service definitions and payments.

A fourth issue has to do with the cost allocation methodologies used by billing companies to claim the administrative outreach activities. The billing companies regard these methodologies in some States as proprietary and not public.

Each one has developed its own allocation methodology for determining the administrative outreach claim. Those States that have changed from one billing agent to another would likely mean a new approach, with different time study methods and survey forms. Some billing companies market their approaches better or more productively in terms of Federal reimbursement.

Again, I believe a uniform and public cost allocation methodology would benefit all parties, and I applaud HCFA for planning to address this issue in the near future.

One additional thing. I had not come prepared to talk about an issue which Dr. Scanlon raised relating to the distribution of Federal funds between the State and locals in the second of his graphics which was displayed. He indicated that in Michigan the local districts received 60 percent of the Federal money, and that State retains 40 percent.

At the time this arrangement was struck, the funding for schools was 60 percent local, 40 percent State, and the distribution of the Federal money was considered appropriate on that basis.

That concludes my statement at this time. I thank you, Mr. Chairman. I would be happy to respond to any questions.

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

The CHAIRMAN. Our next witness is Gregory Vadner, who is director of the Division of Medical Services of the Missouri Department of Social Services.

Please proceed, Mr. Vadner.

STATEMENT OF GREGORY A. VADNER, DIRECTOR, DIVISION OF MEDICAL SERVICES, MISSOURI DEPARTMENT OF SOCIAL SERVICES, JEFFERSON CITY, MO

Mr. VADNER. Thank you, Mr. Chairman. My name is Greg Vadner. I am the director of the Missouri Medicaid program and I am very honored to be here today in that capacity to talk to the committee.

In Missouri, we do believe, as the other speakers acknowledge, that school-based services are an important part of ensuring children's access to health care. They are a critical component of children's readiness to learn.

I would like to add to the reasons that were already stated by the former panelists as to why this is such an important issue today. Also, we have recently, in March, had a Supreme Court case out of Cedar Rapids, Iowa, the Cedar Rapids Community School District v. Garrett F. This case ultimately is going to have the ef-

fect of increasing the need for each school system's desire and fiscal need to capture eligible Medicaid money for their special needs children.

The court basically ruled that schools are responsible for these cases. Medicaid, under the idea of law being the payor of first resort in many of these cases, is obviously going to be something that schools will have to access, and do a better job of it.

Missouri is a State that, as you saw from the earlier charts, has been paying for school-based services for a number of years. We have had a basic fee-for-service type of billing system.

I would like to talk to you just a minute about our experience. We started in 1992 with just a handful of our 525 districts participating. Over the last 7 years, we have never reached any number higher than 20 percent of the total districts participating. Why this discrepancy? Obviously there are eligible children, with eligible services being given in all of these districts.

When we go out and talk to our schools, the answer is very simple: they are not in the business of billing for services, they are not used to it, they do not understand it, and to do it they have to set up new processes that they have never really dealt with before. So, particularly the smaller rural districts and the poorer districts are not able to participate, while the richer, wealthier, or more sophisticated districts do.

Ultimately, since we do send the money back to the districts, this means that those that essentially need additional funding more than the others, or the ones that are not able to participate, in addition, money is spent chasing paper, doing the labor-intensive billing and so forth, not coordinating and delivering services. It runs counter to the current trends in buying packages of services instead of piecemeal services.

The resulting thing with the court case out of Cedar Rapids means that there will be increased pressure on all districts across the country to look for ways to capture eligible Medicaid funds. So, regardless of the bundling issue, this will continue to be an area where you will see an increase in cost. I think the real issue is to make sure those are legitimate costs.

In fact, we believe if a good, sound bundling system is not allowed, States will look for other ways, and so will school districts and so will contractors, to come in and capture money. We are fearful that some of those ways will be even less efficient and less able to track and ferret out waste, fraud and abuse than a good, tight, bundling system.

We think the Federal Government must play a critical role in this process of designing and figuring out what this system looks like, whether it is bundling or anything else. The integrity of efficiency of the program must be designed so that money is not wasted and the chances for waste, fraud, and abuse are minimized.

Where outside contractors are a part of the design or the operation of the program, we believe the competitive bidding process should be looked at, it should be validated, it should be above board.

Most importantly, we believe that any approved plan must have a method to ensure that the children that receive health care services which they need, that we can document that they actually get

those services. In most cases, this can be part of their individual education plan, but there are other ways that we can track this back, even in a bundling system.

I am concerned, and I believe many States are, that the recent HCFA directive suddenly outlaws currently approved plans and allows States time to make transition to some other unknown system. But that seems like a small consolation when suddenly faced with a complete reversal of policy.

We are talking about throwing away fully approved and operational State plans that have lengthy development and Federal approval processes behind them. We believe this is a terrible precedent for the Federal/State partnership. We think a better approach would be to work with States to identify and correct any weaknesses in the bundling plans, or, for that matter, in a fee-for-service plan. We believe, where abuses are found, tough measures should be taken.

In summary, I think that we should not lose sight of the fact, as we have all stated, about the importance of school-based services and we ought to work for good ways to capture those in a good, tight, documented system. But we should not throw the baby out with the bath water overnight just to fix this tough policy issue.

Thank you.

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

The CHAIRMAN. Finally, we will hear from Sue Gamm, who is chief specialized services officer of the Chicago Public Schools. Ms. Gamm will bring an educational perspective to our discussion.

Ms. Gamm?

STATEMENT OF SUE GAMM, CHIEF SPECIALIZED SERVICES OFFICER, CHICAGO PUBLIC SCHOOLS, CHICAGO, IL

Ms. GAMM. Good afternoon, Mr. Chairman.

I am pleased to be here today on behalf of Mayor Daley, Gary Chico, president of the Chicago School Reform Board of Trustees, and Paul Valis, who is our chief executive officer.

In addition, I am speaking on behalf of the Council of Great City Schools, a coalition of the 55 largest city and urban school districts in the country.

As head of the Office of Specialized Services, I am responsible for managing a budget of one-half billion dollars, incorporating special education and related services for 53,000 children with disabilities, as well as for all 430,000 children of the City of Chicago, health services, violence prevention activities, and crisis intervention. I am speaking from a handout. You might find it a little bit more interesting than the written testimony, and you could follow along with me.

As the third largest school system in the country, we have participated in the Medicaid reimbursement program for 7 years. Through this experience, we believe that consistent, reasonable, and understandable rules must be communicated to schools so that we do not have to rely on expensive vendors to access the system.

On page 2, we talk about, schools are no longer simply responsible for education, we must address our students' nutrition, health, safety, and social needs.

As Mr. Vadner indicated, through the U.S. Supreme Court Garrett case, we must provide the necessary support services to our children with disabilities, even a one-on-one nurse if that is what the child requires.

At one time, you may remember that the Chicago Public Schools was referred to as the worst school system in the Nation. In 1995, the Illinois legislature gave Mayor Daley what he asked for, the authority to effectively manager the city schools. We are now pleased to have received some recognition as a national model for school reform.

We certainly have our challenges. Eighty-five percent of our study body are enrolled in the Federal Free Lunch Program. Even though Illinois uses this similar criteria for enrollment in the CHP program, only 53 percent of our children are currently enrolled.

We spent $209 million annually through 2,500 clinicians to provide Medicaid outreach, crisis intervention, mental and physical health services. We assess health needs, provide EPDST services and transportation.

As you can see through the graph on page 5, we have evolved over the years. This did not happen overnight. We began our involvement with Medicaid in 1991 and we were thrilled when we received $1.5 million for our efforts.

In 1994, we realized that, to meaningful access this program, we needed a vendor with significant expertise. We did not understand the complexities of reimbursement. We lacked access to the State's power structure and we received little or no assistance from Federal or State agencies.

So we retained an outside consulting firm with a 20 percent revenue commission rate to help us navigate uncharted waters.

This program was extremely successful. But, with our new administration, our top priority was to directly manage our program and to lower processing costs. We were concerned that service documentation was being collected for Medicaid-enrolled students only, and this provided us no data to manage our services.

There was insufficient accountability for service delivery and we had revenue that could have been used for health services that was diverted to a vendor.

To address these issues, in 1997 we redesigned our program to focus on health services management. We hired a new vendor through a competitive process, and now work with them at a flat fee. We directly partner with our State and Federal agencies.

In our latest phase of development, we are striving to ensure that all of our students have access to preventative and primary health services. We strongly believe that this is an essential element for improved educational performance and many of our services and activities are described on page 8.

To maximize support for our expanded health care services, we learned the rules of administrative outreach and fee-for-service. We believe we have designed our processes according to these rules and consistent with the operation of schools.

We have leveraged the most current technology available to streamline and improve services management, as well as the Medicaid reimbursement processes. We actually provided laptops to 1,500 clinicians and eliminated use of the so-called bubble sheets

for them to document their services. They now have information in real time as opposed to month-old time.

We designed custom software. We have eliminated errors through electronic edit checks. Staff have accountability by being able to see electronic reports that show IEP services required against those that have actually been provided.

Slides on pages 11 and 12 give you an example of the kind of information that our clinicians view. It is hard to see page 12 through the print work, but it gives you an idea of what a child actually may require for IP services and what they are actually provided.

Page 13 shows how we have cut administrative costs and have increased reimbursement. I continue to show you what we are doing now and in the future. Some of our recommendations are on page 15.

We are available to continue to provide you some information, as well our fellow school districts, about the kind of work that we have provided. Thank you.

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

The CHAIRMAN. Well, thank you, Ms. Gamm.

I was impressed by your charts. On page 1, you talk about, "communication of consistent, reasonable, and understandable rules so schools do not have to rely on expensive vendors to access the system." It makes a lot of sense to me, Ms. Richardson. Why is that not the case?

Ms. RICHARDSON. We agree with you, Mr. Chairman. We did issue a guideline in 1997 on administrative claiming in schools, but we have found from our own work in this arena that it is not sufficient enough.

So we are in the process now of preparing a new administrative guideline which we will be issuing to schools this summer. It will be quite definitive in providing information related to administrative claiming so that schools themselves will find consistent guidance that they can use, written in real language, for them to do administrative claiming correctly.

In addition to that, we will be going out to our regional offices and through our regional offices working both with States and with the regional office staff so that they all will clearly understand what this administrative claiming guide allows, and what it does not allow. We hope, with that action, to begin really improving the vagueness that people have said our 1997 manual had in it.

The CHAIRMAN. Well, it seems to me we need a crash program. I find it very bothersome.

If I understand correctly, Dr. Scanlon, there are cases where, for $10 reimbursement, $2 goes to a consulting firm, maybe $2.50, and $4 goes to State, and only $4 of the $10 goes to the people we are trying to help?

Dr. SCANLON. That is correct, Mr. Chairman.

The CHAIRMAN. How widespread is that?

Dr. SCANLON. It has occurred quite extensively in at least one of the States that we have visited. We have had a chance, in this period of time that we were looking at this, to only visit or interview officials in about 12 of the 18 States that are doing administrative claiming.

So, it may be more widespread than that. It is prevalent enough that it is of significant concern, and we are hoping that in the guidelines that HCFA prepares, that this kind of a practice is curbed and hopefully eliminated.

Reimbursement should be only for the services necessary by the consultant, not on the basis of the amount of money the consultant can generate in total.

The CHAIRMAN. As I understand it, many of them go out and say, hire me and I will get you more money. Is that right?

Dr. SCANLON. You are right, Mr. Chairman. It is very clear in their marketing materials that their goal is to maximize reimbursement. It is not in a discussion in terms of maximizing services, it is a goal of maximizing reimbursement.

The CHAIRMAN. They get paid sort of a contingent fee, do they not?

Dr. SCANLON. Yes, sir.

The CHAIRMAN. Is that legal?

Dr. SCANLON. We think it is legal, but we certainly question the proprietary of it.

The CHAIRMAN. Should it be legal? To me, it is incomprehensible that, here we have a program—and the CHP program started right here in this committee, right here in this room—and a system now where, out of $10, those who are entitled to the service, need the service, are only getting $4.

You mentioned the court case. To me, that only underscores the importance of correcting the abuse. Undoubtedly, you are right, it will become more expensive. What we want is this money to go to the disabled, to the children in need. That is the whole point of it.

Let me ask you this, Ms. Richardson. One of the assumptions behind the approved bundling system currently in place has been that the States reconcile payment with services provided. Is that happening?

Ms. RICHARDSON. No. That is one of the reasons why we went out with our letter in May saying that we would no longer approve bundled rates. There are eight States now that are using bundled rates. Only one of them was documenting the services provided, and they were ceasing to do that. Our feeling was that we had to come to grips with this documentation problem.

I agree that being able to document the fact that Medicaid services being provided to Medicaid eligibles is essential in maintaining the integrity of the Medicaid program. The States that were using bundled rates were not documenting either that the services were being delivered to Medicaid eligibles or, as a matter of fact, what actual services were taking place, necessarily.

