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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: HB 1853

RELATING TO: Medicaid School-Based Services

SPONSOR(S): Rep. Culp & others

STATUTE(S) AFFECTED: Sections 236.0812, 409.9071, 409.908, 409.9122, 409.9126, F.S.

COMPANION BILL(S): CS/SB 2194(s)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES
(2) HEALTH & HUMAN SERVICES APPROPRIATIONS
(3)
(4)
(5)

I. SUMMARY:

In 1995, the Legislature created the Medicaid match program to reimburse school districts for physical, occupational, and speech therapies provided to children eligible for both Medicaid and the exceptional student education program. Despite the availability of $50 million in federal match funding, school district participation has been limited. The purpose of this bill is to increase school districts' participation and earning potential under this program. To that effect, the bill would:

- Expand services eligible for federal reimbursement;
- Direct the Agency for Health Care Administration (AHCA) to amend the state plan to permit reimbursement for "school-based" services under the Medicaid "rehabilitative services" option;
- Expand the categories of Medicaid-eligible children for whom a school district could receive reimbursement to include children eligible under the IDEAS Act, the exceptional student education program, or who have an individualized educational plan;
- Delete the requirement that school districts maintain "medical" records and substitute the "individual education plan";
- Permit school districts to be reimbursed on a cost-based reimbursement schedule;
- Permit retroactive payment for services provided prior to the effective date of this bill;
- Permit AHCA to conduct pre-enrollment reviews of school districts to ensure the district has the capability to comply with the Medicaid provider enrollment requirements;
- Exempt school district employees from undergoing a Medicaid provider criminal record check;
- Encourage coordination between the school districts and the child's managed care provider.

No direct fiscal impact is anticipated.

II. SUBSTANTIVE RESEARCH:

A. PRESENT SITUATION:

The Federal Medicaid program, Title XIX of the Social Security Act, was created in 1965 as a public health insurance program for economically disadvantaged individuals. The Medicaid program was subsequently implemented in Florida on January 1, 1970. To participate a state must provide mandatory services and match federal funding (45% state/55% federal). In Florida, the Department of Children & Family Services determines eligibility and the Agency for Health Care Administration administers the program. Federal oversight of Medicaid resides with the Health Care Financing Administration (HCFA) in the Department of Health & Human Services.

In 1995, the Legislature created the Medicaid certified school match program to access federal Medicaid match for occupational, physical, and speech therapies provided by, or through school districts (s. 236.0812, F.S.). Federal passage of the Individuals with Disabilities Education Act (IDEA) obligated states and their school system to ensure that children with specified disabilities receive a free and appropriate public education. This includes providing the special education and medical services needed.

Medicaid reimbursement is limited to children with specified disabilities who are eligible for both Medicaid and the exceptional student education program. Without the program, school districts use education funds to finance Medicaid eligible health services provided by the school system, or contract with community providers who bill Medicaid instead of the school district for services provided on school campuses.

School districts must certify 100% of the state match with state and local education funds to receive the federal match — no state general revenue is involved. By statute, school districts are reimbursed the lesser of the Medicaid fee or the school district's allowable cost. The Department of Education is required to monitor compliance by each participating school district.

The certified school match program was implemented January 1, 1996. Fifteen school districts and the Florida School for the Deaf & Blind participate in the program: Clay, Citrus, Gadsden, Hillsborough, Lee, Leon, Manatee, Marion, Martin, Monroe, Palm Beach, Pinellas, Polk, Sarasota, and Seminole. [Another 3 counties, Broward, Bay, and DeSoto, are qualified and enrolled as Medicaid providers under s. 409.907, F.S., for the purposes of providing specific Medicaid reimbursed services.] In 1996, a total of $265,125.28, in federal match was paid to the participating school districts. Thus far, a total of 152,473.18 has been paid out in 1997. This is significantly less than the $50 million in federal funds the Legislature budgeted for the program in both FY 1995-96 and 1996-97.

School districts cite several obstacles to increasing their participation in the school match program. First, Florida Medicaid treats school-based therapy services like private community therapy providers administratively. This means that the schools are required to keep detailed documentation and medical records for all students served. While school districts are skilled at keeping detailed educational records and progress notes, they have little experience in establishing and maintaining complex medical records. Second, many billing errors occur because the schools lack experience with the

complicated billing requirements which even experienced Medicaid providers often do not fully understand.

