



*in*Forum

In Depth Policy Analysis

School-based Medicaid for Children with Disabilities

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School-based Medicaid for Children with Disabilities

Obtaining sufficient funding to cover ever-increasing costs of services for students with disabilities is a critical responsibility for state and district special education directors. Medicaid is a possible source of support for certain school-based services in conjunction with other federal funds. This policy analysis provides a brief background of how the Medicaid program interfaces with the Individuals with Disabilities Education Act of 2004 (IDEA) and an analysis of how Medicaid resources are accessed and used in five states. Project Forum at the National Association of State Directors of Special Education (NASDSE) produced this document as part of its cooperative agreement with the U.S. Department of Education's Office of Special Education Programs (OSEP).

Introduction to the Medicaid Program

Medicaid is a federal-state matching entitlement program designed to help fund health and medical services for low-income individuals across the United States. Medicaid currently serves more than 57 million Americans, which includes 28 million children and 8.6 million individuals with disabilities (Herz, 2005). This jointly-financed program provided \$287 billion in Medicaid benefit payments in fiscal year 2004—the federal share was \$168 billion and the states share was \$119 billion (Aronovitz, 2006). The program originated in Title XIX of the Social Security Act of 1965 and the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT)¹ was added to the Medicaid program in 1967 to provide well-child and comprehensive pediatric care for children up to 20 years of age. Medicaid programs, including EPSDT, are administered by individual states but must operate within broad parameters of federal Medicaid laws and regulations. Each state describes its Medicaid program in a state plan that includes the state's eligibility group and standards, the services provided, any applicable service requirements and the rate of payment for services (CMS, 1997, p.7). Local education agencies (LEAs) can help develop components of the state plan, particularly school health services. The Center for Medicare and Medicaid Services² (CMS) strongly encourages education agencies to develop close working relationships with their state Medicaid agencies.

Funding

The original Medicaid program was a cost-sharing benefits program directed by CMS. The Federal Financial Participation (FFP) is the amount of federal payments to states. States file claims for FFP under two categories: administrative and medical assistance payments. The FFP for administrative expenditures is typically matched at a fixed rate of 50% (with some exceptions) while the FFP medical assistance payments matching rates vary from 50% to 83% of the cost, based on the poverty level of the state (CMS, 1997; Health Management Associates, 2000; Scott, 2005; Smith, 2005). There are no set limits for the total amount paid to a state. The medical assistance reimbursement rates are known as the Federal Medicaid Assistance Percentages (FMAP). Based on the 2006 FMAP, 13 states are reimbursed at a rate of 50%; 30 states receive

¹ For a list of select acronyms used in this document, see Appendix C

² The Center for Medicare and Medicaid Services was previously known as the Health Care Financing Administration.

reimbursement at a rate between 50-70% and seven states receive reimbursement at a rate of 70% or more (Scott, 2005).

School-Based Medicaid

One of the most convenient and accessible means of providing outreach for the Medicaid program is through school-based health services. However, throughout the history of Medicaid, schools have faced challenges in understanding Medicaid procedures, implementing sudden Medicaid policy changes and obtaining clear, specific guidelines from CMS. The Medicaid program, as related to school-based health services and administrative claiming, has undergone numerous changes since its inception, making it difficult for states to fully participate in all aspects of the Medicaid program. A table summarizing the history of Medicaid and school-based health services is provided in Appendix A.

IDEA and Medicaid

Ten years after the Medicaid program began, the Education of All Handicapped Children Act of 1975 (now known as the Individual with Disabilities Education Act [IDEA³]) was passed by Congress to ensure children with disabilities receive a free appropriate public education in the least restrictive environment based on individual needs and individualized education programs. The Medicaid program provides support for children eligible for special education services who have specific healthcare needs that affect their educational performance as identified in their Individualized Education Program (IEP). The amount of support from Medicaid is less than 2% of the expenditures for special education and related services for children with disabilities (Apling & Herz, 2003).

An important difference between the two programs is that Medicaid is a mandatory funding program and IDEA is a discretionary funding program. In other words, the federal government will ensure needed funds are available for Medicaid services, but is not obligated to ensure needed funds are available for IDEA services, even though all eligible individuals in the two separate programs must receive necessary services as defined by the programs. IDEA provides certain procedural rights and services, but not all of the funds for those services. IDEA also distinguishes between medical services and health services. Only licensed physicians can provide medical services but other health care professionals can provide health services (Apling & Herz, 2003). IDEA specifically refers to the obligation⁴ of other public agencies to provide or pay for services to ensure a free appropriate public education for children with disabilities (Rosenbaum, 2001).

Prior to the 1988 Medicare Catastrophic Coverage Act, Medicaid did not pay for any services listed on a child's IEP since they fell under educational services and Medicaid policy stipulated that Medicaid would be the payor of last resort. Since the 1988 Act, Medicaid *can* pay for

³ The Education of All Handicapped Children Act of 1975 has been amended and reauthorized several times most recently by the Individuals with Disabilities Education Improvement Act (IDEA 2004). The acronym IDEA will be used for the remainder of the paper.

⁴ IDEA §602(a)(12)(B)

medical services listed on a child's IEP, but there is ongoing debate about whether Medicaid is *required* to pay for the services, or simply *allowed* to pay for the services. In contrast, IDEA requires interagency agreements with public agencies (e.g., with vocational rehabilitation agencies) to ensure children with disabilities receive the necessary services for a free appropriate public education and indicates that the fiscal responsibility for those services is with the public agency providing the services. The debate over fiscal responsibility is ongoing.⁵

Medicaid is a complex program with many specific rules and codes, such as eligibility rules for children and various categories. Requirements for approved Medicaid services and Medicaid providers add complexity, as do third party liability, financial arrangements under managed care, filing claims and billing. There are four conditions that must be met for Medicaid to reimburse LEAs for IDEA-related services. They are:

- The child receiving the service must be enrolled in Medicaid.
- The service must be covered in the state Medicaid plan or authorized by the federal Medicaid statute.
- The service must be listed in the child's IEP.
- The LEA must be authorized by the state as a qualified Medicaid provider (Herz, 2006).

Due to the complexities of Medicaid and the medical model and language used, many schools find it difficult and time consuming to use Medicaid to fund appropriate services on a child's IEP.