The CHAIRMAN. How many years has this been going on?

Ms. RICHARDSON. It varies. I would say it is a construction of the 1990's, this last decade. I do not think it is school-based clinic services. Those services have been going on for a much longer period of time. I cannot tell you when the first bundled rate was put in place, but I imagine it was somewhere in the 1990's.

The CHAIRMAN. Why was it permitted to develop the way it has?

Ms. RICHARDSON. I am guessing, according to the history, what I have heard from our regional offices as well, what someone mentioned here in the testimony, schools are not providers and, there-

fore, they do not have in place the systems that allow them to easily do fee-for-service billing.

It requires a whole new administrative structure within the school system. There are 31 States that provide school-based services and use fee-for-service billing. Some bill through billing contractors as Dr. Smith described, while others do it themselves.

Basically, I think there were school systems that have proposed bundled rates to allow them to do a single billing for a set of services for a Medicaid individual. These were allowed as payment methodologies through our regional offices.

The CHAIRMAN. Let me ask you, Dr. Scanlon. There has been no methodology to ensure that this so-called bundling was based on a realistic factor?

Dr. SCANLON. That is the concern that has existed and which, as Ms. Richardson indicated, led to their May letter outlawing this practice. While bundled rates may make for some administrative efficiency in terms of submitting claims and may allow for some efficiencies in terms of substituting among services, they also create an issue of accountability.

You are paying a larger sum of money and you want to know that you have gotten with certainty the right amount of services for that money. Without the ability to sort of define the service package, it becomes very problematic.

Given that there are not in place the mechanisms to either define the package or make sure that it is being delivered, we concur with HCFA's efforts to curtail this practice.

The CHAIRMAN. Let me go back again to that paragraph I read in this chart, where "communication of consistent, reasonable, and understandable rules so schools do not have to rely on expensive vendors to access the system." As I said, I think that makes a lot of sense. What are we doing in HCFA to try to develop that, if anything?

Ms. RICHARDSON. Well, in addition to working with the administrative claiming part of school-based services, we also have asked the National Association of State Medicaid Directors to sit down with us in a work group that can work through appropriate methodologies for paying for medical services as well. In addition, the group can identify appropriate methods of documenting so we can have several models out there of medical services payments that States can have that clearly document the services that are provided.

The CHAIRMAN. What is the deadline? When do you expect to have it completed?

Ms. RICHARDSON. We hope that we can get this work done somewhere between 6 weeks and 2 months. We really want to get it moving and put sufficient resources in so that we have these models available to States going forward.

The CHAIRMAN. Now, I understand that HCFA questioned the appropriateness of transportation payment practices in as many as 15 States. What have these States done wrong, and when is it appropriate for Medicaid to reimburse for transportation expenditures? I understand there is one case where a whole fleet of new buses were bought.

Ms. RICHARDSON. I would hope not, but that could be the case. Basically, the policy is, and has always been, that Medicaid only pays for specialized transportation for children whose individualized education plan includes specialized transportation. We only pay it on the day that that child receives a medical service at school.

What we have found in looking into this situation is that, as a matter of fact, some school districts were claiming for children who were riding regular yellow school buses to school. We found that children without an IEP that required specialized transportation were also being paid for by Medicaid.

Sometimes they were paying for every ride that the child took on specialized transportation, whether that child was receiving a medical service or not. That is why we clarified the policy in our letter to the States and are going to adhere to it strictly.

The CHAIRMAN. Let me ask you, Dr. Scanlon. What have you found to be the practices in the transportation area?

Dr. SCANLON. In the transportation area, we saw similar evidence to what HCFA used in terms of issuing its May ruling. Essentially, that services were being paid for that involved ordinary transportation to and from school as opposed to transportation that was associated with the medical services necessary because of someone's disability or condition.

It has been Medicaid's basic principle that Medicaid is a program to fund health services to serve an individual's condition or disability, therefore, you do not expand that to provide sort of other types of supportive services. So HCFA's efforts in their May letter very clearly define which transportation services are allowable, we think, is very appropriate.

The CHAIRMAN. I understand Senator Grassley is chairing another hearing. Would you like to inquire?

Senator GRASSLEY. Yes. If I could interrupt, please, just for a moment. First of all, to thank the Chairman for calling today's hearing to examine the current financial practices relating to Medicaid's financing of health care and administrative services being delivered to school children in school-based settings. Also, to bring out a concern that I have.

Clearly, enabling States and school districts to carry out the daily challenges they face in educating and nurturing our Nation's children is of utmost importance. It is also imperative that federally-financed services be clearly accounted for at all times, and especially so during this time of extremely tight Federal budget constraints. That is why I am troubled by the accounts of inadequate oversight of Federal Medicaid dollars.

As the Chairman said, I am chairing a hearing of the Aging Committee. I am going to have to return to that. It is a hearing on retirement savings. I cannot stay to ask questions.

But, before I go, I would like to ask for the Chairman's consent to accept written testimony for our hearing record that will be submitted by the committee from Iowa's work group on the Treatment Component of Child Welfare Services. This group of top-notch experts has been working diligently for 18 months to improve the way rehabilitative treatment services are delivered in the State of Iowa.

I would also thank one of our panelists, Ms. Sally Richardson, for meeting with this group at HCFA's central office on May 24 regarding Iowa's pending State Medicaid plan amendment.

I have been kept apprised over the last 18 months of the development of this work group, which has had the assistance of staff from HCFA's Kansas City regional office.

I have confidence that Iowa's work group has achieved an accountable, innovative approach to better serving Iowa's youth who need rehabilitative services. Their testimony will offer valuable insight into accountable Medicaid financial practices, and I thank the committee for its attention to this request, but also the value that will come from one State's experience.

The CHAIRMAN. The testimony will be included in the record.

[The information appears on page 72.]

Senator GRASSLEY. And thank you for letting me break in.

The CHAIRMAN. Yes. Thank you for being here.

Dr. Scanlon, the whole situation I find unbelievable, to be blunt about it. But these consulting firms, as I understand it, are going around selling their services based on the theory that they will maximize your reimbursement, if you pay them this contingent fee, the size of which depends on how much money. So the more they can bill the school, the more they make. It seems to me another area, at least in the defense area, that is illegal.

Dr. SCANLON. We found no information that it was illegal, per se, in this context. We really do question, though, as you do, the propriety of it. It means that, in an area where we do not have very clear guidance as to what is an allowable expenditure and that there is an incentive for these firms then to take advantage of all that uncertainty and to maximize the Federal reimbursements that are going to be received because it does enhance their incomes.

Our sense is that these services, while valuable to school districts in terms of submitting Medicaid claims, should be paid for in terms of the resources that are involved in delivering the services.

Types of resources that you need to file claims, to be able to develop cost allocation mechanisms. We should pay for those resources, as has been indicated here today, at the most efficient price possible, and competitive bidding is traditionally the way we have gotten to those efficient prices. We do not go into arrangements in the public sector, usually, without doing competitive bidding.

The CHAIRMAN. But it sounds to me that what you have here is consulting firms that look for loopholes or vagueness in the law or regulations and find ways of enhancing compensation, of which they get at least 20 percent.

Dr. SCANLON. That certainly appears to be what they are doing. They have touted themselves in terms of their ability to use the system to increase the reimbursements for school districts.

The CHAIRMAN. It reminds me of, we write a tax law and the people look for some kind of a loophole, and they end up with some gimmick that makes lots of money for somebody, improperly, and they get a rake-off.

Dr. SCANLON. The parallel is very strong.

The CHAIRMAN. Which brings me back, Ms. Richardson. It is very important, in my judgment, that we have simple regulations that

are understandable. The people running our schools are educated people and they should not have to be sophisticated doctors or lawyers. The rules and regulations should be understandable by those who are normally found in that kind of job.

Let me ask you one further question, Ms. Richardson. Is HCFA routinely able to successfully collect disallowances after the fact in response to improper payments?

Ms. RICHARDSON. We are able to do that. It is a fairly long and complicated process, however. It is what we call our compliance process. It requires obvious verification.

In some instances where the State agrees with our finding, they come into compliance and they make the payment that we request for those circumstances. But, where the State disagrees with our finding, we have an administrative law procedure to which the State can appeal its claim. That, sometimes, is a very long and drawn-out process.

The CHAIRMAN. Let me ask you this. Do we collect much money after the fact?

Ms. RICHARDSON. We do better in controlling the finances of things going forward.

The CHAIRMAN. How successful do you think we are? We hear all these cases now of abuse. Do you think that money can be collected now?

Ms. RICHARDSON. I think where we feel we have clear legal authority and where States are really providing and claiming for services and/or administrative claims that are not Medicaid eligible, that we could take a compliance action against those States.

In the case of the bundled rate methodologies, we have in our letter said that we would not look retroactively, but rather work with States going forward proactively to change their methodologies so that they are in line with what we believe are good practices and what we think this committee and the GAO would believe are good practices.

The CHAIRMAN. Let me ask you, Dr. Scanlon. Based on your investigation, are you confident that the fiscal integrity of the Medicaid program has been preserved as it relates to payment for the administration of school-based services?

Dr. SCANLON. No, Mr. Chairman. I think we have identified that clearly that has been breached in certain circumstances. There are instances where HCFA has done an effective job, both in terms of negotiating what is an approved practice with a State and ensuring that the claims that are being paid are appropriate claims.

But there are other instances where the practices have been accepted too readily, claims have been paid, and, as Ms. Richardson indicated, trying to recover funds is a long and laborious process and, I think, not always successful, though we did not look into that in any detail. Our concern is, it is not always successful.

The CHAIRMAN. Well, that is certainly my understanding, too, although it is more anecdotal than based on any careful study. I might say, I am writing a letter to the GAO asking that you and your team continue its investigation, because I really think it is important that we get to the bottom of this as rapidly as possible.

Dr. SCANLON. We would be happy to work with you on this, Mr. Chairman.

The CHAIRMAN. Dr. Smith, in your testimony you mention that you are aware of no other area in Medicaid in which consultants would have a greater role in policy making. Could you elaborate on this, and why it is so troublesome?

Dr. SMITH. Certainly, Mr. Chairman. It just simply struck me, in reflecting on my 18 years in Medicaid administration, that it is quite common for issues relating to Medicaid to be fought out among providers and State officials.

But this was an unusual one in the role that the billing agents played, and I think the reason that billing agents were interested, of course, is obvious, as has been discussed here in terms of the potential for the revenue. It was a significant business opportunity, I believe.

The CHAIRMAN. Mr. Vadner, you indicated that States must have a method to ensure that children receive the health care services they needed. I could not agree more with that statement. But I think the important question is, how do we achieve that goal?

Mr. VADNER. Right. I think that, related to the bundling issue, the whole issue of bundling, pushing the margins, and lack of documentation is one that is critical. I think where the bundling concept has gotten into problems is on the front end rather than the back end. The whole idea of bundling is, you take a picture, if you will, of what is going on with that special needs child in that school system, the actual services needed, and what the cost of those services are. I think where there have been problems, is in taking that picture. Some of those pictures are way too broad. We have talked about the lack of consistent guidelines and how we look at this. Well, if, in taking the picture of what those actual services that are eligible are and how many are given over that period of time, whether it is a month or a year, what the costs are, if that is a very tight process and if that is tied back to the children's individual education plan, and if we have documented that all of those services are given at that point, in validating that picture, that is really what bundling is, then it becomes a much more streamlined and efficient process over time.

What you are doing then is tracking the number of eligible children that have IEPs and you are tailoring the payment back to that picture. Then you are going in and testing that sample periodically, so you are actually looking at the case charts, making sure those services were given. That is a streamlined, efficient process, really, in a way, statistically as valid as looking at every discrete service, which is a fee-for-service concept.

In the fee-for-service concept, you are not taking one efficient picture and moving forward with that data and testing it and updating it over time, you are looking at every discrete activity, every day. That is a bureaucratic, paper- and labor-intensive one.

The CHAIRMAN. No question about it.

Mr. VADNER. Frankly, I am very worried that that is where we are ending up. I think that there is a role for contractors, but I do agree that, in the taking of that picture, if the contractor is going to try to make that thing as broad as they can, there is a problem. That is where we ought to focus.

The CHAIRMAN. Dr. Scanlon, do you have any comment on what he just said?

Dr. SCANLON. Mr. Chairman, there is no question that the use of the fee-for-service approach does add to the paperwork burden. But we are also talking about a situation where the schools are providing a variety of services in a mode that we are not used to dealing with in terms of the Medicaid program.

We have talked at other times about the difficulties of working with managed care and looking at the package of services that managed care plans provide, understanding that we are receiving value for the dollar that we pay there.

This is a different situation which I do not think has been resolved, or where we have much experience in trying to resolve, the issue of whether we are getting the right value for our dollar in terms of the package of services that the districts deliver.

