TO BILL OR NOT TO BILL: MEDICAID BILLING FOR SPECIAL EDUCATION
RELATED SERVICES IN ARKANSAS PUBLIC SCHOOLS

by

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TO BILL OR NOT TO BILL: MEDICAID BILLING FOR RELATED SERVICES
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(Abstract) Medicaid is a complicated system for educators to access. LEAs can access Medicaid funds by: billing through a contracted service, establishing their own billing system, or may choose not billing Medicaid. The purpose of this study was to investigate the Medicaid billing processes used in Arkansas public schools. The study considers processes some LEAs use to bill Medicaid for related services, and reasons why other LEAs do not access Medicaid.

All LEA supervisors of special education in the state of Arkansas were sent a survey regarding Medicaid billing practices. A total of 87 supervisors responded to all or part of the survey (80%). The survey included three major parts. All supervisors were asked to complete the first section, which asked demographic information. Supervisors who currently bill Medicaid were asked to respond to the second section of the questionnaire, which sought information about the billing process. The third section of the survey was completed by supervisors of nonbilling LEAs. These supervisors were asked to rate a series of possible reasons LEAs do not bill as each pertained to their decision. They were also asked to list and rate any other reasons why they do not bill Medicaid.

The respondents worked in systems where attendances usually ranged between 500 and 5,000 students with 106-525 of those students receiving
special education.

Most school systems in the sample have participated in Medicaid billing (80%). Most (76%) prefer billing Medicaid directly rather than using a billing service. Ninety-seven percent bill Medicaid for speech therapy, 72% for occupational therapy, and 79% for physical therapy. In addition, 31% bill Medicaid for Early Periodic Screening Diagnosis and Treatment (EPSDT).

The data suggest that the billing procedures can be incorporated with relative ease into a clerical/secretarial assignment, taking less than four hours per week to transact. Various technologies were utilized for processing, but the most popular was the AEVCS machine.

Almost half of the supervisors billing Medicaid experienced problems with other agencies. Suggestions for improvements fell into four categories. These were providing ongoing training for billing districts, simplifying billing requirements and paperwork, improving the software used to submit information, and dealing with DHS and Medicaid agency representatives. For the LEAs responding to the survey, total Medicaid reimbursement was $2,237,006.55. This is 78% of the statewide total.

Nonbilling districts indicated that the complexity of the billing process, and personnel factors were reasons they decided against seeking Medicaid reimbursement.

The findings of the study lead to recommendations for access to billing information, training, and communication with others involved in the process.
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The great thing in this world
is not so much where we are, but in what direction
we are moving.--Oliver Wendell Holmes

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CHAPTER 1
INTRODUCTION

Providing a free, appropriate public education has long been a confusing process to those involved in providing special education and related services to students with disabilities. Local education agency (LEA) personnel may believe that money earmarked for special education by federal, state and local governments is the only funding sources available to provide related services. To ensure the provision of special education and related services at no cost to parents, LEAs need to be aware of all funding sources available.

Public Law 94-142 (20 U.S.C. 1401-1420), amended in 1990 by P.L. 101-476 and now known as the Individuals with Disabilities Education Act (IDEA), indicates that states may use joint agreements between agencies to share costs for services. Related services mandated by P.L. 101-476 often overlap or directly duplicate responsibilities assigned to other state and local agencies under earlier legislation such as Titles V (the Maternal and Child Health Care Program) and XIX (Medicaid) of the Social Security Act (Gerry, 1989). For example, a Medicaid-eligible student needing speech therapy may receive the service from a licensed therapist in a health clinic (mandated by Titles V and XIX) or in a school (mandated by IDEA). Either agency may bill Medicaid. It is cost efficient for one agency to provide the service and bill Medicaid.

In this example, the student receiving speech therapy is the first party, the clinic or school is the second party, and Medicaid is the third party. Third party payers include any organization, public or
private, that reimburse health and medical expenses for beneficiaries or recipients. IDEA addresses third party payments in Part 300.301 (b) of the Code of Federal Regulations (CFR). It states that third party payers are not relieved of valid obligations to provide or pay for services provided to a child with disabilities.