Federal Guidance

CMS has provided a few guidance documents and administrative policy letters to all states regarding school-based Medicaid. However, because the guides lacked the necessary specificity and/or explanations, some states did not change their practices in accordance with the provided guidance. The primary guidance documents from CMS include the *August 1997 Technical Assistance Guide on Medicaid and School Health*, the 1999 administrative policy letter prohibiting bundled payments,⁶ the 2002 administrative policy letter eliminating enhanced reimbursement rates for skilled professional medical personnel and the 2003 final *Medicaid School-Based Administrative Claiming Guide*.⁷ The purpose of the first guide was to “provide information and technical assistance regarding the specific Federal Medicaid requirements associated with implementing a school health service program and seeking Medicaid funding for school health services” (CMS, 1997, p.4). The administrative policy letters identified specific changes regarding bundled payments, transportation, skilled professional medical personnel, referral verification and disallowance of IEP preparation as an administrative reimbursable activity. The underlying purpose of the *Medicaid School-Based Administrative Claiming Guide* was to address the rapid rate of growth of administrative costs claimed by various states because of the unclear and inconsistent application of employee administrative tasks related to school-

⁵ For additional information regarding the link between Medicaid and IDEA, refer to Apling and Herz (2003) and Herz (2006). Complete references can be found in the bibliography at the end of this document.

⁶ A bundled payment rate is a single rate for a group of different services delivered to an eligible individual during a fixed period of time (Richardson, 1999).

⁷ See Appendix B for additional information about the *Medicaid School-Based Administrative Claiming Guide*.

based Medicaid. In the guide, CMS tried to define and codify more concisely these tasks, provide a methodology for measuring these tasks and eliminate charging for overlapping activities that are already being reimbursed by other federal, state or insurance agencies.

Upon issuing the 2003 guide, CMS rescinded all prior approvals of states' school-based administrative claiming programs. This required all states to revise their programs to be in compliance with this new guide and resubmit them for CMS approval. The guide clarified that an interagency agreement between the state Medicaid agency and the state Department of Education and/or local entities or school districts conducting the activities must exist prior to submitting claims for reimbursement. It further indicated that the state Medicaid agency is the only entity that may submit claims to CMS to receive the federal matching funds, and interagency agreements may only exist between governmental entities (i.e., there should be no interagency agreements with private contractors or consultants). It warned states that consultant service fees were not reimbursable from federal matching funds if the fees were "contingent upon recovery of the costs from the Federal government" (CMS, 2003, p.47).

Congressional Activity

Since Medicaid is a federally funded program, members of Congress have interest in the Medicaid program and expectations about its effectiveness. Over time, Congress has held hearings related to school-based Medicaid. In 1999 and 2000, the General Accounting Office (GAO), now the Government Accountability Office, presented to Congress three studies⁸ citing "improper payments" of school-based Medicaid to states based on improper fee-for-service claims and improper administrative claims. Some of the discrepancies the GAO discovered were:

- claims for transportation without verifying that the child actually used the school bus on that particular day;
- group therapy sessions billed as individual therapy sessions;
- administrative claims submitted for activities not clearly related to Medicaid such as general health screening, family communication, or training;
- claims for activities performed for the benefit of non-Medicaid eligible children;
- inadequate documentation of the need for skilled professional medical personnel in certain administrative activities;
- the 1998-99 average annual Medicaid school-based administrative claim among states ranged from less than \$1 to \$818 per eligible child; and
- consultants received alarmingly high contingency-based⁹ fees (Allen, 2000).

⁸ GAO, *Medicaid: Questionable Practices Boost Federal Payments for School-Based Services*. GAO/HEHS-99-148. Washington, DC: June 17, 1999.

GAO, *Medicaid in Schools: Poor Oversight and Improper Payments Compromise Potential Benefit* GAO/HEHS/OSI-00-87. Washington, DC: April 5, 2000.

GAO, *Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight* GAO/HEHS/OSI-00-69. Washington, DC: April 5, 2000.

⁹ Consultants were paid a percentage of the amount of federal Medicaid dollars received rather than a flat fee.

In 2005, the GAO identified Medicaid as a high-risk federal program and the U.S. Senate Committee on Finance held more hearings. These hearings addressed states' practices of maximizing federal reimbursements through Medicaid. The GAO released a series of reports¹⁰ identifying strategies states were using to obtain Medicaid reimbursements. In general, the strategies included using contingency-fee consultants, submitting inappropriate claims for targeted case management and improperly using intergovernmental transfers of funds (Allen, 2005; Smith, 2005). The Health and Human Services (HHS) Office of the Inspector General (OIG) found that states retained some of the federal Medicaid reimbursements generated through school-based claims instead of sending all of the funds to the school districts (Allen, 2005). In addition, states submitted Medicaid claims for case management services provided by other state agencies such as Departments of Social Services, Juvenile Justice, Family and Children Services, and Mental Health, and reassigned non-federal public funds between local providers and the state Medicaid agency.

In response to the GAO reports and Congressional hearings, a new division of CMS, known as the Division of Reimbursement and State Financing (DRSF), was created to review state plan amendments and address state Medicaid policy and state Medicaid funding issues. The primary responsibility of DRSF is to ensure nationwide consistency of Medicaid payment and funding policy (Smith, 2005). More recently, CMS reported the addition of the Medicaid Integrity Program to review, audit, and identify and recover overpayments (Smith, 2006).

Since both Medicaid and IDEA are federally funded, they are included in the federal budget. In response to the proposed fiscal year 2007 federal budget, members of Congress recently introduced bipartisan legislation in both the House of Representatives (H.R. 5834) and Senate (S.3705) that would permit states and local school districts to continue Medicaid administrative claiming and reimbursement of transportation costs for Medicaid eligible children with disabilities who receive special education and related services through IDEA.

Audits

Upon distribution of the *School-Based Medicaid Administrative Claiming Guide* in 2003, OIG began to conduct audits in several states to determine if Medicaid payments for school-based health services were in accordance with applicable laws and regulations. As of March, 2006, OIG had completed audits of 18 states (Herz, 2006). Audit reports show that federal Medicaid funds were inappropriately claimed for:

¹⁰ GAO, *Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*. GAO-05-748. Washington, DC: June 28, 2005.

GAO, *Medicaid: States' Efforts to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*. GAO-05-836T. Washington, DC: June 28, 2005.

GAO, *Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes*. GAO-04-574T. Washington, DC: March 18, 2004.

GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes is Needed*. GAO-04-228. Washington, DC: February 13, 2004.

- services that were not approved in the state plan;
- services that were not sufficiently documented to ensure that services prescribed in student IEPs were delivered;
- services that were not authorized or were in excess of the quantity authorized in the IEP;
- transportation services when there was no authorized Medicaid service on the same day;
- services rendered by health care providers that did not have the qualifications required by Medicaid regulations;
- services provided free to other students; and
- students who were absent.

CMS has recommended that several states refund the improperly claimed funds to the federal government. Most audited states have negotiated with CMS regarding the audit, requested additional documentation or support and sought input on new plans to improve their programs.