If the statistical methods are as tightly defined and implemented as Mr. Vadner indicated, then we maybe could consider this approach. We just have not seen that rigor in terms of the areas that we have looked at. We would be happy to look into this more for you to see if there is merit in trying to have this approach used.

The CHAIRMAN. Well, it certainly seems important to me that we do some considerable work in trying to find a proper solution. I am not persuaded at this stage that we have one.

Ms. Gamm, would you like to comment?

Ms. GAMM. Sure. In Chicago, we do use the fee-for-service model as well as the administrative outreach model. I would just say that we expend an incredible amount of work. As I indicated, we moved from bubble sheet documentation for each child to an electronic process.

The CHAIRMAN. Explain to me again what you mean by "bubble sheet."

Ms. GAMM. Bubble sheet is the term we use, if you take a standardized exam, there are the little circles on it and you fill in the circle with a black mark. Those are scanned through a process that then gives you your data from that documentation.

That is very intensive. You do it child by child, day by day. It was a very difficult process to manage. So we then went into an electronic, automatic entering process, where we gave our clinicians a hand-held computer and they enter their data onto their computer, and then download it into our main data bank. As a result, we are able to use the information that we collect for all children to look at service management, and we have a highly efficient accountability system.

I should say, though, this is not easy to do. It took a lot of money to develop. It was not done overnight. I do not want to stand here to say that, because we are doing it, it is easy for everybody else just to mimic and copy. We feel good about the process, but this is more than a notion to implement.

The CHAIRMAN. Well, this brings us to the completion of the hearing. Let me say that I really am very, very much concerned about the status of the school-based health services. First of all, we are not certain that the children with special needs are getting the service that is being paid for. That is not being documented.

Second, we find that large amounts of money that are being paid are not going for health services, but going to consultants, diverted to States, possibly, in some cases. The funds are being used not in

connection with transportation or health services, but connected directly with the needs of these disabled children, or children with special needs.

Let me say, ladies and gentlemen, I just think we have a very, very critical problem that needs to be addressed as quickly as possible. On the surface, it seems to me the first step is that HCFA has got to develop some simple rules that are understandable.

Dr. Scanlon, as I say, we are writing a letter asking further investigations on this, because this is a very important program, a very expensive program, but, more importantly, one that we want to help children and not to be used for other purposes.

So, I appreciate your being here, even though I am very unhappy with the results. Thank you very much for being here. We will be following through on developments. I do urge, Ms. Richardson, that HCFA put some real power behind this, because I think time is of the essence. It is complicated, I understand that.

Ms. RICHARDSON. We are taking the concerns of the committee very seriously, sir.

The CHAIRMAN. Thank you.

The committee is in recess.

[Whereupon, at 3:15 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF SUE GAMM

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

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

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

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

BACKGROUND

Schools are no longer simply responsible for education. To ensure that all students have an opportunity to learn, schools must address their nutrition, health, safety, and social needs. The U.S. Supreme Court affirmed in *Garret v. Cedar Rapids School District* that federal law requires schools to ensure physical and mental health services are provided to disabled students in order to guarantee an appropriate education. To provide such services, schools need the assistance and financial aid of other governmental agencies.

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

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

CPS HEALTH CARE SERVICES

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

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

HISTORY

Infancy (1991-94)

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

Reimbursement Program (1994-97)

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

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

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

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

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

Health Services Management (1997—current)

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

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

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

CRITICAL COMPONENTS OF HEALTH SERVICES MANAGEMENT SYSTEM

Financial Management

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

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

Information Technology

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

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

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

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

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

FUTURE CPS INITIATIVES

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

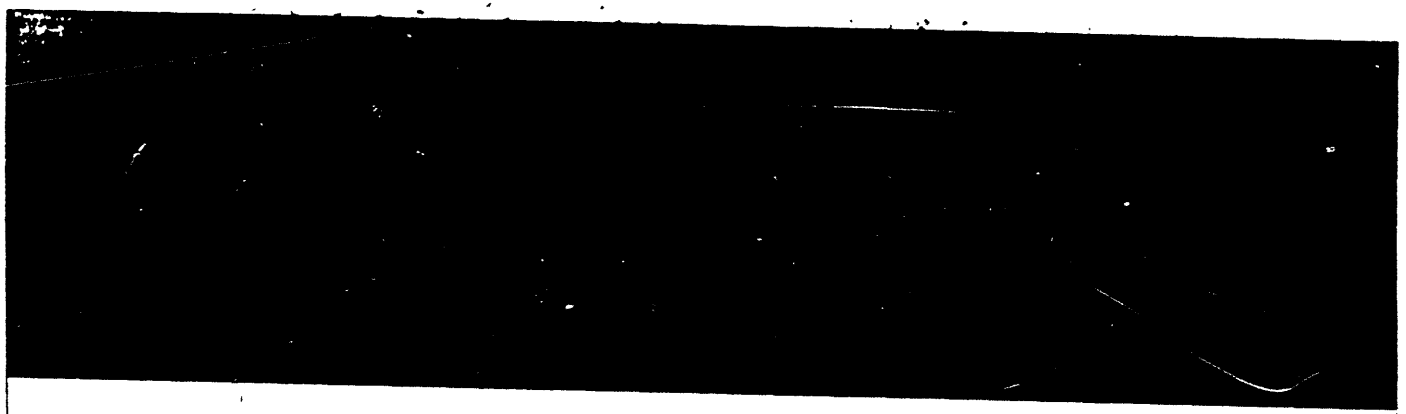
- CPS intranet e-mail account;
- On-line Individual Education Plans (IEPs) and other required forms;
- Instructional testing materials and research through internet; and
- Staff development through computer-based distance learning.

RECOMMENDATIONS

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

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

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



HEALTH SERVICES MANAGEMENT PROGRAM

Committee on Finance
United States Senate

June 17, 1999

TODAY'S DISCUSSION

- ✓ CPS is the third largest school system in the country
- ✓ Participation in the Medicaid reimbursement program for seven years
  - ❖ Health services and Medicaid outreach have been greatly expanded
- ✓ Success of this program moving forward requires:
  - ❖ Communication of consistent, reasonable, and understandable rules so schools do not have to rely on expensive vendors to access the system
  - ❖ Ability to appropriately utilize existing Federal and State financial resources

BACKGROUND

- ✓ Schools are no longer simply responsible for education. To ensure that students have an opportunity to learn, schools must address the nutrition, health, safety and social needs of students
- ✓ U.S. Supreme Court affirmed in *Garret v. Cedar Rapids School District* that federal law requires schools to give health services, including individual nursing, to students with disabilities if necessary to provide them with a free appropriate public education
- ✓ To provide such services, schools need the assistance and financial aid of other governmental agencies

CHICAGO CONTEXT

- ✓ Chicago labeled "worst school system in the nation" by Secretary of Education William Bennett in the mid-1980's
- ✓ Schools placed under the control of Mayor Richard Daley in 1995
  - ❖ School Reform Board of Trustees established
  - ❖ Paul Vallas appointed Chief Executive Officer
  - ❖ "*Children First*" established as CPS mission
- ✓ Chicago Public Schools now recognized as a national model for school reform

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CPS HEALTH SERVICES

WHAT IS CPS?

- ✓ Second largest employer in State
- ✓ 430,000 Students
- ✓ 85% Enrollment in National School Breakfast/Lunch Program
- ✓ 53% Medicaid Enrollment
- ✓ 15% English Language Learners
- ✓ 12% Students with Disabilities

WHO ARE OUR CLINICIANS?

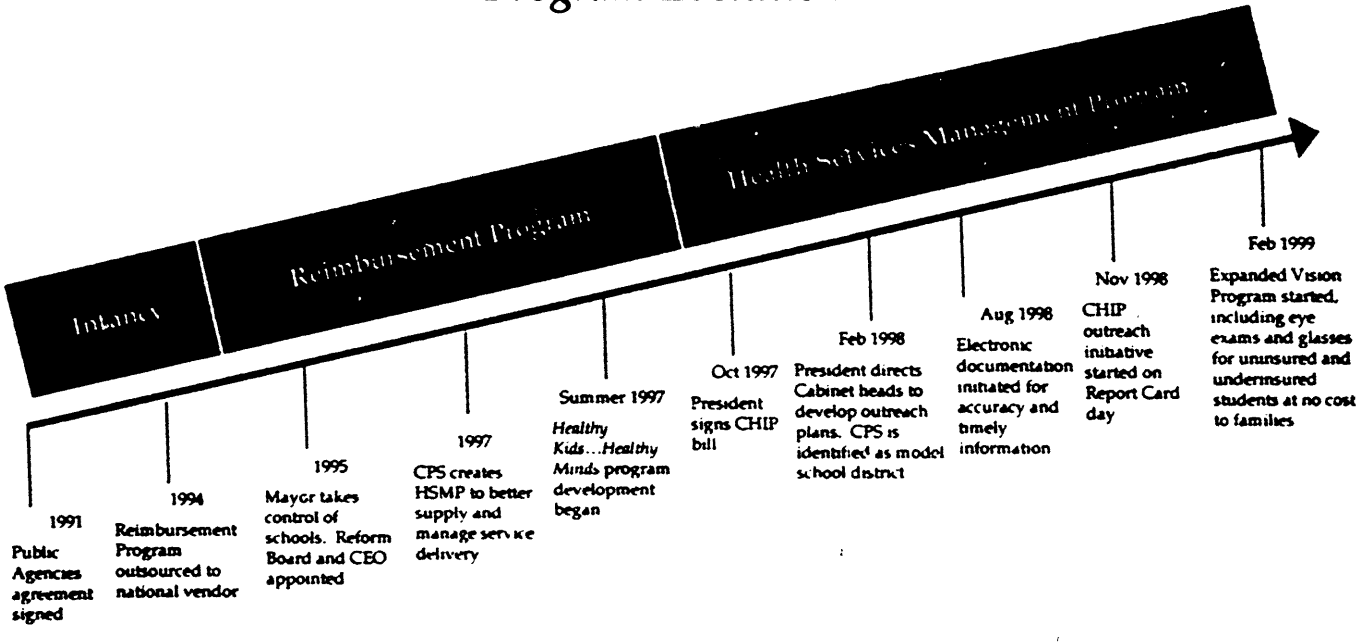
[illegible]	[illegible]	[illegible]
Psychiatry	1	112
Audiology	9	4,814
Nurse	276	210,999
Occupational Therapy	98	65,186
Physical Therapy	39	41,438
Psychology	220	93,842
Social Work	313	299,017
Speech Pathology	329	468,859
Hearing & Vision Screens	76	191,942
Counselors/Case Managers	1,135	N/A (AOC)
Totals	2,496	1,336,209

WHAT SERVICES DO WE PROVIDE OUR STUDENTS?

- ✓ Medicaid Outreach
- ✓ Crisis Intervention
- ✓ Mental Health Services & Counseling
- ✓ Physical Health Services
- ✓ Assessment of Health Needs
- ✓ EPSDT Services
- ✓ Transportation

PROGRAM HISTORY

Program Evolution



PROGRAM HISTORY

✓ Issues (Pre-1994):
- No experience with complexities of Medicaid reimbursement, environment and rules
- Lack of access to State decision making and power structure
- Critical information not used for management purposes

✓ CPS Response (1994-1997):

Retain high cost outside consulting firm (20% commission) to:
- Expand fee-for-service billing program
- Develop administrative outreach claim
- Act as CPS's agent with Federal and State agencies to increase rates, enhance reimbursement and expand current programs

PROGRAM HISTORY

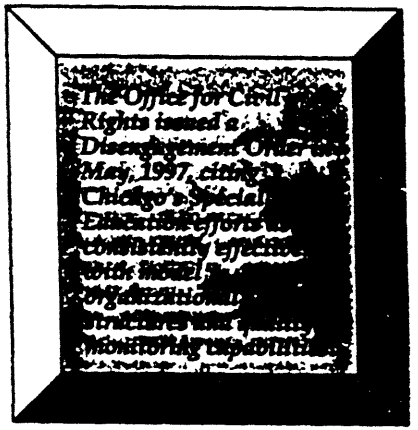
✓ Issues (1994-1997):
- Service data collected for Medicaid enrolled students only
- No coordination between reimbursement initiative and service delivery requirements for students
- Insufficient accountability for service delivery by clinicians, principals, and regional and central office administrators
- Service information was neither analyzed nor used for management of health service delivery
- Revenue that could have been used for health services was diverted for an administrative vendor

✓ CPS Response (1997 and beyond):
- Take over management of program, placing focus on health services management; service data collected for all students
- Retain new outside vendor for processing of claims at greatly reduced rates
- Take lead with Federal and State agencies to streamline administrative components of program and enhance its effectiveness

HEALTH CARE MANAGEMENT

Universal access to preventative and primary health services is an essential element for improved educational performance.