Public Law 99-457 clarified Congressional intent for third parties other than state and local education agencies to share the responsibility of paying for related services. The statute requires states to develop interagency agreements financing special education and related services. The goal of this requirement is to reduce the financial burdens of providing these services carried by state and local education agencies. The new provisions direct states not to reduce or deny assistance available to children with disabilities under the Maternal and Child Health program (aforementioned Title XIX) and the Medicaid program because of their eligibility for services under IDEA.

Public Law 100-360, the Medicare Catastrophic Coverage Act of 1988, allows LEAs to enroll as Medicaid providers. Districts can then bill Medicaid for reimbursable related services included in eligible students' IEPs. This law authorizes school districts to enroll as Medicaid providers, helping schools offset the costs of providing related services. The law is designed to supplement district funds for related services. By the 1996-97 school year, LEAs in 46 states were billing Medicaid for related services, (ASHA, 1997). Arkansas enacted its Medicaid plan for schools in August 1989, which reimbursed for speech/language pathology and physical and occupational therapy.

Throughout the 1990s, health care reform has been prominent in the news. Medicaid may be revamped or replaced sometime in the future.
Medicaid systems in some states, including Tennessee and Oregon, have already undergone major changes, with promises of better health care for more recipients and savings for taxpayers. Efficiency of these revamped systems is currently being evaluated.

Statement of the Problem

The state of Arkansas spent an average of $3,155 per pupil in average daily attendance during the 91-92 school year (Arkansas Department of Education, 1993). Because funding to districts has not kept up with rising costs, it is important for Arkansas' 321 school districts to access as many resources as possible. Medicaid is a complicated system for educators to access. Consequently, funding models need to be easy for local education agencies to set up and use. LEAs have three alternatives when considering access to Medicaid funding: bill through a contracted service, establish their own billing system, or not bill Medicaid. To date, none of these alternatives have been studied for effectiveness based on LEA characteristics such as size, student population or personnel.

Plans to explore and capitalize on new revenue sources imply system changes, creating anxiety among members of the system (Kastoff, 1991). LEA supervisors should anticipate concerns expressed by superintendents and providers by displaying evidence that supports Medicaid billing. Administrators need to know what factors in the present system and student population make a particular billing alternative most practical. Currently, no definitive set of criteria exists that districts may use to evaluate themselves or a billing alternative. Compatibility is necessary to maximize third party billing returns.
To date, no study has attempted to determine LEA characteristics that would help select an appropriate billing alternative. Without an effective method, such as a district profile, to determine which billing alternative to choose, many districts may not fully realize the possible monetary benefits of accessing Medicaid.

**Purpose Statement**

The purpose of this study was to investigate the Medicaid billing processes used in Arkansas public schools. The study considers processes some LEAs use to bill Medicaid for related services, and reasons why other LEAs do not or cannot access Medicaid.

The product of the study will help LEAs understand the billing process and maximize Medicaid returns. It also will assist LEAs, the Departments of Education and Human Services, and state legislators in Arkansas and elsewhere determine program needs or possible changes in their current reimbursement systems.

**Need for Medicaid Reimbursement Data**

The IDEA mandates a free, appropriate public education to all students, despite cost. Providing related services, including speech/language, physical, and occupational therapy is necessary for some students to benefit from special education programs. Congress has not yet met its funding commitment to pay 40% special education and related services excess costs. Rogers (1993) found that on average, the federal contribution to special education programs is about 9 percent of what it costs to educate students with disabilities. The American Speech-Language Hearing Association (ASHA) reported that federal support has never risen above 12 percent (ASHA, 1991). This creates financial adversity for school districts meeting the increasingly diverse
educational needs of these students. The expense of related services has forced public schools to find and utilize funding sources other than state, local, and federal VI-B funds to pay for services in students' Individualized Education Programs (IEPs).

Access to Medicaid funds for related services is a relatively new concept to some LEAs. Arkansas' Medicaid reimbursement plan went into effect in August 1989. It has yet to be assessed for easy use by LEAs. Other states realize the need for a Medicaid reimbursement plan, but have not identified implementation obstacles and benefits. It is important for state and LEAs, Medicaid, and taxpayers to know what return is realized from their investment in the program.