State Interviews

Throughout the history of Medicaid policy changes, retractions and audits, states have continued to maintain Medicaid programs to meet the health needs of students in schools. The remainder of this document provides information from five different states (*Kansas, Kentucky, Minnesota, Texas, and Vermont*) regarding their use of Medicaid school-based health services and administrative claiming. The state special education director or a specified individual in the education agency and a specified individual in the state Medicaid agency in the five states were contacted to participate in the interview. After a review of specific questions and data from the 2005 survey conducted by the NCRRC and NAME to form a database of information and analysis of school-based Medicaid in states, Project Forum developed and emailed interview questions to the five states' education and Medicaid agencies. Interviewees were asked a set of standard questions regarding the amount of Medicaid funds used for school-based Medicaid programs and school-based administrative claiming, billing practices, monitoring practices, use of funds, relevant state policies or statutes and effective practices (see Appendix C for a copy of the interview protocol). Medicaid agency representatives and education agency representatives in two states (KS, KY) requested that they participate in the interview at the same time. Interviews were conducted in March and April 2006 with additional follow-up through e-mail communications throughout May 2006. Responses to each interview question were initially analyzed for common themes among the five interviewed states. The content of responses was grouped into categories developed from the interview questions and common themes.

Overview

As can be seen in Table 1, in the five interviewed states, between 43.7% and 59.7% of all Medicaid-eligible individuals are ages one through 21.¹¹ Although a significant percentage of children eligible for Medicaid are probably also receiving special education services, no national data are available to support this claim. In addition, most states do not collect data to determine

¹¹Data retrieved May 7, 2006 from www.cms.hhs.gov/Medicaid/DataSourcesGenInfo/Downloads/MSISTables2003.pdf

the number of students with an IEP/IFSP who are enrolled in Medicaid. However, *Minnesota* and *Texas* estimate that 25% and 30% respectively of their students enrolled in Medicaid receive special education services. *Vermont* reported that 8,868 students with disabilities, (approximately 60% of the total number of students receiving special education services), are enrolled in Medicaid.

Table 1. Resident population and percentages of students in special education and Medicaid

	Texas	Minnesota	Kentucky	Kansas	Vermont
Resident Population 3-21 years ¹² (2004-05)	6,499,757	1,343,314	1,050,040	738,298	151,596
Percentage receiving Special Education Services ¹³ (2004)	7.9%	8.6%	10.2%	8.9%	9.2%
Medicaid Eligible Population ¹⁴ (2003)	3,661,163	730,195	810,159	32,177	159,701
Percentage of all Medicaid eligible individuals that are 1-21 years (2003)	59.7%	50.2%	51.0%	57.2%	43.7%
Percentage of students receiving special education enrolled in Medicaid	30% (Estimated)	25% (Estimated)	Data not collected	Data not collected	60%

Some states began using Medicaid funds for school-based direct health care services for children with an IEP/IFSP shortly after the Medicare Catastrophic Coverage Act in 1988 declared that Medicaid is allowed to pay for appropriate services on an IEP or IFSP while some states began participating much later.

- *Minnesota* reported only approximately 20 school districts tried to bill Medicaid for IEP/IFSP related services between 1989 and 2000. Legislation in *Minnesota* (1998 and 1999) mandated schools to bill third parties, both public and private, for IEP/IFSP direct health care services. Schools responded in July 2000 when the mandate was effective by billing third parties, including Medicaid.
- *Texas* reported that it has been involved with Medicaid fee-for-service¹⁵ since 1994.
- *Kansas* reported using a fee-for-service model initially, but changed to bundled rates in 1996.

¹²Data retrieved May 7, 2006 from www.ideadata.org/tables28th/ar_C-1.htm

¹³Data retrieved May 7, 2006 from www.ideadata.org/tables28th/ar_1-1.htm

¹⁴Data retrieved May 7, 2006 from www.cms.hhs.gov/Medicaid/DataSourcesGenInfo/Downloads/MSISTables2003.pdf

¹⁵ The program is called School Health and Related Services (SHARS) in Texas.

- *Vermont* indicated that its school-based health services program started in 1998 when state statute required schools to use the funds generated by school-based claiming of direct services for prevention and intervention programs.
- *Kentucky* could not report a specific start date as a state but indicated that school districts could individually indicate when they started billing Medicaid for school-based direct health care services for children with an IEP/IFSP.

States also varied in their use of Medicaid for school-based administrative claims, partially due to the lack of clarity from CMS regarding “reasonable” and “allocatable” costs, and partially due to the complexity of billing Medicaid in general. *Texas* and *Minnesota* started Medicaid administrative claiming (MAC) programs in 1996, *Kentucky* started in 2003, *Kansas* started in 2004, and *Vermont* never implemented a MAC program. Since the initial draft of the school-based Medicaid administrative claiming guide was issued in 2000 and the final guide was issued in 2003, states have used MAC with unclear and varying regional guidance.

Amount and Use of Medicaid Dollars

The amount of Medicaid dollars used for direct health care services for children with an IEP/IFSP and school-based administration varied greatly. Table 2 summarizes the amount and use of Medicaid dollars by the five interviewed states. All states indicated that the LEAs are responsible for matching the Federal Financial Participation (FFP). Two states explained their mechanisms for matching funds as a paper trail rather than direct exchange of money. *Vermont’s* schools bill Medicaid directly for direct health care services, and that money is sent to the state education agency rather than the state Medicaid agency. The Medicaid agency certifies the match at the special education department level through a paper process without exchange of money since the funds go directly to the department of education. *Kansas* reported that quarterly forms are sent to the state Medicaid agency for both direct health care services and administrative claiming to certify the match through a paper process.

The FFP for *direct health care services* varies by state through use of their federal Medicaid Assistance Percentages (FMAP).¹⁶ States also differ in their policy on the dissemination of funds for direct health care services received from the federal government.

- *Kansas, Kentucky, and Texas* reported that 100% of the FFP based on FMAP went to the schools. (However, *Kansas* pays the schools bundled rates monthly, and also assesses schools 5% of that amount on a monthly basis. That 5% returns to the state Medicaid agency, so essentially *Kansas* schools receive 95% of the FMAP.)
- *Minnesota* reported that its Medicaid agency keeps up to 5% of the federal share of Medicaid payment for direct health care services for children with an IEP. School districts in the state are responsible for the non-federal share. The administration fee is up to 5%; however the state Medicaid agency retains only the actual administrative costs and

¹⁶ The FMAP relates only to direct health care services and is based on the poverty level of the state; therefore, the FMAP varies by state.

returns the remainder collected to school districts annually. School districts retain 95% or more of the federal share, nothing goes to the state education agency.

- *Vermont's* state education agency, not the Medicaid agency, keeps 50% of the FMAP and sends the remaining 50% directly to the schools submitting claims. (Of the 50% of the FMAP kept by the state, 11% is used for program administration and 39% is deposited in the education fund to be distributed to schools in different ways.)