- ✓ Health services expansion through *Healthy Kids...Healthy Minds* program
  - ❖ Hearing aids, eye exams, and eye glasses
  - ❖ Expansion of school based & linked physical and mental health services
  - ❖ Dental screenings
  - ❖ Health education
  - ❖ Database to track referrals for care, follow-up attempts, and services received
- ✓ Health service information system implemented
- ✓ Enhancement of public health insurance enrollment through CHIP
- ✓ Service documentation required for all students
- ✓ Accountability structure for clinicians, principals, and central and regional administrators developed
- ✓ Improved organization of clinicians and principals, resulting in higher accountability and greater principal participation



FINANCIAL MANAGEMENT

Maximize support for expanded health care services through learning rules of administrative outreach (AOC) and fee-for-service (FFS) and designing our processes according to these rules and consistent with the operation of schools

- ✓ Addressing complex and time consuming activities related to FFS documentation by school health clinicians
- ✓ Management of AOC to include allowable activities related to the early identification of mental and physical health services
- ✓ Establishment of data exchange procedures with the Illinois Department of Public Aid to identify more fully the actual population of Medicaid enrolled children
- ✓ Delineation of actual cost of student health services
  - ❖ Medicaid reimbursement rates significantly below CPS' actual costs
- ✓ Internal controls over claim submission
  - ❖ Electronic documentation edits that decrease the number of errors
- ✓ Management reporting
  - ❖ Comparison of actual services against IEP standards
  - ❖ Benchmark clinician productivity
- ✓ Adopt health care industry best practices on reimbursement management, including:
  - ❖ Use of primary and secondary collection vendors
  - ❖ Root cause analysis of payment denials
  - ❖ Reports for management decision making, including receivables stratification and aging

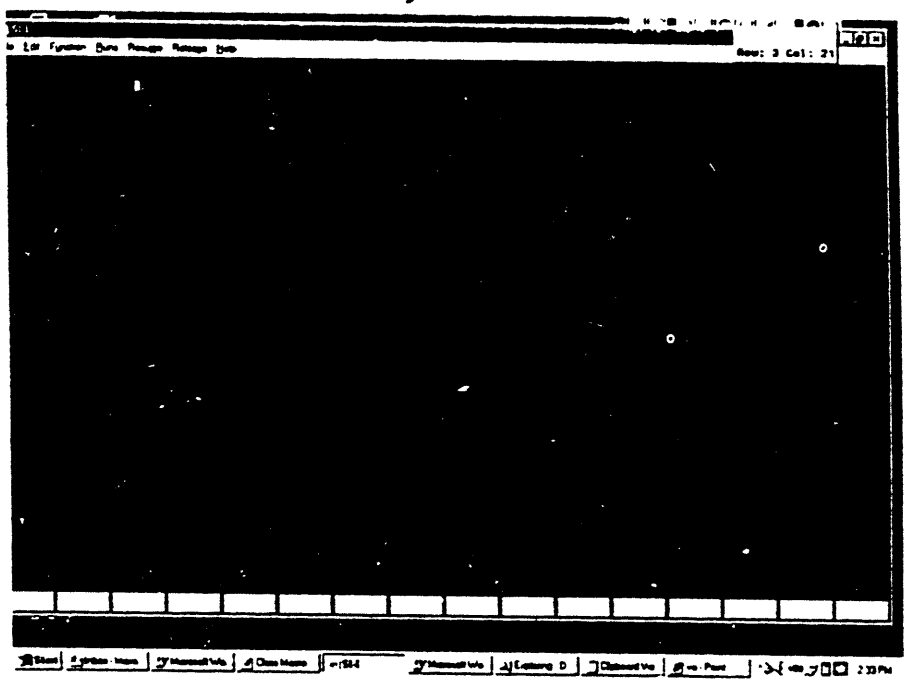
INFORMATION TECHNOLOGY

Leverage the most current technology available to streamline and improve health services management and Medicaid reimbursement processes

- ✓ Deployment of laptops to 1,500 clinicians
  - ❖ Eliminate "bubble" sheets and scanning technology
  - ❖ Real-time information
  - ❖ Weekly uploads of clinical information
- ✓ Custom software
  - ❖ Clinician controlled download of student information
  - ❖ Control upload of health service records
- ✓ Elimination of errors that included:
  - ❖ Incorrect/missing student ID numbers and birth dates
  - ❖ Misspelled names
  - ❖ Lost paper case logs
- ✓ View of complete child service needs across all disciplines
- ✓ Established accountability through electronic reports for clinicians, principals, and administrators
  - ❖ Compare health services to service documentation information

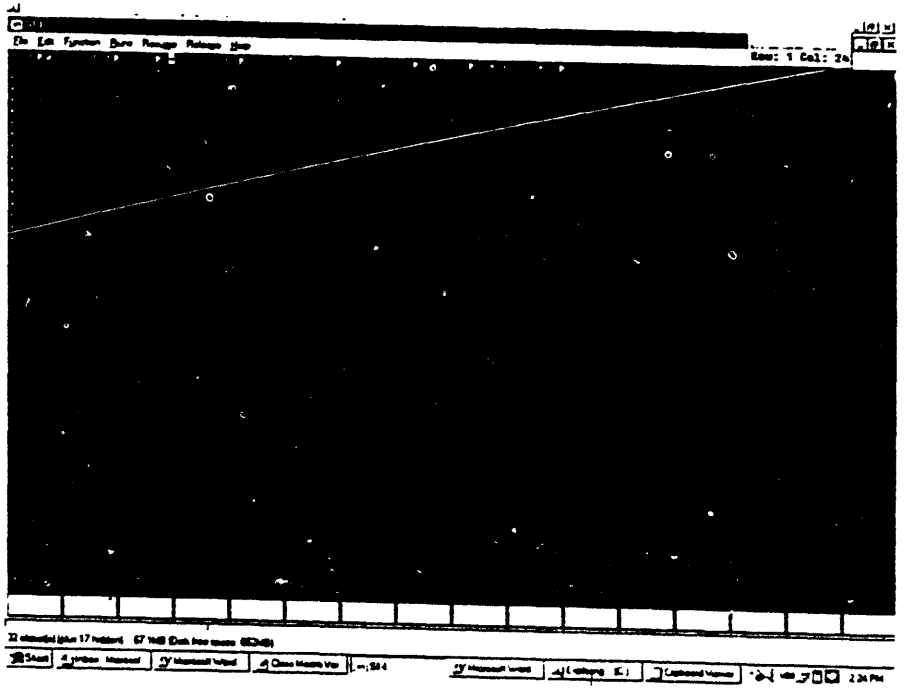
ELECTRONIC DATA ACCESS

Clinician-friendly electronic service documentation entry and health information access



VISIBLE ACCOUNTABILITY

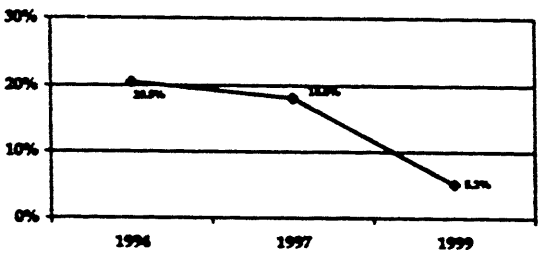
Required health services are compared with service documentation



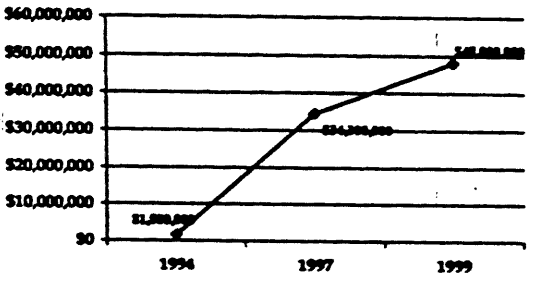
COST CUT & REVENUE INCREASED

HEALTH SERVICES COSTS	MEDICAID VENDOR COSTS	MEDICAID REIMBURSEMENT
FY94 - $103,000,000	$ 308,000 *(flat fee)*	$ 1,500,000
FY97 - $157,000,000	$6,168,000 *(20% commission)*	$34,300,000
FY99 - $209,000,000	$2,500,000 *(pre-3/99 - 4.5% commission post-3/99 - flat fee)*	$48,000,000

Vendor Costs as a Percentage of Medicaid Reimbursement



Medicaid Reimbursement



THE FUTURE

- ✓ Quality of Care
  - Case manager approach towards monitoring the type, quantity and timing of care to students
  - Continuum of care through student's life for primary care needs, impacting success in schools
  - Outcomes reporting between health care services provided and impact on educational performance
- ✓ Cost of Care
  - Enhance productivity of clinician
  - Eliminate non-value added tasks (e.g. travel)
  - Reduction of paperwork
  - Collection of all receivables from Public Aid
- ✓ Expansion of Care
  - Ensure all CPS students are served for primary care, dental, vision and hearing care
  - Partnerships and sponsorships with community organizations to provide free glasses and hearing aids for uninsured students
  - Work with Federal and State organizations to expand coverage of all eligible CPS students through CHIP
- ✓ Technology Enhancements
  - More efficient interactions for clinicians and schools
  - Automated Individual Education Plans (IEP) and other required management reports
  - Access to Instructional Testing Materials and research via Internet
  - Staff Development through Computer-Based Distance Learning

RECOMMENDATIONS

- ✓ Rules should be fair and consistently interpreted across the country
- ✓ Federal officials should:
  - ❖ Actively study and understand the uniqueness of school health services delivery models
  - ❖ Utilize this information as rules are interpreted for the school setting, and
  - ❖ Consult with school officials prior to the finalization of rule interpretations
- ✓ Rules should be understandable, and State and Federal agencies should take an active role in communicating with and assisting school officials so they are not unreasonably dependent on private vendors
- ✓ Promote reimbursement models whereby school districts may receive sufficient financial resources to support the provision of health care services to all Medicaid/CHIP eligible children
- ✓ Establish CHIP enrollment processes consistent with the successful model of the National School Breakfast/Lunch Program.
  - ❖ Eliminate barriers to successful data exchanges between school districts and State Medicaid agencies consistent with the Memorandum of Understanding between the U.S. Departments of Education and Agriculture.

Children who are fed and who have their physical and mental needs addressed will achieve greater academic success

PREPARED STATEMENT OF HON. JAMES M. JEFFORDS

The Health Care Financing Administration's (HCFA) recent change in policy, from allowing bundled payments and approaches for school-based Medicaid-eligible services to disallowing them, has consequences for health services offered to our children. I am pleased to have this opportunity to represent one of the eight States directly affected by these modifications. As the Senator from Vermont, one of the States that currently uses a bundled billing approach to facilitate and enhance school-based care for Medicaid-eligible children, I am deeply concerned by these changes.

I would like to explain briefly why I believe Medicaid reimbursement for school-based services using a bundled payment approach, with appropriate Federal safeguards, serves both Federal and State objectives.

The importance of school-based health care services for children eligible under Medicaid and the Individuals with Disabilities Education Act (IDEA) is widely recognized. The recent Supreme Court decision, *Cedar Rapids Community School District v. Garrett F.*, confirms that schools must make necessary school-based health services available. The question before us is how to provide the best access and services for children with special needs.

As the August, 1997, HCFA Medicaid Technical Assistance Guide states " . . . billing for Medicaid reimbursement sometimes requires more administrative work than schools have the time and personnel to invest." In order to alleviate the administrative burden and allow schools to offer the needed services, HCFA approved bundled billing payment systems, which is no different from capitated rates paid to an HMO, or a DRG payment to a hospital.

My home State of Vermont is at the forefront of "mainstreaming" children with special health needs into regular classrooms. Eighty-five percent of Vermont special education students receive services and are able to attend regular classrooms. This is almost double the national average of 45 percent. In Vermont schools, health care professionals provide care to children with serious medical conditions and severe disabilities. If these services were not available in schools, many children would be placed in hospitals, intermediate-care facilities for the mentally handicapped, or other institutions, at a higher cost to the Medicaid program. More importantly, the availability of health services in schools permits all children to participate in, and benefit from, the classroom setting with their peers.

The State of Vermont Medicaid program began its school-based health services program in 1995. The reimbursement method was a cumbersome system that required school-based providers to document and report very detailed information in order to submit claims. Because of the administrative resources necessary to support the billing process, school participation in the program was limited.

In 1997, the State of Vermont undertook an initiative to restructure the payment methodology for school-based services. The goal was to improve care by broadening participation, availability, and quality. The rate-setting process was developed fairly and with the cooperation of HCFA. An extensive review of over 1, 100 Individualized Education Plans and claims from over 2,700 children led to the development with HCFA of fair and equitable Level of Care reimbursement rates. The bundled payment methodology significantly decreases administrative burdens, freeing resources to focus on health care service delivery to children in need.