To address these concerns, information on LEAs' reimbursement systems is needed. Who collects the information provided to Medicaid? Are additional personnel needed to deal with Medicaid related paperwork? What information has to be collected? How is it collected and how often? How is it processed? What obstacles stand in the way of information collection? No efficient reimbursement system may be implemented without answers to these questions.

Student information is needed. It is important to know how many students are Medicaid eligible. How LEAs inform parents of Medicaid billing and obtain necessary information and permission from them should be considered.

This information will allow school administrators, billing agents, department of education personnel, Medicaid agency personnel, and legislators determine if the Medicaid program is working as planned. This information will help determine if program changes are necessary.

To date, research on Medicaid reimbursement has concentrated on
state education agencies, e.g., Dugger, A.J., Kirby, R.S., Feild, C.R., Nosal, T.J., & Duncan-Malone, L. (1993); Gerry, M. (1989); and Rogers, J. (1993). Research dealing with local education agencies has only dealt with try out sites for setting up Medicaid billing, e.g., Smokoski et al., (1991). Reports on first year implementation have been published, but have not methodically questioned LEAs concerning difficulties faced when billing Medicaid, e.g., Radigan, (1992).

**Research Questions**

The study will yield answers to questions about Medicaid reimbursement for related services. An attempt will be made to ascertain information about the billing processes used by LEAs indicating a preferred system for billing Medicaid. The study will address the following questions:

1. What LEA variables contribute to the feasibility of a particular billing system? For example: (a) Numbers of Medicaid-eligible students receiving billable services may be an important variable to consider; (b) consideration of service providers is also important because they must meet professional standards required by Medicaid and must be trained to handle Medicaid paperwork before any funds can be received; (c) there must also be personnel who can handle the actual billing, whether the billing is done independently or through a billing service.

2. How functional are the billing systems LEAs are currently using? This section addresses how LEAs comply with Medicaid and special education regulations. For example: (a) LEAs must establish congenial relationships with other service providing agencies; (b) billing liable third parties before Medicaid must be evident for
auditors; (c) parental permission must be obtained before school districts can access Medicaid for services provided in their child's IEP; (d) parents must be informed of their rights concerning Medicaid reimbursement; (e) Medicaid's required access to information must not breach confidentiality of special education records; (f) how schools inform parents of their rights concerning Medicaid and gather information on Medicaid-eligible children are key elements driving a billing system.

3. What barriers do schools face when attempting to access Medicaid? The survey asked about conflict with other agencies considering themselves the insurer of last resort. LEA supervisors may feel that Medicaid regulations change too frequently making them difficult to understand or carry out correctly. With reported shortages of speech, physical, and occupational therapists, qualified service providers may be unavailable in the district.

4. What improvements can be made upon the current model for Medicaid reimbursement in Arkansas? Special education supervisors may have viable ideas to improve the Medicaid reimbursement system. They were asked to list any improvements they may have conceived while working within the current system.

Definitions

The terms defining school Medicaid billing reach into several professional fields: speech, occupational, and physical therapy; health care; and special education. The following definitions reflect this; they are taken from professional organizations’ literature, the Arkansas Medicaid Manual, from Program Standards and Eligibility Criteria for Special Education, and from the Code of Federal Regulations.
Early Periodic Screening Diagnosis & Treatment (EPSDT). EPSDT is a federally required benefit for Medicaid-eligible children from birth to age 21. EPSDT requires states to provide all necessary federally allowable Medicaid services despite limitations in a particular state's Medicaid plan. EPSDT screening services include comprehensive health and developmental screens, dental examination, hearing examinations and vision examinations (U.S. Department of Health and Human Services, 1991).

Related services. (See 34 C.F.R. 300.13(a)) Related services are transportation and such developmental, corrective, and other supportive services as are required to assist a child with disabilities to benefit from special education. Related services do not stand alone, but are only provided if they are needed for the child to benefit from specially designed instruction.