The FFP for *administrative claiming* is a fixed rate of 50%. States disseminate these funds as follows:

- *Minnesota* sends 100% of that FFP to its local collaboratives (groups of agencies and schools) and the governing board of each collaborative decides how the money is used.
- *Texas* and *Kansas* send 95% of the FFP to the schools and keep 5% for the state Medicaid agencies.
- *Kentucky* sends 60% of the FFP to the schools, 35% stays with the state Medicaid agency, and 5% goes to the state education agency.
- *Vermont* does not participate in school-based administrative claiming except under EPSDT.

Table 2. Amount and Use of Medicaid Dollars by State Education Agencies

		Texas	Minnesota	Kentucky	Kansas	Vermont
Amount used for direct health care for students with IEP/ IFSP	FY 2004	\$ 66 M (based on date of service)	\$ 11.2 M (based on date of payment)	\$ 2.1 M	Data not available	\$ 31.3 M approved claims
	FY 2005	\$ 60 M (based on date of service)	\$ 16.7 M (date of payment)	\$ 2.5 M	Data not available	\$ 38.5 M approved claims
Amount used for school-based administrative claiming	FY 2004	\$ 20 M	\$ 6 M	None (new program)	\$ 5.2 M (date of payment)	\$ 446,000
	FY 2005	\$ 12 M	3.5%	\$ 8.0 M	Data not available	\$ 684,000
FMAP ¹⁷		60.66%	50.00%	69.26%	60.41%	58.49%

¹⁷ Federal Medicaid Assistance Percentages

		Texas	Minnesota	Kentucky	Kansas	Vermont
Funds received by LEAs for direct health care services	Percentage of the FFP/FMAP ¹⁸	100%	95%	100%	95%	50%
Funds received by LEAs for administrative claiming	Percentage of the FFP	95%	100% to local collaboratives	60%	95%	LEAs do not make administrative claims
Remaining funds distributed		5% to Medicaid	Up to 5% to Medicaid	35% to Medicaid; 5% to education	5% to Medicaid	50% to Education with 11% for program administration & remainder in education funds

Policies, Plans, and Goals

Relevant State Policies for School-based Medicaid and Special Education

Texas does not have a specific state statute regarding the provision of special education services as appropriate Medicaid expenditures. However, the *Texas* Department of Education has procedural policy in its school health and related services program (SHARS) that relates to special education. The *Texas* Medicaid agency has a separate policy and reimbursement methodology for school-based services. The *Texas* Department of Education is currently working on a state plan amendment with CMS that will require school districts to follow the same policies and procedures as other Medicaid providers.

Vermont has an education statute that clarifies how schools can spend the Medicaid payment for direct health care services for children with an IEP/IFSP. *Minnesota* has a variety of related education and Medicaid statutes. *Kentucky* has a Medicaid statute with regulations regarding the kinds of service Medicaid allows reimbursement for and special education services are tied into the statute. *Kentucky* also has recent legislation through the state budget bill that requires the SEA to implement school-based administrative claiming in collaboration with the state Medicaid agency. *Kansas* has a state plan amendment that outlines typical services in bundled rates and other policy changes to ensure that the bundled rates payment and assessment system work effectively.

¹⁸ The FFP/FMAP is the federal financial participation of federal Medicaid assistance percentages that are based on the poverty level of the state.

Medicaid Administrative Claiming Plans

Kentucky has an administrative claiming plan that the state submitted to CMS in 2004, but CMS has not yet provided feedback or approval of the plan. *Kansas* has a MAC handbook approved by CMS, while *Texas* and *Minnesota* have approved cost allocation plans that may change due to the recent audits of administrative claiming in their states. *Vermont* reports no MAC plan because they do not participate in school-based administrative claiming.

State Education Agency Goals and Strategies for School-based Medicaid Billing

Kentucky and *Vermont* do not have specific goals or strategies outlined in their special education continuous improvement plans regarding school-based Medicaid billing. *Kentucky* encourages schools to access Medicaid funds. *Texas* does not have any state level goals and strategies because it is a local control state with independent school districts. In *Kansas*, the SEA serves as a liaison for the state Medicaid agency, but school-based Medicaid is not a major initiative for the SEA at this time. *Kansas's* Medicaid agency keeps the education agency informed about significant issues that impact schools.

In contrast, *Minnesota* has a variety of goals and strategies for school-based Medicaid. *Minnesota* mandates that all schools access available revenue from all third parties; including Medicaid. However, schools and the SEA are currently reviewing how to maximize Medicaid revenue with little or no cost to them. They are trying to decide when it is reasonable to bill Medicaid and are developing cost-effectiveness guidelines. In addition, the state's Medicaid and education agencies are working together to develop an interagency agreement and the state education agency would like the Medicaid agency to take on the responsibility of billing for school-based services.

The Medicaid System: Billing, Data Collection, and Monitoring

Billing Practices

Most schools in the five states interviewed engage in direct billing to Medicaid for the direct health care services for children with an IEP/IFSP. *Kentucky*, *Minnesota*, and *Vermont* use electronic billing methods either through special software or web-based billing systems. All five states have some schools that use a standard "paper and pencil" method for billing.

The five states also report the use of vendors to bill for services. Twenty percent of LEAs in *Minnesota*, approximately 80% of LEAs in *Kentucky*, two LEAs in *Vermont* and most LEAs in *Texas* use a vendor to bill for services. *Kansas* reported that all of its LEAs are enrolled Medicaid providers with Medicaid identification numbers and payments are calculated using the same method as any other Medicaid providers. However, for school-based services only, the federal share based on the FMAP is sent to the LEAs instead of 100% of the calculated amount. Many *Kansas* LEAs use vendors to bill for services but two large LEAs (*Wichita* and *Kansas City*) complete their own billing process.

Minnesota LEAs participate in random moment sampling time studies and apply those results to a cost pool to bill for Medicaid Administration. Random moment sampling involves measuring the amount of time spent on administrative activities at random moments using a statistically valid and reliable methodology (CMS, 2003). Schools use this type of claiming mechanism rather than specifically billing Medicaid. *Texas* has Medicaid Administrative Claiming (MAC) consortiums that conduct the billing for MAC since the state Medicaid office would be overburdened with the number of claims to process. These *Texas* consortiums rely on interagency agreements for oversight of MAC. *Vermont* does not participate in school-based administrative claiming.

Data Collection

Most of the five states interviewed reported the use of specific codes for school-based direct health care services, which allows them to collect data on school-based Medicaid services and payments. *Kansas* restricts the number and types of bundled rate codes that LEAs can use in the state's bundled payment system. *Minnesota* uses two sets of codes—one set of codes identifies when LEAs receive Medicaid money and one set of codes identifies when the LEAs spend the Medicaid money. *Texas* and *Vermont* both use a fiscal agent who queries the claim data and expended revenue. *Texas* is currently working with CMS to implement provider cost reports for annual cost reconciliation purposes.