Unfortunately, the State received a letter from HCFA last month stating that bundled payment approaches would no longer be permitted immediately. The letter indicated that States with approved bundled payment approaches would be required to revise their systems. This new development has the potential to reverse the progress Vermont has made to improve its school-based health services program.

The Federal Government serves an important role in ensuring that State Medicaid programs are in compliance with Federal laws and regulations. However, while Federal policies may be redesigned to prevent abuses, the same policies may restrict development of innovative programs which are both reasonable and equitable and which achieve important policy goals. I would suggest that evaluation of successful programs, such as the one in Vermont, would lead to an appreciation of the advantages of the bundled payment methodology for school-based services.

As we undertake the evaluation of Medicaid reimbursement policies for school-based health services, I urge the Committee to recognize that bundled payment approaches, when properly designed, can meet essential objectives. These include the following:

- enabling schools to address the medical needs of disabled children
- reimbursing schools for Medicaid-eligible services equitably and efficiently
- fulfilling State and Federal goals to enhance access to medically necessary services, including early intervention and preventative services

We should continue to limit fraud and abuse, and we should support efficient delivery of health care services to our needy children. But rather than restricting innovative programs, I would suggest that we learn from successes, such as the Vermont school-based services program. And while we work to create a better method, we should allow schools to be reimbursed using their current methods so that they can continue delivery of essential school-based services to our children with special needs.

PREPARED STATEMENT OF HON. DANIEL PATRICK MOYNIHAN

I would like to commend the Chairman for holding this hearing and exhibiting such diligence in ensuring the financial integrity and, ultimately, preservation of the Medicaid program. This hearing will examine how Medicaid reimburses schools for health-related services provided to children with special needs. As we know, the Individuals with Disabilities Education Act (IDEA) requires schools to provide the services a child needs to be able to learn. And Medicaid will pay for those services provided to Medicaid eligible children.

I share the Chairman's sentiments: The goal is to ensure that children receive services they need in order to learn. The funding is available. However, without sufficient safeguards and financial guidance, abuses of federal funding can become all too common, which, in turn, can inevitably jeopardize the viability of the program.

Our witnesses today will explain how states currently fund school-based services through Medicaid and which practices are problematic and potentially abusive. Sally Richardson for the Health Care Financing Administration (HCFA) and William J. Scanlon of the General Accounting Office (GAO) will testify about some questionable methods used to claim Medicaid funding and recommendations for addressing potential abuses. Vernon Smith, a former state Medicaid Director and consultant, Sue Gamm, a representative for the Council of Great City Schools, and Gregory A. Vadner, a current state Medicaid Director, will testify to the importance of ensuring that schools can continue to seek federal funds while acknowledging the need for appropriate guidelines that maintain financial integrity.

We would all like to avoid the financial schemes of the past: states generated federal funding through Medicaid match and intergovernmental transfers that effectively reduced the state's financial share in the Medicaid program and assisted in funding other state programs. When funding schemes lack financial integrity, programs are placed in Jeopardy. Let us assure that this does not happen to funding for school services.

PREPARED STATEMENT OF SALLY RICHARDSON

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

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

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

- "bundled" payment for groups of services to disabled children without documentation of the actual delivery of services or their costs;
- billing for transportation costs that Medicaid does not cover; and
- billing for administrative activities that Medicaid does not cover. We believe we must act now to clarify issues, eliminate any inappropriate practices that exist, and protect the integrity of Medicaid funding for school-based services. We, therefore, sent State Medicaid Directors a letter May 21, 1999 that modifies and clarifies policy in these areas. Specifically:
- we will no longer approve federal Medicaid matching funds for bundled payments for school-based services;

- we will only pay transportation costs for children with special transportation needs; and
- we will issue guidance this Summer on Medicaid covered administrative costs.

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

BACKGROUND

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

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

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

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

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

Bundling

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

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

However, in most States that make bundled payments to schools, school-based providers are not maintaining adequate documentation for bundled payments. In fact, most do not have the administrative structure for maintaining such documentation. Also, State Medicaid agencies are not conducting periodic reviews to reconcile claims to services delivered and plan approved costs. Without proper documentation of services included in bundled rates, there is no reliable basis for determining whether the needed service was delivered at a reasonable rate. This creates the potential for States to obtain Federal matching funds for care which has not been provided.

That is why our May 21, 1999 letter to State Medicaid Directors made clear that we will no longer recognize bundled rates for school-based health services. States that currently pay bundled rates for school-based services must develop and pro-

spectively implement an alternative reimbursement methodology. We will meet with a workgroup of States, the Department of Education, and other interested parties to discuss ways to pay for school-based services that provide full accountability and administrative efficiency. In the meantime, our regional offices also will actively work with States to assist in the development and implementation of non-bundled rates.

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

Transportation

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

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

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

The letter also makes clear that:

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

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

Administrative Claiming

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

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

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

CONCLUSION

We are committed to supporting school-based health care services and promoting their potential to afford access to children who otherwise might go without needed

care. We must, however, make sure that Medicaid payments for school-based services are appropriate.

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

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

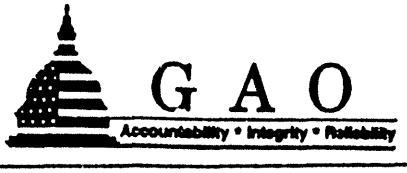
United States General Accounting Office
GAO
Testimony
Before the Committee on Finance, U.S. Senate

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

MEDICAID

Questionable Practices Boost Federal Payments for School-Based Services

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



GAO/T-HEHS-99-148

Mr. Chairman and Members of the Committee:

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

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

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

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

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

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

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

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

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

BACKGROUND

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

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

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

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

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

Medicaid's Reimbursement of
School-Based Administrative Services

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

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

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

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

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

Previous Financing Mechanisms
Used by States and Later Prohibited in Law

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

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

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

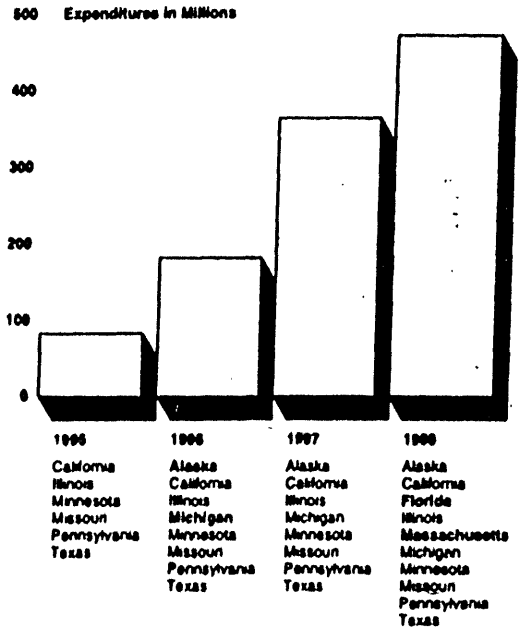
public and private hospitals. Overall, DSH payments to state psychiatric hospitals in six states we reviewed averaged about $29 million per hospital compared with $1.75 million for private hospitals. Such payments enabled the states to obtain federal matching funds to indirectly cover costs of services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

MEDICAID CLAIMS FOR ADMINISTRATIVE EXPENDITURES HAVE INCREASED DRAMATICALLY IN SOME STATES

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

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

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



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

Source: State-reported claims.

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

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

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

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

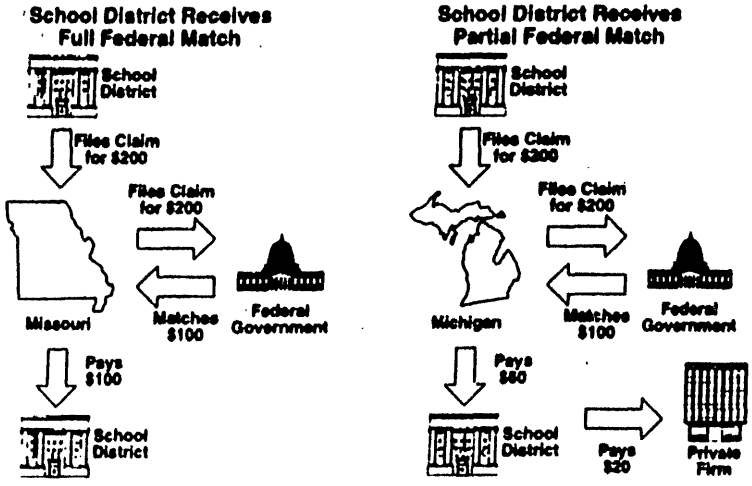
IN SOME STATES, MEDICAID FUNDS TO REIMBURSE SCHOOLS GO TO STATE TREASURIES AND PRIVATE FIRMS

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

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

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

Figure 2: Two Approaches to School-Based Administrative Claiming



Note: Examples assume a federal share of 50 percent.

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

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

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

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

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

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

Broad HCFA Guidance Leaves Payment Determinations Largely to Regional Discretion

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

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

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

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

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

HCFA Oversight Fails to Discourage Suspect Billing Practices

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUDING OBSERVATIONS

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

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

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

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

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

GAO CONTACT AND ACKNOWLEDGMENTS

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

RELATED GAO PRODUCTS

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

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

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

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

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

(101833)

PREPARED STATEMENT OF VERNON K. SMITH, PH.D.

Mr. Chairman and Members of the Committee:

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

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

CONTEXT AND BACKGROUND

Over the past decade, Medicaid has undergone tremendous change and growth. Most of the focus has been on the growth in enrollment and costs, which has been significant. Less focus has been placed on an equally significant phenomenon: the increased use of Medicaid as a source of funding for state programs that provide health services for low-income persons.

From 1990 to 1999, the number of persons enrolled in Medicaid soared from about 28 million to 42 million (according to the Congressional Budget Office, 1999 Baseline, February 1, 1999.) During the same period, total program expenditures grew from about $72 billion to almost $192 billion.

Most importantly for states, the state general fund cost of Medicaid increased so much faster than state revenues that Medicaid quickly grew to be the largest program in many state budgets. In 1985, for example, Medicaid expenditures were 8% of state budgets, on average, according to the National Association of State Budget Officers. By 1990, that portion had grown to 14%, and by 1995, to 20%. Obviously, Medicaid has taken significant state resources away from other worthwhile public purposes.

For state officials, it is an important obligation to obtain every federal dollar that the state is eligible to receive to support state programs. As the cost of Medicaid increased during a time of economic stress in the early 1990's, state officials placed great priority on finding previously untapped, legal and appropriate sources of funding, to minimize or avoid otherwise necessary budget cuts and program reductions. As a result of these efforts, Medicaid funding is now common in many state health programs that serve lower-income populations, in particular in public health and mental health.

In the past decade, Medicaid funding has also increased in schools, for qualifying medical services and certain administrative activities. Historically, medical services provided by schools did not qualify for Medicaid funding. Even though the children may have been eligible for Medicaid, and the same services would have qualified for Medicaid funding if they had been provided in a medical clinic, such services in a school setting were funded by state and local funds and not by Medicaid.

However, with the passage of P. L. 94-142, the federal Education of all Handicapped Children Act of 1975, and more recently, in the federal Individuals with Disabilities Education Act (IDEA), schools were mandated to provide a number of services, and Medicaid funding was authorized to help pay for medical services that are included in a student's Individualized Education Plan. Since that time, most states have adopted policies to allow Medicaid coverage and reimbursement for these services.

In general, Medicaid pays for medical services provided to special education students, and for "administrative activities" that assist the Medicaid agency in outreach and enrollment, arranging for needed medical services and case management. For the most part, administrative activities are reimbursable by Medicaid only for students who qualify for Medicaid. Over the past decade, an increasing percentage of school-age children have qualified for Medicaid. In 1996, there were 7 million children ages 6 to 14 enrolled in Medicaid, about one-fifth of all such children in the U.S. In some school districts, the Medicaid percentage may be quite high, perhaps 70% or 80% or more of all students. These numbers are certain to increase

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

CURRENT STATE PARTICIPATION IN MEDICAID SUPPORTED SCHOOL-BASED SERVICES

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

Summary of results for medical services:

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

Summary of results relating to administrative outreach activities:

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

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

ISSUES IN MEDICAID FUNDING OF SCHOOL-BASED MEDICAL SERVICES AND ADMINISTRATIVE OUTREACH

Medicaid funding for medical services in schools has proven to be of great assistance as school districts have tried to find ways to support the very expensive services they are required to provide in their special education programs.

Although states have generally been open to the idea of Medicaid funding for school health services, the development of Medicaid funding for school-based services and related administrative activities has been driven to an unusual extent by billing agents.

It is no secret that the possibility of Medicaid funding for schools has sometimes been brought to the attention of state Legislatures, budget and Medicaid agencies by billing companies, who have advocated for the adoption of Medicaid coverage of these services and the enrollment of schools as Medicaid providers.

