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CRS Report for Congress

Medicaid and Schools

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Summary

As a condition of accepting funds under the Individuals with Disabilities Education Act (IDEA), public schools must provide special education and related services necessary for children with disabilities to benefit from a public education. Generally, states can finance only a portion of these costs with federal IDEA funds. Medicaid, the federal-state program that finances medical and health services for the poor, can cover IDEA required health-related services for enrolled children as well as related administrative activities (e.g., outreach for Medicaid enrollment purposes, medical care coordination). Despite written federal guidance, schools have difficulty meeting the complex reimbursement rules under Medicaid. According to federal investigations and congressional hearings, Medicaid payments to schools have sometimes been improper. During 2007, Congress passed two bills to continue funding of the State Children's Health Insurance Program (SCHIP). H.R. 976 and H.R. 3963 included a moratorium on the issuance of new federal regulations restricting Medicaid coverage or payments for school-based services; both bills were vetoed by the President. In September 2007, the Bush Administration issued such a proposed rule. In mid-December, Congress passed the Medicare, Medicaid and SCHIP Extension Act of 2007 (S. 2499), which included a moratorium on the issuance of such a regulation until June 30, 2008.

Under IDEA, public schools are required to provide children with disabilities with a free appropriate public education (FAPE), including special education and related services according to each child's individualized education plan (IEP) or individualized family service plan (IFSP). States receive some federal aid under IDEA, but are otherwise responsible for the expense of special education and related services. One approach Congress has taken to ease the burden on states and school districts of fulfilling these IDEA requirements is to allow Medicaid to finance covered health services (e.g., physical, occupational and speech therapy, and diagnostic, preventive and rehabilitation services) delivered to low-income, Medicaid-eligible special education students.

Recent History

Prior to 1988, Medicaid did not pay for coverable services that were listed in a child's IEP/IFSP since special education funds were available to pay for these services,

and because generally (with a few explicit exceptions), Medicaid is always the payer of last resort. Congress changed the financing relationship between IDEA and Medicaid in the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360). However, there is some controversy about the exact nature of this legislative change. IDEA requires states to establish interagency agreements to ensure that IDEA-eligible students receive the services to which they are entitled. These agreements must include an identification of the financial responsibility of all relevant agencies. IDEA regulations further stipulate that the financial responsibility of Medicaid and other public insurers *must* precede the financial responsibility of the local education agency (LEA) or the state agency responsible for developing the child's IEP. In other words, Medicaid is deemed to be the first payer. In contrast, according to officials with the Centers for Medicare and Medicaid Services (CMS) — the federal agency that administers the Medicaid program — the 1988 law *allows*, but does not require, state Medicaid agencies to pay for services included in an IEP/IFSP.[1] Thus, given CMS' interpretation of this law, the IDEA requirement that Medicaid be the first payer applies only to those states that have elected to pay for services listed in IEPs/IFSPs. According to CMS, most states do pay for these services.

Since 1988, other complicated issues surrounding the relationship between IDEA, schools and Medicaid have arisen. While Congress made it clear that Medicaid funds can be used to pay for reimbursable school-based services rendered to IDEA children enrolled in Medicaid, at various points in time some Members have expressed concern that some of these Medicaid payments may be made improperly. In 1999 and 2000, the Senate Finance Committee asked the U.S. General Accounting Office (GAO; later renamed the Government Accountability Office) to examine Medicaid school-based services and held two hearings on this subject.[2] Three main concerns were identified in the GAO studies and accompanying testimony:

- Billing practices for school-based administrative services, coupled with uneven oversight of these practices by the Health Care Financing Administration (HCFA; now CMS), resulted in at least 2 of 17 states receiving improper payments.
- "Bundled" billing methods for school-based services used by seven states failed to account for variations in service needs among children and often lacked adequate documentation demonstrating that the benefits paid for were actually delivered in every case.[3] However, both GAO and HCFA believed that bundled rates, if proper assurances can be built into the approach, are the preferred method for LEAs to bill Medicaid.

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[1] Personal communication with CMS officials, November 14, 2002.