In general, data collection for Medicaid administrative claiming (MAC) seems more ambiguous than Medicaid school-based direct health care services billing. *Minnesota* and *Texas* reported state guidelines and policies on how the MAC money is spent. For example, *Minnesota* policy indicates that MAC money must be spent on prevention and early intervention. *Kentucky's* MAC money is spent for an administrative function relevant to Medicaid based on a staff's percentage of time allotted for MAC. *Kansas* uses a quality assurance method on claim information. *Vermont* does not participate in MAC.

Monitoring

All five states interviewed monitor LEAs' billing practices. In *Kansas*, any LEA that accepts the bundled rates payments agrees to audit a percentage of its population and the LEA audits or tracks those students throughout the process. *Kansas* also uses a quality assurance process at every level, with the SEA providing annual oversight training. *Kentucky* has a process to audit random samplings of claims, in addition to auditing its Medicaid Management Information System (MMIS) system to detect practitioners not approved as Medicaid providers. *Texas* and *Vermont* reported the use of "desk audits." In other words, LEAs' claims and school files are audited individually. In *Vermont*, five field staff meet monthly with each supervisory unit to audit files. *Minnesota* has one full time equivalent (FTE) in the state Medicaid agency allocated to auditing LEAs and two FTE in the state Education agency who monitor the use of Medicaid funds. However, *Minnesota* also delineates a spending policy and the collaboratives, a group of LEAs with related interests and priorities, report their spending to the state Medicaid agency. In addition, since collaboratives are used and schools compete for money with other Medicaid providers, the use of this money is transparent to the communities.

Kentucky provides LEAs with a self-monitoring tool to ensure LEAs understand what records are needed for the audits. *Vermont* provides a guidance manual that is updated annually and regional training three times per year. *Texas* is currently developing a self-monitoring tool.

Federal Office of Inspector General (OIG) Audits

Minnesota and *Kentucky* reported no audits from the federal level for school-based direct health care services. *Minnesota* reported that CMS attended the training program when the state changed its program. *Minnesota* also reported a recent audit of its cost allocation plan for MAC and is currently awaiting the report.

Vermont was audited October 2001 through September 2002 for school-based direct health care services. Procedural errors were identified by OIG—services were not specified in the child’s IEP, services were not billed at the appropriate level of reimbursement, unallowable services were claimed, and clerical errors were evident (OIG, 2005a). *Vermont* responded by increasing the number of field staff and audits to strengthen procedural oversight. Although OIG recommended that *Vermont* refund approximately \$1.5 million to the federal government, the state is still working on resolutions on a claim-by-claim basis with CMS.

Texas school-based direct health care services were audited in 2002 and the state is only recently receiving reports from that federal audit. CMS expects *Texas* to refund approximately \$8.8 million for school-based health services that were not allowable because of programmatic deficiencies; services rendered by unlicensed providers; and overpayments resulting from claims exceeding maximum allowable fees established by the state agency (OIG, 2006a). A significant challenge is that *Texas* provides state board of education certificates for diagnosticians, speech-language pathologists and counselors but CMS does not recognize practitioners with certificates but no licenses as appropriate Medicaid service providers.

Two large school districts/collaboratives in *Texas* were also audited for Medicaid administrative claiming. According to the Texas interviewee, one audit involved negotiations resulting in a “reasonable” amount of reimbursement and is now settled. CMS expects *Texas* to refund \$2.5 million more for school-based administrative costs that were not reasonable, allowable, or adequately supported (OIG, 2006a) in an audit of a different, but very large, collaborative. CMS recommended that *Texas* monitor school district claims periodically; make appropriate financial adjustments for unallowable services, direct school districts to ensure service providers meet licensing requirements; and issue guidance to school districts to bill only for allowable services rendered by licensed individuals. *Texas* asked CMS for additional documentation and more specific information on 11 school district audits. Some changes that *Texas* implemented since this audit include requiring and reviewing detailed session notes and development of a state plan to allow group rates rather than individual rates.

Kansas’ use of bundled rate payments was audited for fiscal years 1998-2003 with the report available in February 2006. *Kansas*’ use of time-studies and cost reports for administrative claiming were also audited, with the report available in April 2005. OIG found that *Kansas* designed its monthly bundled rate payments program to reimburse school districts for a full year

of costs over a nine-month period (academic school year). However, due to miscommunication, the schools billed for a twelve-month period instead of nine, which resulted in overpayment by the Federal government (OIG, 2005b). OIG recommended that *Kansas* refund \$13.9 million to the federal government. *Kansas* agreed with these particular findings and has refunded \$5.1 million to date. *Kansas* interviewees reported concerns about the other bundled rates audit because they believe the audits are threatening the continual use of this type of payments. *Kansas* continues to negotiate with CMS regarding bundled rate payments and described a dispute over the Consumer Price Index used to calculate payments. *Kansas* administrative claiming practices were also audited—particularly time studies and cost reports. Again, the OIG found that *Kansas* did not accurately complete the time studies and cost reports and recommended that *Kansas* return another \$350,000 to the federal government, which it did. *Kansas* implemented some changes to the audits but continues to negotiate with CMS regarding OIG findings and recommendations. *Kansas* increased its monitoring capacity to address some of the OIG findings.

While the audits may be helpful for improving Medicaid billing, they are time-intensive. The three states identifying audits indicated a significant delay in receiving reports from the OIG audits and continue to negotiate with CMS regarding the findings and recommendations. In general, the audit reports were not available until three years after the audit occurred, which caused states to continue using “inappropriate” billing practices.

Successes and Barriers of Medicaid Billing Practices

School-based direct health care services

Interviewees from four of the five states believe their Medicaid billing practices for school-based direct health care services are successful. Most states defined “successful” as the amount of money they received. *Kansas* found its bundled rate payments effective for generating money for schools and does not want to use a fee-for-service model since the billing process is too cumbersome causing many schools to not participate. Vermont uses a bundled rate payment system. Under the bundled rate system 100% of supervisory units participate by billing direct services to the school-based health services program. *Texas* uses a fee-for-service billing method and reports that the process works well, although in *Texas*, the time to receive payment is sometimes delayed. *Minnesota* also finds its program successful, although some schools think the required documentation is a barrier. *Kentucky* does not believe its program is successful because it obtains only \$2 million federal Medicaid dollars for school-based direct health care services when the state expends considerably more than that amount.