Among medical providers, it is not unusual to use billing companies to create claims for services provided. However, I am aware of no other area in the Medicaid or health care arena where those who prepare the claims for reimbursement sometimes have played a greater role in policy making than those who actually provide the services.

In this case, the actual provider of services is the school district. School districts, however, have traditionally not billed third parties for medical services as other medical providers would. Almost universally, schools simply do not have the resources, experience or expertise to create a medical claim that would meet Medicaid requirements. The billing companies have provided a valuable service without which almost no school district would have been able to participate and bill Medicaid.

At the same time, for some billing companies, creating claims for schools has been regarded as a significant business opportunity, based on the potential to earn considerable "commissions" on the new federal revenue generated for schools.

As Medicaid funding has evolved for school-based services and administrative outreach activities, a number of issues have developed that in my view need to be addressed to better ensure the fiscal integrity of the program:

Issue #1: School Districts Often Select a Billing Agent to Create Medicaid Claims without a Competitive Procurement

For almost all public sector procurements, it is a requirement that a vendor be selected through a competitive process. Certainly, that is the requirement of Medicaid agencies in order to qualify for federal Medicaid matching funds.

It is my belief that in the case of a public provider, such as a school, or public health or mental health agency, it is not unreasonable that as a condition of qualifying for Medicaid funds, that a billing agent be selected through a competitive procurement.

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

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

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

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

Issue #3: Bundled billing

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

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

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

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

I believe that a uniform and public cost allocation methodology would benefit all parties. In its recent letter to Medicaid directors, HCFA has indicated it plans to address this issue in the near future.

SUMMARY

The services provided through Medicaid are so important, and the amount of money paid through the program is so great, that there can be no compromise on issues relating to financial integrity. It is absolutely necessary to have controls, documentation and accountability. There is no room for even the smallest suggestion of inappropriate financial or program policies or practices, by state programs or by providers or their agents.

Billing Medicaid for school-based services is a relatively recent phenomenon. States have pursued Medicaid funding for these services and activities to help address the significant growth in special education costs and services related to federal requirements. School districts have used the additional funds to reduce the deficits they have incurred in this area.

As the Medicaid funding has grown, certain issues have arisen that need to be addressed as the program grows and becomes more mature. The issues listed in this

statement are in the category of improving the program as new situations have developed that would have been difficult to anticipate at an earlier date.

Each of the recommendations outlined in this statement can be accomplished expeditiously, with the support of this Committee.

I thank the Committee for the opportunity to present my views. I would be more than pleased to respond to any questions or issues you might wish to address.

PREPARED STATEMENT OF GREGORY A. VADNER

Mr. Chairman, Members of the Committee:

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

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

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

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

- Funding for services and service coordination through case management is not equitable. Sophisticated "wealthier" systems are better able to participate, while poorer and smaller rural districts have not;
- Money is spent chasing paper, not coordinating access and services. This runs counter to the current trend of buying packages of services and coverage instead of piecemeal services;
- The resulting situation with most districts not able to participate puts pressure on all of us to look for efficiencies and increase participation.

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

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

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

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

I am concerned that the recent HCFA directive suddenly outlaws currently approved programs. Allowing states time to make the transition to some other, unknown system seems small consolation when suddenly faced with a complete reversal of policy. We are talking about throwing away fully approved and operational state plans with lengthy development and federal approval processes behind them, a terrible precedent for this federal/state partnership. Wouldn't a better approach be to work with states to identify and correct any weaknesses in these plans. Where abuses are found, tough measures should be taken to stop them. In my opinion, current and developing bundled rate programs ought to be made to meet the federal tests I have outlined. They should not be invalidated overnight as a simple solution to tough policy issues. Close federal scrutiny and legitimate concerns ought to bring constructive improvements developed in full and ongoing partnership with the states.

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

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

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

I thank the committee for visiting these important issues.

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SUPPORTING DOCUMENTATION TO THE TESTIMONY OF GREGORY A. VADNER, DIRECTOR DIVISION OF MEDICAL SERVICES MISSOURI DEPARTMENT OF SOCIAL SERVICES JUNE 17, 1999

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

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

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

The cost of providing these services to children with severe disabilities can become very high, as is illustrated by the U.S. Supreme Court's decision a few months ago in *Cedar Rapids Community School District v. Garrett F.*, 119 S. Ct. 992 (1999). In that case, the Supreme Court held that IDEA required the school district to provided one-on-one continual nursing care to a child who was in a wheelchair and ventilator dependent. The Court's decision describes quite vividly the array of health care services that may need to be provided throughout the school day in order for

a disabled child to remain in school. The school district argued that IDEA did not require it to provide this type of continual care, which it estimated would cost $30,000 to $40,000 a year, but the Supreme Court disagreed and held that the school had to provide and pay for the care necessary to keep the child in school.

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

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

JOINT STATEMENT ON SCHOOL HEALTH

by

The Secretaries of Education and Health and Human Services

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

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

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

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

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

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

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

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

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

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

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

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

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

Richard W. Riley
Secretary of Education

Donna E. Shalala
Secretary of Health and Human Services

COMMUNICATIONS

STATEMENT OF THE BOSTON PUBLIC SCHOOLS

Dear Senator Roth:

We understand that you are currently reviewing three types of reimbursement methodologies employed by State Medicaid agencies in the reimbursement of School-based Medicaid providers. The city of Boston and the Boston Public Schools have experience with the relevant methodologies in claiming reimbursement, and we believe that our experience with and insights into these methodologies may be helpful to you as you consider these programs.

Background

The Boston Public Schools provides a variety of health-related assistance to our student population of 63,000 students, including more intensive services to 14,000 students with disabilities. These address a range of health issues from vision and hearing exams to physical therapy and nursing services for medically frail and needy children enrolled in the District.

Each year the number and type of services needed by our students continues to grow, as do the costs in providing these much-needed services. Many of these services are mandated by the Individuals with Disabilities Act (IDEA), an under funded mandate. Programs provided as part of IDEA represent 23.7% of the Boston Public Schools annual budget. We had understood that as part of OBRA 89, Congress specified that health-related services under IDEA are eligible for reimbursement by the Medicaid program. We saw this regulation as an effort to defray at least a small part of our otherwise under funded IDEA costs.

In 1993, we began working to claim reimbursement from the Massachusetts Medicaid program. The reimbursement from this program helps the city and schools to offset a portion of the costs associated with providing school-based health services. As such, we believe that this program aids Boston considerably in the delivery of health services to the children of our city.

Per Diem Claiming

Currently, the Massachusetts Medicaid employs a per diem or "bundled" rate methodology for the reimbursement of school-based services. It appears that the Senate is questioning whether this is a valid methodology for reimbursement, and whether schools and their vendors unfairly "take advantage" of this methodology.

There are a few important points to be made regarding the per diem, bundled rate methodology in use in Massachusetts. First, it is our understanding that the per diem rate is based on a structure that compensates for the average service "bundle" that is provided to the students. This type of model, like other bundled methodologies in the healthcare industry,

reimburses based on a typical, expected, service delivery pattern – meaning that it is intended not to reimburse the specific amount for each service but overall the expectation that costs and reimbursement average out.

We are aware that other healthcare providers are compensated using "bundled" or capitated rates. Medicaid pays managed care organizations based on flat monthly rates. Under this methodology, Medicaid does not receive or require service-specific information. This monthly payment means that, in some instances, Medicaid pays the monthly fee regardless of whether the patient received no services during the month; and as with the Massachusetts per diem methodology, it also means that sometimes Medicaid pays far less than the cost of actual services provided. In addition, some hospitals are paid per discharge for all of the services they provide, rather than requiring or reimbursing for each specific service provided. These payments, based on Diagnosis Related Groups (DRGs) relate to the level of services provided to the patients. It is our understanding that the premise for both managed care and DRG payments is that use of capitated, average, or bundled rates are valid ways to accurately reimburse providers for services they provide.

It is our understanding that the current claiming methodology was developed by experts from the State of Massachusetts and was reviewed and approved by the Health Care Financing Administration (HCFA) before the initial claims were paid. In fact, we understand that HCFA's review of the methodology and rates resulted in a modification of rates proposed by the state prior to the payment of any claims. Moreover, HCFA reviewed claims from a number of districts in 1994 and did not issue any negative findings, comments or advice. We understand these reviews to indicate HCFA's understanding, agreement, and support of this methodology. It is confusing to us that HCFA would now state that the methodology is flawed and not valid.

You hypothesize that under this type of program, services could be claimed even if children do not receive services; we do not believe that this is an accurate assumption. Massachusetts schools can only claim reimbursement using the bundled rate for those students who have valid Individualized Education Plan (IEPs). IEPs clearly articulate the type and quantity of service needed by the students (including related health services), and the school district is legally obligated to provide the services specified. The Massachusetts Department of Education conducts extensive monitoring to ensure that Boston and other Massachusetts districts fulfill IEP requirements. We believe that while Massachusetts Department of Education monitoring is not required by the state Medicaid agency, it does nevertheless provide support of the services provided and therefore the reimbursement claimed.

Another of the Senate's concern seems to focus on high administrative and/or vendor costs. If the Federal government moves to eliminate the per diem methodology in favor of a fee-for-service (FFS) model, the result will be an increase in the need for and the cost of outside vendors, in addition to increasing the administrative burden and costs born by school districts. Most school districts do not have staff with experience in the various types of Medicaid billing. Therefore, a significant change in the current program would require schools to gain more help from consultants in order to understand and transition to the new model. In addition, the collection of the information needed for FFS billing will undoubtedly require a redesign of existing documentation requirement, necessitate new training programs for staff, and increase the amount of time clinicians would need to document services. All of these requirements have administrative costs associated with them.

We understand HCFA's mission to ensure fair and appropriate reimbursement of Medicaid-allowable services. As such, rates and methodologies should fairly compensate providers for the Medicaid-covered services they provide to Medicaid-covered individuals. We agree that HCFA and the federal government should take precautions against overpaying all providers, including school districts. However, we do not believe that it is necessary to eliminate all bundled rates in order to ensure accurate and fair reimbursement. If HCFA's real concern relates to the lack of supporting documentation or lack of reconciliation and review of rates, we believe that the best option would be for the state Medicaid agency to conduct a periodic (annual or bi-annual) sampling process to ensure that the bundled rates accurately reflect the costs of Medicaid-covered services provided as part of bundled rate methods. Then these are the items that should be revised, not the entire bundled rate methodology.

Effective date of bundled rate changes
In her testimony before the Senate Finance Committee, Ms. Sally Richardson references her letter of May 21, 1999 that states that HCFA "will no longer recognize bundled rates for school-based health services." The letter states that this policy will be effective immediately. We would like to clarify HCFA's intent regarding the payment of claims for school districts in states that employ a bundled rate methodology.

We understand that the issue of bundled rates is being reviewed and possibly revised. We would like to confirm that until such time as HCFA and/or State Medicaid agency articulate specific program changes to us, the current program would remain in effect. The Division of Medical Assistance has not advised Massachusetts schools of any change to the current program and therefore we expect that the existing program will remain in place until changes (if any) are articulated and implemented.

The Boston Public Schools continues to provide health-related services to children in our district and we are continuing to submit claims for these services using the existing methodology. The Medicaid reimbursement we receive under this program is important to our ongoing financial ability to provide services. We urge HCFA and the Senate not to interrupt payment of these claims.

Transportation Claiming

In her testimony on June 17, 1999, Ms. Richardson described HCFA's concerns regarding certain transportation claims filed by school districts. These concerns appear to be related only to states in which transportation is claimed on a fee-for-service (FFS) basis. In Massachusetts, the Division of Medical Assistance implemented reimbursement of Medicaid-covered transportation as part of the administrative claim. The reimbursement methodology does not reimburse us for all transportation provided to students with IEPs, rather "carves out" non-health-related costs. As a result, we understand it to be appropriate under state and federal Medicaid law.

Given that Ms. Richardson's comments regarding transportation were directed towards FFS claiming models, it is not clear whether they are meant to have implications for the Massachusetts program. Our costs for transportation for students with disabilities are significant and we feel strongly that the Medicaid program should continue to provide

reimbursement for these important services.

Administrative Activities Claiming

Program controls and quality
The Background provided in your press release of June 10, 1999 describes some of the Senate's concerns regarding Administrative Claiming. Administrative Claiming (AC) was developed and implemented by the Massachusetts Division of Medical Assistance (DMA) in the fall of 1997. The program in Massachusetts clearly outlines the types of activities, the costs that are allowable, the method for allocating costs, and the fact that Medicaid eligibility must be factored into claims such that Medicaid only pays for costs that are considered Medicaid administration. Both the state and our vendor clearly defined the difference between Medicaid administration and administration that relates to BPS's educational/other operations.