Health Care Finance Administration (HCFA). HCFA is the federal agency of the Department of Health and Human Services responsible for administering the Medicaid program. HCFA reviews and interprets each state Medicaid plan and regulates services (U.S. Department of Human Services, 1991).

Occupational therapy. Occupational therapy is a health care profession in which purposeful activities are utilized as a means of overcoming physical, mental or emotional disabilities (American Occupational Therapy Association, 1997). Services provided to a recipient by or under the direction of a qualified occupational therapist. Services in public schools mainly involve the remediation or development of handwriting and fine motor skills.
Qualified Occupational Therapist. This is a service provider registered by the American Occupational Therapy Association (AOTA), or a graduate of a program in occupational therapy approved by the Council on Medical Education or the American Medical Association and engaged in the supplemental clinical experience required before registration by the AOTA (Arkansas Department of Human Services, 1995).

Physical therapy. Treatment includes therapeutic exercise, cardiovascular endurance training, and training in activities of daily living (American Physical Therapy Association, 1997). Services must be provided by or under the direction of a qualified physical therapist.

Qualified Physical Therapist. This is a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent and licensed by the State (Arkansas Department of Human Services, 1995).

Speech pathology. These are services for individuals with speech and/or language disorders provided by or under the direction of a qualified speech pathologist. Treatment includes exercises to improve articulation and the use of expressive language (Arkansas Department of Human Services, 1995).

A Qualified Speech Pathologist. This therapist must have a Certificate of Clinical Competence (CCC) from the American Speech/Language and Hearing Association. If the therapist does not have the CCC, he/she must have completed the equivalent educational requirements and work experience necessary for the CCC, or have completed the academic program and be working to acquire supervised work experience to qualify for the CCC. Where applicable, the therapist must
be licensed as a speech pathologist in his/her state (Arkansas Department of Human Services, 1995).

**Direct supervision.** This occurs when an enrolled, qualified occupational therapist, physical therapist, or speech pathologist monitors the quality of work of the supervised therapist (Arkansas Department of Education, 1993). The supervisor must be immediately available to the therapist, in person or by telephone. The supervisor must review and approve all evaluations performed by the therapist. Thirty minutes of direct supervision of therapy and thirty minutes of consultation must be carried out weekly, with documentation on file in the LEA employing the therapist. The LEA also must have the therapist’s W-4 form for the therapist on file for audit purposes.

**Federal Laws and Regulations Pertaining to Provision of Related Services**

Public Law 101-476, The Individuals with Disabilities Education Act (IDEA). The IDEA, codified in 34 C.F.R. Part 300.13, defines related services and lists different services that students with disabilities may need to benefit from a special education program. Under 34 C.F.R. Part 300.13(a), the term "related services" means, transportation and such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education, and includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training.
The comment under Reg.300.13 states that,

The Committee bill provides a definition of 'related services' making clear that all such related services may not be required for each individual child and that such term includes early identification and assessment of handicapping conditions and the provision of services to minimize the effects of such conditions.

It further states that the list provided is not exhaustive and may include other services as required to assist a child with disabilities in benefiting from special education. Furthermore, each related service defined under the regulation may include appropriate administrative and supervisory activities necessary for program planning, management, and evaluation.

Assistance to States for Education of Handicapped Children (34 Code of Federal Regulations Part 300-301) (a) explains that each state may use whatever local, state, federal or private sources of funding available to meet regulation requirements, (b) that insurers or similar third parties are not relieved from valid obligations to provide or pay for services for children with disabilities and (c) states that related services are to be contained in the child's IEP, at 34 C.F.R. Part 300-346.

Public Law 99-457. Law which amended P.L. 94-142 in 1986, states in Section 202 that "no other agencies' responsibilities are limited or reduced by the new law, new funds cannot reduce or alter existing eligibility and funding for medical and other health services under Medicaid and Federal Maternal and Child Health funding." (P.L. 99-457, Feild, et al., 1991). This law requires states to establish interagency
agreements defining the financial responsibilities of each service agency (U.S. Department of Health and Human Services, 1991a). Educators began to notice Medicaid's potential as P.L. 99-457 was implemented (Staff Education of the Handicapped, 1989).