Minnesota changed its program significantly in 2000. State legislation was passed that mandated schools to bill Medicaid for school-based services and mandated the Medicaid agency to simplify the billing process for schools. The legislation also clarified the purposes for which the money could be used—the cost of providing services, training and technical assistance, and other activities that benefit children with special needs. This coerced collaboration resulted in an effective program. Prior to the legislation, *Minnesota* received \$200,000 of federal Medicaid money for school-based services and after the legislation the state received approximately \$11.2 million in 2004.

Kentucky and *Minnesota* reported several barriers in the Medicaid school-based program centering predominantly on required paperwork and permission. Schools must receive signed consent from parents before they can bill for services and many parents either do not respond to the request for consent or refuse consent. Many districts also do not want to approach parents for consent. Schools also must receive a statement from the third party insurance denying payment of services before they can bill Medicaid for services. Both of these requirements significantly increase the administrative burden schools must bear to participate in the Medicaid program. Additional barriers reported were the incapacity of the current data system to produce electronic claims for Medicaid billing and the ineffective communication and collaboration between education and Medicaid agencies. While Medicaid agencies follow a medical model, education agencies do not, resulting in language barriers and lack of understanding in addition to territoriality of agencies. *Minnesota* reported that the language barriers and lack of understanding for districts significantly decreased due to ongoing training and support provided by both the state Medicaid and education agencies.

School-based Medicaid Administrative Claiming (MAC)

In general, the four states that participate in school-based MAC believe the program is effective in generating revenue, but they readily identify barriers to its implementation. *Kentucky's* MAC program is successful because it uses only one vendor for the state and pays flat fee rather than a percentage of the revenue collected. In *Kansas* personnel changes and timeliness of its vendor processing files and making payments have been barriers. *Texas* and *Minnesota* each use a collaborative consortium to participate in the MAC program, which resulted in additional barriers. For example, the consortium board members decide how the money is spent and distributed. This can result in parity, territoriality, financial and relationship issues. In addition, school-based administrative claiming is based on random moment time sampling studies conducted a few times per year, whereas other state Medicaid administrative claiming is based on a 100% of recorded time for administrative tasks. Due to this, schools often feel short-changed for the administrative work they do.

Effective Policies and Practices

While there is variety between states in their school-based Medicaid billing policies, procedures and practices, there is a general consensus that effective communication and collaboration between the education agency and Medicaid agency is essential for a successful program. Direct lines of communication, a strong understanding of the vocabulary used by each agency and commitment to collaboration are important. Practices that increase the effectiveness of the MAC program vary between the states, but include use of established policies to support bundled rate practices, a single statewide vendor, a cost-based system with specific procedural codes by category with a set payment and bundled rates.

Summary of State Interviews

Medicaid is a federal health-care assistance program that states choose to use for school-based direct health care services and/or administrative claiming reimbursements. There is great variation among the five states interviewed on their use of Medicaid to the following areas:

- when they began using it for school-based services;
- the amount of Medicaid dollars received by the state; and
- the amount of Medicaid dollars received by the LEAs.

There are also variations in the strategies and methods implemented by states in many areas:

- obtaining Medicaid funds;
- collecting data;
- monitoring Medicaid practices;
- state policies and legislation to support the use of Medicaid for school-based services and administrative claiming;
- the procedures used to bill Medicaid; and
- the tracking methods to monitor use of Medicaid dollars.

Implications

IDEA is a federal program designed with the intent to help children with disabilities and Medicaid is a federal program designed with the intent to help children from low-income households. These programs need to work together to achieve their complementary ends. The five states interviewed indicated that the most critical component for achieving success with school-based Medicaid is collaboration. Not only should the Medicaid and education agencies at the state levels collaborate, but the regional and federal Medicaid and education offices should model this collaboration at their levels and with state level teams. It is imperative that Medicaid and education agencies work together to understand each other's programs, develop a common language and achieve the intent of the programs—supporting all children to become contributing members of society through a free appropriate public education.

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Appendix A

<i>A Brief History of School-Based Medicaid</i>	
1965	Medicaid, a federal-state matching entitlement program designed to help fund health and medical services for low-income individuals, begins as Title XIX of the Social Security Act. Individual states develop their own Medicaid plan within the parameters of federal Medicaid laws and regulations.
1967	Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) program is added to Medicaid. This program was established specifically for children to receive screening and diagnostic services as well as any medically necessary treatments allowable under federal Medicaid law even if it is not included in a state's Medicaid plan (Lewin, 1991).
1975	Education of All Handicapped Children Act is passed and implemented to ensure children with disabilities receive a free appropriate public education in the least restrictive environment based on individual needs and Individualized Education Programs (IEPs).
1982	Health Care Financing Administration ²⁰ (HCFA) declares that no Medicaid funds are available for services included in a child's IEP/Individualized Family Service Plan (IFSP) since it is a school district financial responsibility. This declaration causes much controversy and dissension between schools and the Medicaid program.
1988	Medicare Catastrophic Coverage Act revokes HCFA declaration. Medicaid may pay for health related services based on a child's IEP/IFSP if the child is Medicaid eligible and if the service is covered in the state Medicaid plan or if medically necessary through EPSDT (Scanlon, 1999). Schools begin using Medicaid for school health programs and appropriate services for a child with an IEP/IFSP.
1988-1997	Schools use basic fee-for-service models for Medicaid claims but receive no specific federal, regional or state guidance. Private consulting firms began to help schools with Medicaid billing, but charge fees from 3% to 25% of the Medicaid money received by the schools.

²⁰ HCFA is now known as the Center for Medicare and Medicaid Services (CMS).

1995-1998	More schools make school-based administrative services claims for Medicaid reimbursement resulting in a fivefold increase in the amount of administrative activity expenditures claimed (Scanlon, 1999). The 10 regional Center for Medicare and Medicaid Services (CMS) offices determine what was reimbursed and what was not, with great disparity between regions and states. CMS acknowledges its lack of guidance and its weak, uneven oversight.
1997	The 1997 Amendments to the Individuals with Disabilities Education Act (IDEA) clarify and reinforce expectations that educational agencies work closely with Medicaid agencies to coordinate provision of services for eligible children (CMS, 1997), but neither program provides concise definitions on which school-based services qualify for Medicaid funding.
1997	The <i>Medicaid and School Health: A Technical Assistance Guide</i> is disseminated to all states. The guide tries to clarify Medicaid requirements for school-based services, but it does not clearly specify “reasonable” and “allocable” costs or provide decisive guidance to the regional Medicaid offices. The guide emphasizes the importance of Medicaid and education agencies working together and warns states that consultants are expensive and an unacceptable substitute for developing close working relations with Medicaid and education agencies.
1999 May	CMS sends administrative policy letter to all state Medicaid directors: CMS prohibits use of bundled payment rates due to insufficient documentation of accurate and reasonable payments, tries to clarify payment for transportation for children with disabilities and shares that guiding principles for school-based administrative activity claims is forthcoming.
1999-2000	Congressional Hearings and Government Accounting Office (GAO) reports on Medicaid’s improper payments of school-based Medicaid services. The reports and hearings identify discrepancies that resulted in improper fee for service claims and administrative claims such as transportation claims without verification of transportation usage on the specific day, group therapy sessions billed as individual therapy sessions, administrative claims for non-Medicaid related activities, claims or activities that support non-Medicaid eligible children and high contingency-based consultant fees (Allen, 2000).