Other states have designed certified school match programs which are more accessible and less administratively complicated for their school systems. Some of these states also cover more services in their certified school match programs. Medicaid has hired a contractor to examine these programs and develop a model program for Florida. The contractor's report is due in June 1997.

The Medicaid Reform Task Force which issued their report in March of this year, recommended that the state explore measures to simplify the administrative process for receiving Medicaid payments, and expand the services for which Medicaid will pay the school districts. One option would be to move school-based services from a *medical coverage* option to a *rehabilitative service* coverage option. According to the report the benefits would be two-fold: (1) it would allow the schools to offer a broader array of services to eligible children, and (2) the administrative requirements are less complex. Services could also be reimbursed on a cost basis, increasing claims payments.

Some school districts have entered into contracts with consultants who advise the district on the best way to maximize participation in the Medicaid program. The consultants do everything from enrolling the instructional staff, to setting up record systems, to preparing claims for submission. Consultants are often paid a percentage of the money the school district receives in reimbursement from the federal government. The percentages vary to a maximum of approximately 20%. Payment to consultants has been an issue because HCFA will not permit the school district to recover the consultant cost from the federal reimbursement (42 CFR 447.10(f)). Thus the higher the percentage paid to the consultant, the lower the amount the school district recoups in reimbursement for services. In addition, s. 409.913(9), F.S., forbids "billing agents or persons participating in the preparation of a Medicaid claim" from basing their fees on the "amounts for which they bill . . . (or) the amount a provider receives from the Medicaid program."

B. EFFECT OF PROPOSED CHANGES:

The overall effect of the bill will be to increase school districts' earnings potential for federal Medicaid funds.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

No.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

The bill's requirement that AHCA conduct pre-enrollment reviews and develop a cost-based reimbursement schedule, and that AHCA and DOE assist in the verification of Medicaid eligibility, will increase the workload of AHCA and DOE staff. In addition, managed care and MediPass providers will have to be more involved in coordinating services between the provider and the school districts.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. <u>Lower Taxes:</u>

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

Because the bill permits the school districts to bill on a cost-based reimbursement schedule, the school districts may be able to get a higher reimbursement rate from Medicaid.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

The school districts provide the local funds for the state match in order to draw down the federal match.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

Because school districts will have more flexibility in providing services to handicapped children, these children and their families should have more options for receiving needed services.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

No.

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. SECTION-BY-SECTION RESEARCH:

Section 1. Amends s. 236.0812, F.S., relating to Medicaid school funding, to:
(a) Expand "school-based" services reimbursable under Medicaid to include behavioral health services, mental health services, transportation services, EPSDT outreach, etc., and expressly exclude family planning, immunization, and prenatal care services;
(b) Repeal language directing that the Medicaid funds be deposited in a certain trust fund, and other obsolete language; and
(c) Authorize funds to be used for autism therapy services.

Section 2. Amends s. 409.9071, F.S., relating to Medicaid provider agreements for school districts, to:
(a) Require AHCA to submit a state plan by September 1997, and seek federal waivers to facilitate Medicaid reimbursement for school-based services;

(b) Permit funds to be used for Medicaid eligible children who are eligible under the federal Individuals with Disabilities Education Act, the exceptional student education program, or who have an individualized education plan, and deletes requirement that services be determined to be medically necessary;
(c) Repeal language requiring school district to verify monthly that child was eligible for services and substitute that school district simply verifies Medicaid eligibility, assisted by AHCA and DOE;
(d) Direct DOE to maintain “individual education plan” records rather than “medical” records;
(e) Permit, rather than require, education dollars to be capped based on the amount of federal participation;
(f) Authorize AHCA to review capability of a school district to enroll as a Medicaid provider;
(g) Direct AHCA to develop a cost-based reimbursement schedule for school-based services, subject to federal approval; and
(h) Permit retroactive payment for newly authorized services, subject to federal approval.

Section 3. Amends s. 409.908, F.S., relating to Medicaid reimbursement, to:
(a) Direct that AHCA reimburse school districts based on the cost-based reimbursement schedule rather than being limited to the lesser of allowable costs or the Medicaid fee; and
(b) Exempt school district employees who have received a criminal background screening from AHCA background screening requirements.