As stated above, the AC method was developed and implemented by DMA. This methodology is the standard for Massachusetts and we are not aware that any other process or method is valid. All municipalities in the Commonwealth are subject to the same, uniform requirements regardless of size, demographics and whether or not a vendor is involved.

As part of the claim preparation process, the school district, in conjunction with our vendor, conducts clinician training that educates our staff regarding the appropriate categorization of time for Medicaid Administrative purposes. The training clearly delineates the definition of each activity and it in no way prompts clinicians as to how to increase the claim – in fact, clinicians are never told which categories are and are not reimbursable.

In addition, the Boston Public Schools financial staff spends time each quarter with our vendor reviewing costs and determining which categories are allowable under relevant state and federal regulations and policies. The cost allocation method used conforms with federal circular OMB-A87.

The claim that we submit each quarter clearly presents all of the costs that are included in the claim, the specific time-survey results, the Medicaid eligibility rate for BPS, and how all of these factors are used to calculate our claim amount. This level of documentation provides State and Federal reviewers with a great deal of information (most of which is not required) to support and validate our claim. We believe that all of these factors demonstrate that Administrative Claiming is not an arbitrary or loosely controlled process in Massachusetts, but rather one with the structure and controls to ensure accuracy and adherence with relevant regulations.

Vendors and Cost of Preparing Claims
In your press release and in testimony presented on June 17, 1999, concerns were raised regarding costs schools incur in using billing vendors to prepare claims. The example in your press release state that of $100 claimed and FFP of $53 that $10.60 would go to the vendor, $21.20 would go to the State, and $21.20 would come to us. Our experience is very different.

If the FFP is $53, Boston would receive $50.22, our vendor would receive $2.78, and the State would receive nothing. Moreover, the $21.20 in your example is compared to "the full $53" that would be paid to a district under a "clean, traditional reimbursement situation." This analysis is faulty because it assumes that in a "clean, traditional" situation (one in which providers do not use vendors) the provider does not incur any costs to prepare and submit

claims. In making our decision to outsource this function, Boston has considered the costs required to bring this program "in house". The costs would be significant; they include the development/purchase of billing systems, ongoing collection and processing of information, verification of Medicaid eligibility, clinician training, administration of time surveys, compilation and validation of survey results, preparation of survey results, quality assurance reviews and preparation of audit trials, and ongoing monitoring of federal and state regulations which continue to change. These activities are areas where school districts have little background and, in order to complete them, our district would incur significant costs which, we believe, would exceed the costs of outsourcing. This is particularly true given the cyclical nature of claiming and the need for many staff at peak times, and only a few at others. As with other similar types of services (e.g. transportation), the Boston Public Schools uses a vendor for this service because we believe it makes good sense in terms of both completing the work and in reducing costs.

Summary

If the program is to be improved, we urge HCFA to include school districts in this process. Some of the issues raised, and HCFA's proposed solutions to them reflect a lack of understandi about how schools provide health-related services. There are significant differences between the service delivery model for schools and those for other healthcare providers. We believe that for HCFA to develop a revised program that will be truly effective – for schools and for Medicaid – the agency must include not only state Medicaid officials, but schools as well. The Boston Public Schools would welcome this opportunity to meet with and collaborate with HCFA on this important initiative.

We agree with the Senate that school-based claiming should have requirements that prevent overpayment and fraudulent claiming. However, we see these topics as important to all Medicaid providers and not confined exclusively to school-based providers. School districts like Boston have made and continue to make every effort to comply with both the spirit and the letter of Medicaid requirements. We seek only fair reimbursement of Medicaid costs and we would only work with a vendor that shared this commitment. We urge you not to penalize all districts and all states because of what may be weaknesses in only a few locations.

We appreciate the assistance that Congress provided to schools in 1989 by clarifying Medicaid's responsibility for the Medicaid-covered IDEA services that we provide. This mission articulated by Congress translated into the school-based program implemented earlier this decade; as a result, we look forward to your continued assistance in this program as we move into the new millennium.

Sincerely,

Thomas M. Menino
Mayor of Boston

Sincerely,

Thomas W. Payzant
Superintendent of Boston Public Schools

Written Testimony from
Iowa Department of Human Services
Des Moines, Iowa
Jessie K. Rasmussen, Director
and
Treatment Component of Child Welfare Services Work Group
Des Moines, Iowa
Charles Bruner and Arlene Dayhoff, Co-Chairs
submitted to the
Committee on Finance
U. S. Senate
Washington, D. C.
William V. Roth, Jr., Chairman

Mr. Chairman and Members of the Committee:
Thank you for allowing the Iowa Department of Human Services and the Treatment Component of Child Welfare Services Work Group to submit for the record, written testimony pertaining to your hearing on Medicaid and School Based Services held Thursday, June 17, 1999. This testimony represents an elaboration on some of the remarks presented by Senator Grassley during that hearing regarding Iowa's approach.

Iowa currently is seeking approval of a Medicaid Plan amendment to allow it to convert its current system of financing rehabilitative treatment services within its child welfare system to a bundled service and blended rate system as a transition to a capitated payment system under a publicly managed care arrangement.

Iowa's proposal has important distinctions from bundled services as they are applied within school settings and clearly is not the reason for this Congressional hearing. Unfortunately, it is possible that Iowa's efforts to receive authorization to proceed could become intertwined with the issue of bundled services within school settings.

The following is a brief overview of these distinctions:

Iowa's proposal was developed through the efforts of a broad based group of Iowa citizens over the past eighteen months to design a new service delivery structure.
This is not a leveraging strategy. No federal funds will be channeled to the State General Fund under this proposal. No funds will go to consultants for contingency fees.
A case reading process was used to determine the proper allocation to the Medicaid Program for each bundled service.
Iowa's proposal is a transition strategy moving Iowa to the ultimate goal of capitated publicly managed care.
Development of the Iowa proposal has been a collaboration process involving the Health Care Financing Administration (ironically, it was the HCFA Regional office which initially recommended use of this methodology) and the Administration for Children and Families.

We believe some of the principles that guided the development of Iowa's approach -- such as a commitment to improved results, a reinvestment of funds within the system, and stewardship of public resources -- may be applicable as the Committee and HCFA considers guidelines for approving school based health services.

That is not our reason for testifying, however.

First, as Congress addresses the important issue of Medicaid funding for school based health services, we hope that Congressional actions will not inadvertently impact Iowa's efforts. We will be pleased to share with you more details on Iowa's efforts, as your deliberations proceed, so that distinctions between the approaches are clear.

Second, Iowa's approach is one that builds upon prior efforts and successes in Iowa, both in nationally-recognized decategorization projects moving to more community-based systems of care within child welfare and juvenile justice and in managed care contracts for behavioral health and substance abuse treatment within Medicaid. We believe Iowa's approach to bundled services and blended rates leading to publicly managed care deserves to be supported and can yield valuable lessons to the federal government and other states. Should we seek such authorization, we hope Iowa will receive consideration by Congress as a demonstration site in developing more integrated, community-based, and results-accountable services for children in the child welfare and juvenile justice systems who require treatment services.

We thank you for the opportunity to submit these comments. If you have questions or desire additional information, please feel free to contact:

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Addendum:

While the primary purpose of this testimony is to differentiate Iowa's approach from school health services, we also have the following comments to present on the specific subject of Medicaid and school based services.

The Individuals with Disabilities Education Act (IDEA) requires that "all children with disabilities have access to a free appropriate public education which emphasizes special education and related services designed to meet their unique needs." Further, Medicaid, which is traditionally the "payer of last resort," has been directed by Congress to make payment for health services provided for in the state Medicaid agency's State Plan, when those services are provided in the school setting.

We understand the issues of Congressional concern include the use of consultants for the billing of school based services and the use of a bundled services/blended rates methodology for billing such services. Additionally, there appear to be concerns around administrative claiming and the billing of transportation related to school based services. We have reviewed the letter from the Health Care Financing Administration addressed to all State Medicaid Directors.

We have major concerns about the implications of the letter for the use of Medicaid funding for school based health services and, potentially, for other service settings. Bundled services are not unlike case rates, capitation rates, diagnostic related groups and ambulatory patient groups, all widely accepted payment methodologies in use in Medicaid. The unique feature of bundled services and blended rates is that this methodology recognizes that multiple funding streams often support particular programs. The bundled service and blended rate methodology simplifies administration and allows funding stream differences to become transparent at the provider and consumer level, a goal we all share. Consumers and providers should not be required to submit billings to multiple payment systems, when the technology exists for a single billing and payment methodology.

The issue of Congressional concern regarding school based health services appears to be directed toward ensuring that Medicaid funds are being claimed only for appropriate services and that those funds are being invested in services rather than being diverted to General Fund usage or contingency fee reimbursements to consultants. Iowa understands the need to be accountable for these funds.

PUBLIC
CONSULTING
GROUP, INC.

July 8, 1999

RE: Medicaid and School Health Services

Government
Health Care
Information Technology

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Dear Senator Roth, Members of the Senate Finance Committee,

Public Consulting Group, Inc (PCG) is a management consulting group providing financial planning and management, facilities management, strategic planning, and other advisory services to public sector health and human service providers across the country. Among our clients are approximately forty school districts who we assist in claiming Medicaid reimbursement for health-related services provided to eligible students. Due to our work in a number of states, we are aware of the program variations in several jurisdictions. We hope that this experience and the following discussion regarding Medicaid and school-based services will be helpful in your deliberations.

We agree with several of the concerns and issues raised by the General Accounting Office (GAO), the Health Care Financing Administration (HCFA) and the Senate Finance Committee during the recent hearing. At the same time, we do not believe that these examples are the norm for either school-based providers or vendors.

There are several important vehicles for ensuring a high level of compliance in school-based Medicaid billing. These precautions help to prevent the types of errors and questionable billing practices referenced at the hearing. These controls include:

- **Systems design** - Automated claiming systems should be designed to screen service information to make sure that regulatory requirements are met before creating a claim. Because the methodology for claiming school-Medicaid reimbursement varies from state to state, the specific edits employed must be tailored to meet relevant requirements in each jurisdiction. Federal agencies could request specific system controls be uniformly built into all school-based billing software.
- **Quality Assurance Reviews** - Contractors and/or schools themselves should periodically perform quality assurance reviews of claims to ensure that information continues to be processed correctly. During these reviews, a sample of claims should be selected together with relevant source documents/files to ensure that supporting information is properly reflected on the claims. This practice is not required in most contracts but would go a long way to responding to the concerns expressed by federal oversight agencies.
- **Regulatory review of procedures, operations, and systems** - Firms should maintain legal and regulatory advisors to provide research and technical guidance for any reimbursement engagement.

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They should review relevant regulations for the project and provide legal assistance regarding allowable practices. We believe that this regulatory perspective is invaluable to developing sound claiming practices.

- Compliance Officer - To reinforce the efforts of the regulatory team, school districts and/or billing contractors should take the step of creating a Internal Compliance Officer position. Such a person would ensure that project operations and systems be designed to comply with federal guidelines, that these practices are documented, that quality assurance measures are in place to identify deviations from approved procedures, and that all contractual obligations to the client are met. *We are not aware of many schools, billing and/or consulting firms that have voluntarily created this type of oversight position, but believe that it would demonstrate the commitment of a firm and a school system to maintain regulatory compliance.*

We strive to implement these protocols for each of our school clients as they address complex reimbursement issues. Our experience indicates that school districts have little frame of reference for understanding the Medicaid program, eligible services, billing procedures, or billing systems requirements. As a result, they often seek outside assistance from vendors to develop systems and operations that satisfy both educational and Medicaid requirements. Few, if any, school systems have the internal capacity to keep up with the constant and rapid changes imposed by federal and state oversight agencies to regulations and policy guidelines.

Our school-based clients, like all healthcare providers, want to be sure that they obtain all allowable reimbursement for the services they provide. We understand this goal and commit to assisting them to reach it. In our proposals to prospective clients, however, we try to emphasize not only our ability to assist them in obtaining all allowable revenue, but also the critical need for designing quality assurance practices to prevent inappropriate claiming.

Although the Senate heard testimony on several instances of apparent abuse, we believe that these practices are rare. To summarize our perspective on some of the major issues raised, we offer the following observations and comments:

- *Administrative Costs* - Mr. Scanlon cited an example where a school district had claimed 100% reimbursement for an employee who did not spend 100% of his/her time on Medicaid-allowable administrative activities. PCG would agree that this appears to be an inappropriate practice that can be mitigated through the development of statistically based time-surveys that apportion staff time and effort to allowable and non-allowable activities. Such sampling methodologies are both well established and routinely used throughout federal programs to appropriately allocate costs to Medicaid.

- *Cost Allocation Methodologies* - Mr. Smith identified the practice of certain vendors developing their own cost allocation methodologies which are proprietary and neither are well understood by their clients nor the payers. PCG utilizes cost allocation methodologies that conform to the Office of Budget Management Circular A-87.