<p>2000 February</p>	<p>CMS issues a draft <i>Medicaid Administrative Claiming</i> (MAC) guide to states for comments and feedback. The guide reverses the policy identified in the May 21, 1999 letter to state Medicaid directors regarding bundled payments. After an overwhelming negative response from state Medicaid and education agencies, the guide is temporarily removed from public access. In the interim, many states continue using their previously approved bundled rate systems (personal conversation, B. Hunter, February 2, 2006).</p>
<p>2002 April</p>	<p>An unpublished version of MAC is circulated and school districts responded with comments to CMS.</p>
<p>2002 November</p>	<p>CMS releases a draft final MAC guide with comments due by December 2002. Educational organizations including the National Association of State Directors of Special Education (NASDSE), Council of Chief State School Officers (CCSSO), American Association of School Administrators (AASA) and National School Boards Association (NSBA) are surprised by the unexpected and quick-to-implement directive issued by CMS. They express their concern that schools would lose significant amounts of funds due to the reduced reimbursement rate and believe that policies are being implemented in direct conflict with Congressional intent regarding Medicaid, without proper Congressional input, without a genuine national dialogue and without the interests of children in mind (CGCS, 2002). The organizations also express concerns about the process as well as the intent of guide. The timing is a concern because the time period for comments is only one month. Furthermore, CMS indicates an implementation date for January 1, 2003, which again, raises concerns for organizations since CMS would have only two weeks during the holiday season to review all of the public comments and incorporate them into the final version of the guide. In addition, organizations are suspect of the timing of the release since many states’ political offices are in transition due to recent elections. This would not allow those recently elected to review the guide and participate in the comment process.</p> <p>In its policy letter announcing the major policy changes, CMS announces decreased reimbursement rates from 75% to 50% for skilled professional medical personnel (SPMP), requires schools to be direct healthcare service providers in order to claim administrative reimbursements, instructs schools to verify that each referral is made to a participating Medicaid provider and clarifies that schools cannot be reimbursed under administrative claiming for preparation of IEPs because educational agencies are not secondary to Medicaid and the activity is an “educational activity” that should be paid by IDEA. A variety of states, schools, educational associations and national organizations submit objections to the policy changes, but CMS does not revise the regulations.</p>

2002-2004	The use of contingency-fee based consultants triples with two states significantly increasing the amount of federal reimbursements for Medicaid. Georgia obtains \$1.5 billion while paying consultants \$82 million and Massachusetts obtains \$570 million while paying consultants \$11 million.
2003 May	CMS distributes final MAC guide and expects states to implement changes no later than October 1, 2003, and rescinds all prior approvals of states' school-based administrative claiming programs.
2003 May	The Office of Inspector General (OIG) audits states regarding school-based health services and administrative claims.
2003 September	National Alliance for Medicaid in Education (NAME) forms. ²¹
2005 June	US Senate Committee on Finance holds hearings. Individuals from the Government Accountability Office (GAO), CMS and OIG testify. Kathryn Allen, Director, Health Care, GAO testifies that "...problematic projects often tended to be in areas of Medicaid claims where federal requirements were inconsistently applied, evolving, or not specific (p.4)." Due to the lack of clear guidance from CMS, states develop new financing arrangements or continue to take advantage of the ambiguity. CMS has been working on guidance for more than two years, but no specific guidance has been issued to states as of May 2005. George Reeb, Assistant Inspector General for the Centers of Medicare and Medicaid Audits,) testifies that some states "...take back funds from the school districts as part of the contractual arrangements or require the districts to return a portion of the Medicaid payment to the State through intergovernmental transfers, thus reducing the State's share of the original payment and possibly resulting in a net gain for the state" (p.9). Dennis Smith, Director, Center for Medicaid and State Operations) reports on the creation of the Division of Reimbursement and State Finance (DRSF) to ensure nationwide consistency of Medicaid payment and funding policy.
2005 June	OIG issues final reports of audits for 11 states: many expected to pay money back to federal government.
2005-2006	OIG audits continue with seven additional audits complete by March, 2006.

²¹ See Action Groups described in the text, page 6.

<p>2006 February</p>	<p>Deficit Reduction Act reduces funding for targeted case management and added more requirements for third-party liability among other changes.</p>
<p>2006 February</p>	<p>President Bush’s proposed FY07 budget eliminates Medicaid funding for school-based administrative and transportation costs related to IDEA.</p>
<p>2006 March</p>	<p>Dennis Smith, the director of CMS, reports to Senate subcommittee that CMS is currently planning the implementation of the Medicaid Integrity Program for the purpose of reviewing, auditing, identifying and recovering overpayments. Five million dollars for FY06, \$50 million for FY07 and 08 and \$75 million for each year thereafter are appropriated for the program. Additionally, 100 full-time employees are needed to protect the integrity of the Medicaid program (Smith, 2006).</p>
<p>2006 March</p>	<p>Action group “LEANet” www.theleanet.com is formed to provide regular updates and action steps to support school-based Medicaid.</p>
<p>2006 July</p>	<p>Senator Kennedy and 10 other senators introduce legislation to maintain support for school’s ability to bill Medicaid for administrative and transportation costs. In the House, Representatives Dingell, Miller and Whitfield introduce similar legislation.</p>

Appendix B

Medicaid Administrative Claiming Guide

The purpose articulated in the Medicaid Administrative Claiming Guide is to:

- help schools and school districts prepare appropriate claims for administrative costs under the Medicaid program;
- ensure that the Medicaid program pays only for appropriate school-based administrative activities and that such activities are carried out effectively and efficiently;
- protect the fiscal integrity of the Medicaid program by providing a clear articulation of the requirements for school-based administrative claiming;
- help ensure consistency in the application of federal administrative claiming requirements across regions and states;
- promote the flexibility afforded at the state/local level in the implementation of the Medicaid program;
- assist in the implementation of operational and oversight functions, both at the federal and state levels; and
- provide technical assistance for the intended audience.