[2] See *Medicaid Questionable Practices Boost Federal Payments for School-Based Services*. Testimony by William J. Scanlon before the Senate Finance Committee on June 17, 1999 (GAO/T-HEHS-99-148), and *Medicaid in Schools: Poor Oversight and Improper Payments Compromise Potential Benefit*. Testimony by Kathryn Allen before the Senate Finance Committee on April 5, 2000 (GAO/T-HEHS/OSI-00-87).

[3] Bundled payments typically means a fixed rate is paid for a package of specific services made available to children with a specific condition during a set period of time (e.g., a month). In a May 21, 1999 memorandum to state Medicaid directors, HCFA prohibited additional states from applying to use the bundled rate methodology.

- In some states, school districts received little of the reimbursements claimed for school-based services because state agencies and private contractors, hired by schools to assist in billing Medicaid, retained significant portions of federal payments. For example, seven states retained from 50% to 85% of total federal reimbursements for both health services and administrative activities. Some school districts paid private contractors contingency fees as high as 25% of federal payments for school-based administrative activities. In the worse case reported, schools received as little as $7.50 for every $100 claimed for services and activities performed in support of Medicaid-eligible children.

In order for LEAs providing IDEA-related services to qualify for reimbursement under Medicaid, four conditions must be met: (1) the child receiving the service must be enrolled in Medicaid, (2) the service must be covered in the state Medicaid plan or authorized in federal Medicaid statute, (3) the service must be listed in the child's IEP, and (4) the LEA (or school district) must be authorized by the state as a qualified Medicaid provider. To help schools obtain Medicaid reimbursement for health care services, and also related administrative activities, HCFA and later CMS issued two manuals, *Medicaid and School Health: A Technical Assistance Guide* (August 1997) and *Medicaid School-Based Administrative Claiming Guide* (May 2003). Prior to the release of the 2003 guide, on two occasions, Congress urged the Administration to revise early drafts.[4] The 2003 guide represents a consolidation of existing requirements for administrative claiming, and drew on the input from education community on the two earlier draft versions released in 2000 and 2002. Some in the education field have questioned the usefulness of these guides.[5]

Current Issues

Nationwide, estimated Medicaid expenditures for school-based services were $2.7 billion in FY2006 (see **Table 1**). Roughly $1.9 billion or 69% of total expenditures was for Medicaid benefits provided in schools and about $849 million or 31% was for school-based administration/training activities. There was wide variation in spending patterns across states with respect to the proportion of expenditures for benefits versus administration and training. Among the 45 states reporting any school-based spending, 14 had expenditures for benefits only. At the other extreme, six states reported school-based spending for administration and training only.

In the President's FY2007 budget proposal, the Bush Administration noted that Medicaid claims for services provided in school settings have been prone to abuse and overpayments, especially with respect to transportation and administrative activities. As of November 2007, the HHS Office of Inspector General (OIG) has published reviews of

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[4] See Sec. 321, H.Rept. 106-577 for the Concurrent Resolution on the Budget for Fiscal Year 2001, and page 153 of H.Rept. 106-1033 for the Omnibus Consolidated and Emergency Supplemental Appropriations for Fiscal Year 2001.

[5] See, for example, Travis Hicks: "Special Ed advocates oppose new Medicaid guidance. (Cuts in Medicaid funding for health services professional for special education students)." *Education Daily*, February 6, 2003.

school-based claims in 22 states. Based on this and other research, both the HHS OIG and GAO have reached similar conclusions.[6]

For transportation services, examples of inappropriate Medicaid billing include (1) no verification that transportation was in fact provided, (2) a Medicaid-covered school health service other than transportation was not provided on the day that transportation was billed, and (3) child/family plans did not include a recommendation for transportation services, or there was no IEP or IFSP.

School districts may perform administrative functions for Medicaid purposes, such as outreach, eligibility intake, information and referrals, health service monitoring, and interagency coordination. Examples of inappropriate Medicaid billing include (1) payments based on inaccurate time studies used to allocate the cost of these administrative activities across funding sources including Medicaid; (2) expenditures for school employees who do not perform Medicaid administrative activities; (3) expenditures for operating costs such as nursing supplies, non-Medicaid outreach supplies, and education-related expenditures; (4) expenditures for personnel funded by other federal programs; and (5) payments for personnel who render only direct medical services.