Public Law 100-360, The Medicare Catastrophic Coverage Act of 1988, allows LEAs to enroll as Medicaid providers, billing Medicaid for speech and language pathology services, physical therapy, and occupational therapy if these related services are listed in the IEPs of identified, Medicaid-eligible students. State education agencies remain financially responsible for educational services; state Medicaid agencies remain responsible for related services identified in IEPs, if they are covered under the state's Medicaid plan.

Limitations

This study was limited to LEA special education supervisors in Arkansas. Other education agency administrators, such as developmental center or early childhood education administrators were not included. The survey is limited to evaluating the Medicaid billing process; billing of private insurance or other nongovernmental third party payers were not included. How Medicaid funds are used by LEAs in their special education programs was not assessed.

The study focused on public, governmental, third party payers only. Reimbursement by private health insurance was not included.

Organization of the Study

Chapter One introduces the study and the problem. Chapter Two reviews the literature on school Medicaid billing, and the current status of billing in selected states. Chapter Three discusses the design and procedures of the study. Chapter Four analyzes and explains the study's findings. It includes observations, and recommendations for future school Medicaid billing based on the findings.
Medicaid Program

**History.** Title XIX of the Social Security Act (Medicaid), enacted in 1965, provides states with federal matching funds to provide medical care for Americans meeting poverty index guidelines (English, Kritzler & Scherl, 1984; U.S. Department of Health and Human Services, 1991). Medicaid was established by P.L. 89-97, Grants to States for Medical Assistance Programs, signed by President Johnson July, 30, 1965. Arkansas Section 7 of Act 280 of 1939 and Act 416 of 1977 authorizes the Department of Human Services to establish and maintain a health care program for the poor (Arkansas Medicaid Manual, 1995).

In 1978 the Health Care Finance Administration and the Bureau of the Education of the Handicapped within the Department of Education published memoranda encouraging states to set up interagency agreements permitting use of Medicaid funds for services provided in intermediate care facilities for the mentally retarded (ICF/MRs) (Ross, 1980). These services included health related services outlined in IEPs. The memos indicated that in cases where services could be construed as either habilitative or educational, the agencies involved must determine appropriate funding sources by developing a statement on providing for the comprehensive needs of children in ICF/MRs (Staff, Liaison Bulletin, 1987).

In 1985, the Health Care Finance Administration issued new reimbursement guidelines designed to prohibit schools and other educational facilities from receiving Medicaid reimbursement for health
related services outlined in a student's IEP. The HCFA guidelines postulated that all services described in an IEP should be excluded from Medicaid coverage because they are educational services according to P.L. 94-142 (Staff, Liaison Bulletin, 1987).

The Medicare Catastrophic Coverage Act of 1988 expanded coverage to children receiving services in public schools. The Act clarified Congressional intent for state Medicaid agencies to reimburse public schools for medically necessary related services (Staff, Update: Improving Services for Emotionally Disturbed Children, 1988). Medicaid allows states to impose restrictions on types of services provided.

Three conditions must be met so that related services are reimbursed. First, services must be covered in the state's Medicaid Plan. Second, a physician’s statement defining services as medically necessary (thus reimbursable) must be provided (Kreb, 1990; Hill, 1992 Arkansas Medicaid Manual, 1995). Finally, services must be written in Medicaid-eligible students' IEPs.

**Recipients.** Medicaid is a joint federal-state program covering health care costs for financially needy individuals, including children (Gerry, 1989). In Arkansas, the Medicaid income eligibility level is 133% of the federal poverty level (U.S. Department of Health & Human Services, 1991). In other words, Arkansas children age 6 and over qualify if (for a family of four) their income level is $13,950 or less (Staff, Rural Health Progressive, 1991). Arkansas children receiving Social Security Benefits automatically acquire Medicaid (U.S. Department of Health and Human Services, 1991).

States may establish medically needy programs. These cover those who meet medical eligibility for assistance but not income and resource
eligibility. This group is largely composed of children with catastrophic illnesses or multiple disabilities whose parents work but are not covered by group health insurance.