  In states like Massachusetts, where the Medicaid agency has developed the claim methodology, contractors utilize the plan set forth by the State. In the event that a specific

plan is not developed by the state, we recommend that a plan be developed and presented it to the single State Medicaid agency for approval prior to obtaining reimbursement. Each administrative claim submitted should provide sufficient detail on the costs the school is claiming, the time-survey results for the period and the application of those results, as well as relevant Medicaid-eligibility information. In addition, claims should identify those costs that are "carved out" because they are related to direct service delivery, which are reimbursed through fee-for-service (FFS). This level of detail not only discloses costs that are claimed, but more fully highlights the methodology employed to state and federal agencies. An annotated example of such a claim was provided to GAO for their review in June 1999. In short, state and federal agencies should not reimburse schools for administrative claims if the regulators, or even the schools, are prevented from piercing the protective veil that is artificially constructed by so-called proprietary systems.

- *Skilled Professional Medical Personnel (SPMP)* - We share Mr. Scanlon's concerns regarding lack of clarity regarding SPMPs. Practices in this area vary widely, with some states prohibiting reimbursement at the enhanced rate while other states provide little direction for those activities that may qualify for reimbursement. In Massachusetts, schools have been prohibited from claiming enhanced reimbursement by the regional office (HCFA). This significantly reduces reimbursement for allowable activities performed by skilled staff. In other states including Illinois, the Medicaid agency and local HCFA reviewers (Region V) recognize enhanced FFP (75% match) for SPMPs as both allowable and appropriate. Recently, the Illinois State Board of Education (ISBE) sent out notices instructing providers to claim enhanced FFP for only certain SPMP qualified activities. At this time, no further clarification has been issued on those activities that do not qualify for SPMP reimbursement.

- *Bundled rates* – Public Consulting Group has experience working with school districts that utilize bundled rates, as well as detailed fee-for-service methodologies. It is clear to us that it is far more costly and onerous for schools to develop and maintain intricate fee-for-service operations. Additionally, there is no inherent problem with so-called bundled rates as long as they are statistically valid. Federal and state agencies use bundled rates in myriad programs including Medicare DRGs, capitated payments for managed care, and in hundreds of other instances.

  Mr. Vadner provided an excellent perspective on the rationale for using bundled rates and the necessary controls to ensure that rates calculated reflect an appropriate level of compensation. Through our work with schools during the past eight years, we have found that the service delivery model for schools differs significantly from that for other health care providers. These differences stem from the fact that public schools offer health-services to support student development and prevent illness, incapacity and disability that would adversely impact learning. Since the service delivery model is different, so too are documentation practices.

  Schools do not customarily record information in the manner required to support detailed fee-for-service billing. Federal and state authorities will - in a very tangible way - restrict access to a vital source of health care funding if it requires each school in the nation to develop and implement detailed fee-for-service billing for each health care service they provide. This would require the schools to design and install operations to support service

documentation forms, training programs, documentation and data collection practices, as well as costly information processing systems. These requirements are viewed as so burdensome - if not impossible - that many districts will simply choose not to participate in FFS programs.

While even bundled-rate methodologies are viewed as labor-intensive for school districts, they are viewed as less burdensome. Because bundled rate methodologies typically rely on the types of information already maintained by schools, they are not required to develop as many new systems, documents and operational "work-arounds" to support the claiming activities.

In reviewing the current bundled rate methodologies, we respectfully urge the Senate, HCFA, and GAO to work with school districts to more fully understand what will best work for them while meeting your own important oversight objectives. Conversion to a detailed FFS model will inevitably force many districts out of the program altogether and will, most certainly, increase the administrative burden and costs to schools and local governments across the country.

- *Billing for transportation* - We understand Ms. Richardson's concerns regarding claiming for transportation reimbursement. It makes sense for HCFA and GAO to review practices across the country in this important area. Here, too, we recommend that schools be included in program and policy development. Local school districts incur significant costs to transport students with disabilities while school administrators seek to provide transportation in the most cost-efficient manner possible. Customized transportation schedules and specially adapted vehicles are purchased to accommodate these needs. Without a full understanding of educational practices in this costly area, new reimbursement mandates will simply add layers of administrative burden and restrict access to federal funding.

- *Procurement Practices for Selecting Vendors* - State and local governments are largely responsible for the procurement process. In many cases, these entities select a competitive procurement process that considers both service capabilities and the price of each vendor. Competitive bidding has helped to reduce contractor fees by seventy-five percent (75%) for large school systems. In other instances - particularly with small school districts where the dollar value of the contract is relatively low - school systems view the administrative burden of a competitive bid process as out of proportion with the services required. Under either scenario, procurement decisions reside with local government agencies that are substantially closer to the day-to-day issues than the federal government.

  Contingency Fees for Vendors - During the hearing, there was significant discussion regarding the use of contingency fee structures by schools to compensate billing contractors. Most school systems prefer performance-based fees for two main reasons. *First*, schools are reluctant to commit to a vendor a fixed appropriation regardless of the contractor's performance. Even a vendor that agrees to a low annual fixed fee could cost the school more money than it generates. Many school districts fear they could pay extraordinary fees regardless of contractor performance. *Second*, school districts do not want to enter into arrangements where the compensation structure would result in vendors pursuing only the

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easiest to claims. They want a structure that provides some guarantee that vendors will prepare all allowable claims. Performance-based contracts are viewed as a reasonable method for meeting this objective.

We do not believe that performance-based or contingency fee contracts inherently conflict with good billing practices. Under any compensation structure, vendors should adhere to all relevant regulations. Contractors must understand the billing regulations and requirements that govern school-based programs. They should employ a set of quality assurance measures to ensure compliance with them – *this should be true regardless of the compensation structure for the project.*

We hope the above information is useful to the Committee as it reviews this important matter. We support members in their effort to highlight inappropriate practices under the school-Medicaid program. We hope that as you consider remedies to isolated cases, that consideration also be given to the many districts and vendors that currently employ sound practices. Federal mandates that impact school operations will inevitably require significant time, effort and expense at thousands of local school districts across the country. Federal mandates that are targeted at the manner by which schools procure outside assistance will impact the amount of revenue that school districts receive.

We offer our assistance as you deliberate program and policy changes. We understand that it is the Senate's goal to support the provision of school-base health services. We support this mission and remain committed to supporting our school-based clients to achieve this important goal.

Sincerely,

William S. Mosakowski,
President

July 6, 1999

David Podoff
219 Dirksen
Senate Office Building
Washington, D.C. 20510

RE: Senate Finance Committee Hearing on Medicaid and School-Based Services- June 17, 1999

Dear Mr. Podoff:

It has come to my attention that the Senate Finance Committee is investigating certain aspects of Medicaid reimbursement for school health services. As Superintendent of the St. Louis Public Schools (SLPS) District in Missouri, this is of particular concern for a number of reasons. SLPS has been participating in the Healthy Children and Youth program since 1993, the inception of the program. Through this program the SLPS has been able to obtain partial reimbursement for the costly but much needed health services that are provided to our school children.

In 1993 the State of Missouri, Division of Medical Assistance in conjunction with the Department of Education worked with the Health Care Financing Administration to develop and implement a program by which school districts could receive reimbursement for the health services provided in the school setting. As one of the first states in the nation to implement such a program, Missouri developed what they considered at the time the best program possible. However, over the past few years the State of Missouri has seen a significant decrease in participation by school and recently issued an RFP to assist the State in developing more comprehensive user-friendly program for schools. Health services billing is foreign to most school districts and prevents most from effectively participating in the program.

It appears that Missouri had opted to streamline this process by developing a bundled rate methodology which is more familiar to school systems, because it utilizes school system data. Under the bundled rate method, a rate developed for a range of services that are provided. This rate represents that average costs of provided. This rate represents the average costs of providing services and is used to provide reimbursement for a service. We understand that HCFA is evaluating this methodology and may decide to eliminate it altogether. As long as this rate is accurately developed using actual cost and service data, we view it as a valid payment for services. The SLPS applauds the State of Missouri's attempt to join other states in using this method.

The State also recognizes that unless the schools are involved in case management, screenings, immunizations, and other health services will not be delivered in a timely manner. For the long-term success of the country, we believe that nothing should be done to curtail meeting the health and education needs of our children. As an advocate for these children we ask that the elimination of bundled rates be strongly reconsidered.

Sincerely,

Dr. Cleveland Hammond, Jr.
Superintendent of the St. Louis Public Schools District

State of Vermont

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Statement of
M. Jane Kitchel
Commissioner, Vermont Department Of Social Welfare

To The

Committee on Finance

U.S. Senate

Washington, D.C.

June 17, 1999

Dear Chairman and Members of the Committee:

I am addressing you today as Commissioner of the Department of Social Welfare, which administers the Medicaid program in Vermont, and as Chair of the New England Consortium. The Consortium represents all six New England states, and works collaboratively on issues common to our Medicaid programs, particularly services for individuals covered by both Medicare and Medicaid.

All our states are committed to supporting special education services for our children, ensuring that all children, including those with special health care needs, have access to a good education. In Vermont we have taken great efforts to ensure that children with special needs are able to participate in our classrooms, and to take advantage of the public education that is their right. Today, fully 85 percent of our special education students receive services in the regular classroom setting – nearly double the national average of 45 percent.

Medicaid school-based services are an integral part of our special education system. Vermont has developed and received the Health Care Financing Administration's approval for an innovative and efficient school-based reimbursement system that facilitates important goals at both the Federal and State level. The school-based reimbursement system was designed with the following goals:

- Enhance schools' ability to address the medical needs of disabled children through improved access to medically necessary services, early intervention, and prevention

- Simplify the administrative process for Medicaid billing, thus encouraging broader participation in the program
- Develop reasonable and fair reimbursement rates for Medicaid-covered school-based services, based on the actual costs incurred by schools in purchasing health care services
- Provide financial incentives for a coordinated care approach to the delivery of school-based services

Vermont's reimbursement system, called a Level of Care system, uses a "bundled" rate approach, in which monthly case rate payments are made for most Medicaid-eligible services delivered by school-based health services providers. Each Medicaid-eligible child who has an Individualized Education Plan (IEP) is assigned to one of four Levels of Care, depending on the amount and types of service the child receives. Assignment to a Level of Care is accomplished through the completion of a form, based on service information contained in the child's IEP. The reimbursement rates associated with each Level of Care were developed after extensive review of past claims, and based on recommendations made by HCFA. The rates were approved by HCFA in March 1999.

Following approval of the methodology and rates, Vermont conducted extensive training of the schools' professional and administrative staff over a six-month period. Nearly 1,200 individuals participated in the training program. In addition to the extensive training, Vermont assures the accuracy and validity of the Level of Care claims through all the following:

- Requiring case managers to ensure that all services included in the Level of Care claims are actually provided
- Requiring supervisory unions (school districts) to review and compare services identified in the IEP to the claims
- Performing audits by State staff to ensure that services included in the claims are included in the child's IEP and adequately documented

The system has been successfully implemented, and feedback from school-based providers has been positive. The system has allowed providers to focus on providing care to children, rather than filling out cumbersome paperwork, while maintaining appropriate controls to protect against inaccurate claims.

I fully understand and share the concerns of HCFA and the committee that the current federal Medicaid reimbursement methodology leaves room for abuse and for inappropriately high third-party billing fees. However, caution is needed as we seek to strengthen the Medicaid reimbursement policies for school-based health services. Due recognition must be given for programs that equitably and efficiently reimburse schools for Medicaid-eligible services, comply with Federal Medicaid policies, and enhance schools' ability to address the medical needs of disabled children. States such as Vermont that have designed systems that meet the above objectives should not be punished for misuse by others.

Four of the six New England states use a bundled rate method to pay for school based health services. In Vermont, reversal of our approved bundled payment structure will require extensive re-training, revision of the Medicaid State Plan, development of new claim forms for all services in the bundled payment, and modification of our Medicaid Management Information System. These requirements will jeopardize our schools' ability to adequately provide Medicaid-approved, school-based services – ultimately harming the very children the program is designed to help. I believe similar challenges will be faced by the other states if they are required to change their systems.

I recommend that HCFA follow a two-pronged approach to address issues relative to bundled payment systems for school based health services. First, HCFA should continue to accept a state's bundled claim system until further deliberations determine what provisions need to be accommodated to ensure the integrity of bundled systems. These methodologies have been used for a number of years for reimbursing a variety of providers in the Medicaid program. Second, discussions should take place among involved parties around the structuring of a fiscally sound, fair, efficient, and accurate reimbursement system. Such a system however should not be burdened with requirements to the point that it is impossible to administer. I similarly urge the Committee to use caution in addressing the need for new restrictions or requirements for Medicaid reimbursement of school-based services. Bundled payment systems can offer the appropriate accountability and accuracy we all expect.

Thank you for your interest in this issue. It is one that is very important to Vermont and the other New England states.