In addition, the guide clarifies that “federal matching funds are available for the cost of administrative activities that directly support efforts to identify and enroll potential eligible individuals into Medicaid and that directly support the provision of medical services covered under the state Medicaid plan” (CMS, 2003, p.4). However, Medicaid will not pay for services if a third party is legally liable and responsible for the services and its associated costs. Specific changes aimed to reduce Medicaid Administrative Claiming (MAC) costs include the following:

- prohibiting MAC for “Free Care” activities that are generally available to **all** students without charge;
- prohibiting MAC for EPSDT-type primary and preventative care services not specified in a child’s IEP ;
- eliminating the school-based SPMP enhanced reimbursement rate of 75%;
- mandating that schools must meet specific eligibility requirements (i.e., be a provider of the direct health care service) to be reimbursed for MAC costs;
- prohibiting MAC “Child Find,” evaluation/revaluation and IEP development costs because they are education-related activities covered under IDEA;
- mandating that “extra care must be taken to ensure that there is no duplication of services or payment” for targeted case management (TCM) services; and
- requiring states to coordinate school MAC and managed care providers (MCOs) to reflect only services being provided in a school setting.

The guide discusses operational principles of administrative claiming such as proper and efficient administration, capturing 100% of time, duplicate payments, coordination of activities, case management as administration versus case management as a service, enhanced FFP rates,

provider participation in the Medicaid program, IEP activities, free care and descriptions and examples of activity codes. States must develop an administrative claiming implementation plan with sufficient details for CMS to determine if the administrative claims are reimbursable (i.e. to determine if administrative activities are necessary for the administration of the plan). The plan should include six components: interagency agreements; treatment of indirect costs; certified public expenditures; description of current administrative activities paid by Medicaid; a time study plan; and a monitoring process (CMS, 2003, p.45). In addition, claims for federal matching funds must be filed within a two-year time period from the time the expenditure was made.

The guide also provides more specific information regarding IEP activities. The guide reiterates the 1988 Medicare Catastrophic Coverage Act (P.L. 100-360) that stated Medicaid could pay for health-related services under IDEA based on a child's IEP/IFSP if the child is Medicaid eligible and if the service is covered in the state Medicaid plan, or if medically necessary through EPSDT. However, administrative claims for activities that fulfill education-related mandates under IDEA, such as Child Find, initial evaluation and re-evaluation and IEP development are not allowable (CMS, 2003, p. 18). Only if a state chooses to use targeted case management as a service can they receive Medicaid administrative claiming funds to support the case management activities but the states may not submit Medicaid claims for case management services provided by other state agencies such as Departments of Social Services, Juvenile Justice, Family and Children Services and Mental Health.

Appendix C

Select Abbreviations

CBO	Congressional Budget Office
CMS	Center for Medicare and Medicaid Systems
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
FFP	Federal Financial Participation
FMAP	Federal Medicaid Assistance Percentages
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	U.S. Department of Health and Human Services
IDEA	Individuals with Disabilities Education Improvement Act, 2004
IEP	Individualized Education Program
IFSP	Individualized Family Service Program
LEA	Local Education Agency
MAC	Medicaid Administrative Claiming
MMIS	Medicaid Management Information Systems
NAME	National Alliance for Medicaid in Education
NCRRC	North Central Regional Resource Center
OIG	Office of the Inspector General
SEA	State Education Agency
SPMP	Skilled Professional Medical Personal
TCM	Targeted Case Management

Appendix D

State Interview / Case Study Questions

1. How many students receiving special education services are enrolled in Medicaid?
2. What percentage of total Medicaid dollars in your state was used for direct health care services of children with an IEP or IFSP:
 - a. in Fiscal Year 2004?
 - b. in Fiscal Year 2005?
3. What percentage of total Medicaid dollars in your state was used for school-based Medicaid Administrative Claiming:
 - a. in Fiscal Year 2004?
 - b. in Fiscal Year 2005?
4. What agency (agencies) provides the match to Medicaid Federal Financial Participation?
5. Do the LEAs receive 100% of the Medicaid reimbursement for:
 - a. direct health care services of children with an IEP or IFSP?
 - b. school-based administrative claiming?
6. If the LEAs do not receive 100% of the reimbursement, how is the remaining money used by the state?
7. If your state has policies, in statute or related rules, that identify the provision of special education services as appropriate expenditures of Medicaid revenue, please identify and summarize/discuss the policy.
 - a. Are there separate policies for direct health care services of children with an IEP or IFSP and school-based administrative claiming?
 - b. Is the policy (or policies) you identified Medicaid statute or Education statute?
8. Does your Department of Education have any goals or strategies for school-based Medicaid billing?
9. Does your state have a specific plan for Medicaid Administrative Claiming?
 - a. Has it been approved by CMS?
10. How does your state collect data on the specific amount of Medicaid revenue expended for:
 - a. direct health care services of children with an IEP or IFSP?
 - b. school-based administrative claiming?
11. How do LEAs bill Medicaid for:
 - a. direct health care services of children with an IEP or IFSP?
 - b. school-based administrative claiming?
 - c. Are vendors used by the LEAs? Approximately what percentage of your LEAs use them?
 - d. Are vendors used by the state? How many?

12. How does your state monitor the billing practices for:
 - a. direct health care services of children with an IEP or IFSP?
 - b. school-based administrative claiming?
 - c. Is a self-monitoring tool available for LEAs to use?

13. When was your state last audited for school-based Medicaid services by the Office of Inspector General, specifically for:
 - a. direct health care services of children with an IEP or IFSP?
 - b. school-based administrative claiming?
 - c. What were the findings?
 - d. What was your state's response to those findings?
 - e. What was the resolution of the audit?

14. Are the billing practices for direct health care services of children with an IEP or IFSP viewed to be successful? If not, what do you need to be successful? What are the barriers/challenges?

15. Are the billing practices for school-based Medicaid administrative claiming viewed to be successful? If not, what do you need to be successful? What are the barriers/challenges?

16. Please describe your school-based direct health services for children with an IEP or IFSP.

Do schools in your state:
 - a. directly employ health professionals (physician, nurse, nurse practitioner)
 - b. operate a clinic – how many?
 - c. contract with a provider or clinic?
 - d. Other?

17. Do LEAs seek reimbursement from Medicaid for activities before an IEP/IFSP is completed, such as team meetings, IEP development, etc.?

18. Please identify policies, practices, or procedures developed by your state that you view to be effective for school-based Medicaid billing.
 - a. Use of Targeted case management
 - b. Use of Bundled payments
 - c. Others?

19. Did your state participate in CMS's demonstration project, Payment Accuracy Measurement (PAM) to develop model methodologies to measure the accuracy of payments made for Medicaid services?²² If so, was any part of it directly connected to school-based health services or administrative claiming? Please explain.

²² A payment accuracy rate establishes a base to identify the extent of problems in the payment system, studies causes, and strengthens internal controls. It began in FY 2002 and lasted for four years. It was renamed Payment Error Rate Measurement (PERM).