On September 7, 2007, the Bush Administration issued a proposed rule[7] regarding Medicaid payments for school-based administration and transportation. First, the rule would restrict federal payments for school-based administrative activities (e.g., outreach, service coordination, referrals) that may be conducted on behalf of children dually eligible for Medicaid and IDEA, as well as those eligible for Medicaid only. Second, the rule would restrict federal payments for certain transportation services provided to children dually eligible for Medicaid and IDEA. This rule supercedes prior guidance from CMS on these issues, and is estimated to reduce federal Medicaid outlays by $635 million in FY2009 and by $3.6 billion over the period FY2009-FY2013.

According to CMS, federal Medicaid reimbursement would no longer be available for (1) administrative activities performed by school employees or contractors, or anyone under the control of a public or private educational institution, because of inconsistent application of Medicaid requirements by schools with respect to such administrative activities in the school setting, or (2) transportation from home to school and back for school-aged children with an IEP or IFSP, because such transportation does not meet the definition of an optional medical transportation service, nor is it necessary for the proper and efficient administration of the Medicaid state plan.

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[6] See, for example, HHS OIG, *Review of Medicaid Transportation Claims Made by the New York City Department of Education*, A-02-03-01023, September 2005; HHS OIG, *Audit of LaPorte Consortium's Administrative Costs Claimed for Medicaid School-Based Services*, A-06-02-00051, January 2006; GAO, *Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight*, GAO/HES/OSI-00-69, April 2000, and *Medicaid: States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight*. Testimony by Kathryn Allen before the Senate Finance Committee, June 28, 2005 (GAO-05-836T).

[7] "Medicaid Program; Elimination of Reimbursement under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School," 72 *Federal Register* 51397, September 7, 2007.

Many in the education and state Medicaid communities are opposed to these proposed cuts.[8] Opponents argue that the rule (1) will reduce the availability of, and access to, needed health care for children; (2) is inconsistent with decades of approved state plan amendments allowing federal funding of these administrative and transportation services; and (3) falsely assumes that health care administrative activities performed by school personnel are inconsistent with the proper and efficient administration of the state Medicaid plan because such activities improve children's health, reduce inappropriate medical care utilization, and thus ultimately save money. Moreover, additional federal funding for existing programs like IDEA or other new appropriations to offset these Medicaid cuts are unlikely to be on the horizon.

While the proposed rule would eliminate federal matching funds for certain school-based spending under Medicaid, other types of school-based expenditures remain reimburseable. States may still claim federal matching dollars when school-based administrative activities are conducted by employees of the state or local Medicaid agency for which proper oversight and allocation of costs to Medicaid is more reliable according to CMS. In addition, federal funding would still be available for administrative overhead costs (e.g., patient follow-up, assessment, counseling, education, parent consultations, and billing activities) that are integral to, or an extension of, a specified direct medical service to the extent that those costs are represented in the rate paid for such services and reimbursed at the applicable federal matching rate. Medicaid outreach and eligibility intake, conducted by local or state Medicaid employees, would also remain reimbursable. Finally, CMS would continue to reimburse states for the costs of school-based direct medical services under IDEA that are covered in approved state Medicaid plans, and for transportation of school-age children from school or home to a non-school-based direct medical service provider that participates in Medicaid, or from the non-school-based provider to school or home. In addition, CMS would continue to reimburse states for transportation of children who are not yet school age and are being transported from home to another setting (including school) and back to receive a direct medical service, as long as the visit does not include an educational component or any activity unrelated to the covered direct medical service.

During the summer and fall of 2007, Congress passed legislation to continue federal financing for the State Children's Health Insurance Program (SCHIP) for FY2008 forward. Two House- and Senate-passed bills (H.R. 976 and H.R. 3963) included a provision that would prohibit the Secretary of HHS from taking any actions that would restrict coverage or payments for school-based administration, transportation, or medical services under Medicaid, relative to policies in place on July 1, 2007. This moratorium would have been effective until May 28, 2008, in H.R. 976, versus January 1, 2010, in H.R. 3963. Both bills were vetoed by the President. S. 2499, as passed by the Senate and House in mid-December, includes a similar moratorium until June 30, 2008, with respect to school-based administration and school-based transportation services.