Nearly 11 million children below age 21 were enrolled in the Medicaid program in 1988 (U.S. Department of Health and Human Services, 1991). Over 200,000 children received Medicaid services in Arkansas during the 1997 fiscal year (Tom Shircliff, personal communication, July 27, 1997). Children under age 21 are the single largest beneficiary group covered by the Medicaid program (Rosenbach, 1989). Hill (1992) noted that 75% of recipients are women and children, although spending on services for this population accounts for only 25% of total Medicaid spending. The average Medicaid recipient is young, minority, living in a rural community with a single parent at an income level less than 50% of the Federal poverty level (U.S. Department of Health and Human Services, 1991). Bergman (1988) estimates that 40-60% of children in special education are poor and the great majority of these are probably Medicaid eligible.

Program Characteristics. Medicaid buys service units from established providers (Kastoff, 1991). Professional services, such as school health related services, accounted for 8.9% of the total Arkansas Medicaid expenditures in 1992 (Staff, Rural Health Progressive, 1991).

Two factors make Medicaid billing advantageous for schools (Rogers, 1993). First, the amount contributed by the federal government, called the federal medical assistance percentage, is related to each state's per capita income. The federal share runs from 50% to 80.18%. Arkansas' reimbursement rate is 74.58% (Kreb, 1990). This means that Arkansas Medicaid providers receive approximately three
dollars for every dollar they invest in the program (Kreb, 1990; Bergman & Walsh, 1993). Second, Medicaid is neither a private asset nor does it provide recipients with a fixed dollar allotment. Families do not risk losing or exhausting any benefits when schools access Medicaid.

Billing Systems. Different types of billing mechanisms have been outlined in manuals, books, articles, and presentations. West Virginia's third party billing manual, published by the state department of education in 1990 discusses three billing systems: single district, regional systems through the Regional Education Service Agency (RESA) and private agents.

These systems require LEAs to carry out many initial and ongoing tasks required by Medicaid. Districts initially enroll as group providers and enroll their therapists as individual providers. Next, they determine which students receive or are eligible for Medicaid, and notify parents of Medicaid billing. Then districts maintain eligibility lists, collect and maintain required billing data (West Virginia Department of Education, 1990).

California outlined several possible options for LEAs to choose from when deciding how to bill (Bergman, 1993). These included employing a private billing agent, LEAs forming consortiums to contract with private billing agents, or billing independently. The inservice provided to California LEAs listed these options with a footnote that each LEA must determine if it is desirable and cost effective to use a billing agency or to bill independently. In 1989 California estimated that public schools could produce annual reimbursements in excess of $35 million dollars for related services (Wolf, 1991).
Legal Background

Disputes over third party billing have had mixed results for school districts. Litigation relating to Medicaid billing addresses three main areas of concern: health related services, private insurance, and Medicaid billable services.

Health Related Services. The leading case regarding the provision of health related services, Irving Independent School District v. Tatro (1984), was brought to trial under the premise that clean intermittent catheterization (CIC) was a related service under IDEA. The Supreme Court excluded any health related service that must be performed by a licensed physician. Services like CIC that could be performed by a school nurse or other trained health practitioner were to be provided, according to the Court.

In Detsel v. Sullivan (1990), the Second Circuit decided that private duty nursing services for eligible recipients would be covered during hours when the recipients' normal life activities took them outside the home. If recipients did not need nursing services in the home, hospital, or nursing facility, the services would not be reimbursed in other settings, such as the school. Following this case the Health Care Financing Administration issued a clarification (18 IDEALR 558) stating that eligible Medicaid recipients could receive reimbursed private duty nursing services when their normal life activities took them outside their homes. These two cases broadened the types of services that schools may be expected to provide and pay for under IDEA regulations.

Private Insurance. Monetary reimbursement of $432.80 was awarded to parents in Seals v. Loftis (1985), after the school district accessed
their insurance for a neurological exam and psychological evaluation services, which reduced the family's lifetime benefit. The Multidisciplinary team in the school building recommended a medical evaluation to the parents before designing an educational program for the student. The evaluation’s results were considered as the student's educational program was developed (Rothstein, 1990).