Section 4. Amends s. 409.9122, F.S., relating to Medicaid managed care enrollment, to:
(a) Direct managed care plans to make an effort to execute agreements with school districts relating to school-based services; and
(b) Direct AHCA and DOE to develop procedures for informing a student’s managed care plan or MediPass provider of school-based services that have been provided.

Section 5. Amends s. 409.9126, F.S., relating to children with special needs, to delete limitations on the type of services that may be provided.

Section 6. Provides an effective date of July 1, 1997.

III. FISCAL RESEARCH & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

None.

2. Recurring Effects:

   None.

3. Long Run Effects Other Than Normal Growth:

   None.

4. Total Revenues and Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

   None.

2. Recurring Effects:

   None.

3. Long Run Effects Other Than Normal Growth:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   To the extent that school personnel will be providing services currently being provided by the private sector, this bill may have a negative impact on the private sector. On the other hand, the school district may contract with the private sector to provide these services. In addition, managed care capitation rates may have to be adjusted to avoid duplicate payments for services now provided by the school districts.

2. Direct Private Sector Benefits:

   Handicapped children being main streamed through the school system may experience more coordinated and appropriate services.

3. Effects on Competition, Private Enterprise and Employment Markets:

   To the extent that school districts may be reimbursed at a higher level than private community providers, community providers may object.

D. FISCAL COMMENTS:

The current appropriation in the Medicaid Services for School Refinancing is $50 million in the Medicaid Care Trust Fund. In the Division of Public Schools there is a companion appropriation of $50 million in the Educational Aids Trust Fund. These appropriations do not need to be increased as current reimbursements have been relatively insignificant.

The Department of Education and AHCA have projected the potential total statewide federal Medicaid earnings for current and expanded services rendered through the schools, excluding transportation, to be $57.5 million. Assuming that 50% of the potential earnings are actually achieved the actual federal draw down would total $28,722,885.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to expend funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not limit the ability of counties or municipalities to raise revenues.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

The bill does not reduce the percentage of a state tax shared with counties and municipalities.

V. COMMENTS:

Many of the provisions of this bill may potentially conflict with or do not accurately reflect current federal Medicaid policy and procedures. For example:

- Transportation is not covered as a service under the “rehabilitation option.” [Page 2, line 10]
- EPSDT administrative outreach for the purpose of determining eligibility for exceptional students under Part B or H of the IDEA program is not a reimbursable activity. Outreach for *Medicaid* eligibility could be reimbursable, provided such services are not already being provided through a Medicaid managed care arrangement. [Page 2, lines 11-12]
- The existence of an Individual Education Plan (IEP) is not sufficient to obtain reimbursement for covered services. *Medical necessity* must be demonstrated and there must be a claim for services rendered and the services must be recognized in the state plan. Also, if the school is the enrolled provider, it must maintain records to document the medical services provided as required by HCFA for any medical provider claiming a service under Medicaid. The maintenance of a medical record may be different from an educational record. [Page 4, line 23, and page 5, lines 5-6]

- In order to implement reimbursement under the "rehabilitation option" AHCA needs to submit an *amendment* to the state plan, not a new state plan, and needs to seek federal *authorization*, not *federal waivers.* [Page 4, lines 5-6]
- For *cost-based reimbursement*, federal requirements regarding payment still must be satisfied. The rates must be consistent with efficiency, economy, and quality of care. The State must use accurate and valid data to justify the rates. HCFA also considers the *reasonableness* of payments along with economy and efficiency. Thus if a service is available at less cost in the community it would not be appropriate for the State Medicaid agency to pay more to the school district. [Page 6, lines 5-6, and page 7, lines 3-7]
- For retroactive billing, providers must submit claims no later than 12 months from the date of service. Provider agreements must be in place at the time services are provided. Provider qualifications must be met at the time services are provided, and requirements for billing any third party must be satisfied before submitting the claim. There is no authority for the State to enroll providers and pay for services furnished during periods before the provider agreement was in effect. The federal share is only available for claims that are submitted pursuant to an approved state plan amendment. The federal payment is not available for services provided prior to the effective date of an approved amendment. [page 6, lines 7-10]

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

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