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[8] See, for example, *Joint Association Letter to Secretary Michael O. Levitt*, from a consortia of school organizations, August 23, 2007; Testimony by David Parrella, Director of Medical Care Administration, Connecticut Department of Social Services, and Denise Herrmann, National Association of School Nurses at a hearing held by the House Committee on Oversight and Government Reform entitled *The Administration's Regulatory Actions on Medicaid: The Effects on Patients, Doctors, Hospitals and States*, November 1, 2007.

Table 1. Medicaid School-Based Expenditures by States for FY2006 (in thousands of dollars)

State	Total	Benefits		Admin/Training	
		Dollars	% of Total	Dollars	% of Total
Alabama	5,974	0	0.0	5,974	100.0
Alaska	15,235	38	0.2	15,197	99.8
Arizona	91,126	75,550	82.9	15,576	17.1
Arkansas	4,081	3,136	76.8	945	23.2
California	309,932	130,407	42.1	179,525	57.9
Colorado	27,883	27,883	100.0	0	0.0
Connecticut	44,157	33,585	76.1	10,572	23.9
Delaware	24,950	24,950	100.0	0	0.0
District of Columbia	26,414	26,414	100.0	0	0.0
Florida	110,797	16,091	14.5	94,706	85.5
Georgia	41,760	10,131	24.3	31,629	75.7
Hawaii	0	0	—	0	—
Idaho	15,468	15,468	100.0	0	0.0
Illinois	245,346	82,572	33.7	162,774	66.3
Indiana	2,695	2,695	100.0	0	0.0
Iowa	25,190	24,883	98.8	307	1.2
Kansas	65,855	61,402	93.2	4,453	6.8
Kentucky	7,514	850	11.3	6,664	88.7
Louisiana	0	0	—	0	—
Maine	15,794	15,794	100.0	0	0.0
Maryland	180,328	180,328	100.0	0	0.0
Massachusetts	117,034	113,535	97.0	3,499	3.0
Michigan	0	0	—	0	—
Minnesota	54,906	42,702	77.8	12,204	22.2
Mississippi	3,408	0	0.0	3,408	100.0
Missouri	76,934	68	0.1	76,866	99.9
Montana	17,036	14,966	87.8	2,070	12.2
Nebraska	67,995	6,626	9.7	61,369	90.3
Nevada	1,387	1,387	100.0	0	0.0
New Hampshire	35,759	35,759	100.0	0	0.0
New Jersey	0	0	—	0	—
New Mexico	16,921	13,002	76.8	3,919	23.2
New York	469,653	469,653	100.0	0	0.0
North Carolina	37,313	15,403	41.3	21,910	58.7
North Dakota	1,547	1,547	100.0	0	0.0
Ohio	11,532	11,532	100.0	0	0.0
Oklahoma	5,780	5,780	100.0	0	0.0
Oregon	23,938	6,190	25.9	17,748	74.1
Pennsylvania	240,328	193,378	80.5	46,950	19.5
Rhode Island	5,526	0	0.0	5,526	100.0
South Carolina	56,193	45,258	80.5	10,935	19.5
South Dakota	5,543	0	0.0	5,543	100.0
Tennessee (see note)	504	(216)	-42.9	720	142.9
Texas	301	0	0.0	301	100.0
Utah	16,429	15,060	91.7	1,369	8.3
Vermont	0	0	—	0	—
Virginia	36,178	3,900	10.8	32,278	89.2
Washington	34,364	23,632	68.8	10,732	31.2
West Virginia	52,400	52,400	100.0	0	0.0
Wisconsin	72,697	69,480	95.6	3,217	4.4
Wyoming	0	0	—	0	—
National	2,722,105	1,873,219	68.8	848,886	31.2

Note: In FY2006, Tennessee had a negative adjustment made to its spending on benefits, thus, all net school-based spending was for administration and training.

Source: CMS, Form-64 Information Forms. As submitted quarterly by states on a voluntary basis. States may forego completing Information Forms if it delays reporting of overall Medicaid expenditures. Data may be incomplete for some quarters and may contain amounts for prior periods. Unadjusted by CMS or CRS. Some services can be claimed as either administrative expenses or as a benefit (e.g., case management, transportation).

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