Shook v. Gaston County Board of Education v. State of North Carolina, The North Carolina Board of Education (1989/1990) demonstrated the potential liability school districts face when billing private health insurance for related services. As an adult with a life long debilitating condition, Karen Shook sued the school district to recover funds billed to her parent's insurance company that were spent on her education in a residential school. Unlike other cases in which the impetus for asking parents’ insurance companies to pick up special education costs comes from school officials, the decision to use private insurance was made by Karen’s parents. The Shooks made their decision to place Karen in a residential facility at a time when they and the school district were involved in a dispute over the kinds of services Karen needed (Viadero, 1990). The billing for related services reduced her lifetime benefit by $64,192.22. The court ruled that Karen had sustained a financial loss and was entitled to recovery of the benefits, even though the funds were expended years before the matter ended up in court.

Chester County Intermediate Unit v. Pennsylvania Blue Shield (1989) dealt with billing private insurance for health related services. Pennsylvania Blue Shield contended it did not have reimburse physical therapy services for students when the school district paid families’
deductibles (Viadero, 1990). The court ruled that an insurance company
did not have to reimburse a local education agency that provided
physical therapy to students whose parents held a policy. Exclusionary
policies prohibit payment for services subscribers are not legally
obligated to pay for, such as related services provided under the
provisions of IDEA.

Other cases dealing with billing families’ insurance have had more
encouraging results for school districts, such as the 1982 case, Three
Village Central Schools v. Hufstedler. The court decided that private
insurance could be accessed for related services. Under the ruling,
parents may voluntarily allow school districts to access insurance
companies, if deductibles and other charges are borne by the school
district.

have advised LEAs to avoid billing private insurance based on the
unpredictability of the courts and unforeseeable insurance industry
changes. They stress that an appropriate public education must be free,
and billing a family's private insurance may actually lead to a cost
borne by the family or later in life by the student (Weber, 1991;
Rogers, 1994). Van Dyck (1991) stresses that the education system has
traditionally provided free services to handicapped children and that
billing private insurance could negatively influence parents' perception
of special programs. Others worry that educational use of private
insurance may lead to denial of coverage later in life. Muriel Dawson,
a school board member in Illinois, persuaded her school district to stop
billing private insurance for this reason (Viadero, 1990).

In 1991, the New York State Speech-Language-Hearing Association
published information for parents clearly stating:

A record of claims on your insurance could affect your ability to purchase policies from other companies, affect premium cost, or cause your child to be excluded from a future insurance policy because of a pre-existing condition. It is possible for speech-language pathology services to be eliminated by your insurance policy.

Although NYSSLHA was referring to private insurance, the same type of documentation is maintained for Medicaid reimbursement.

While these experts take a very conservative approach to billing private insurance, others do not. Elaine Little of Illinois, and Karl White of Utah, urge LEAs to take the risk because current benefits are so lucrative; up to 90 percent of children are covered either by Medicaid or private insurance (Staff, *Education of the Handicapped*, 1988). White even says, "It’s a good idea if it’s done right," (Viadero, 1990).

**Medicaid Billable Services.** In *Bowen v. Massachusetts* (1988), the Supreme Court ruled that schools can bill Medicaid for related services if the state Medicaid agency reimburses for the services. The court held that such services were not automatically educational services because they were contained in an IEP. The case also dealt with apportionment of costs between public schools and Medicaid and reinforced the concept of interagency cooperation (Rogers, 1993). This case encouraged Congress to pass the Medicare Catastrophic Coverage Act of 1988.

Another important case concerning Medicaid billing is *Pullen v. Cuomo*, which sprang from the *Detsel* decision. The U.S. Department of
Health and Human Services agreed to accept nationwide the Second Circuit's position regarding provision of private duty nursing services outside a Medicaid recipient's home as originally outlined in *Detsel v. Board of Education*.

Both cases opened Medicaid billing for school districts. These decisions caused LEAs to examine new ways to work with other public agencies to stretch dollars and provide needed services to children.

**Current Arkansas Medicaid Instructions for Funds Received from Medicaid for Physical, Occupational and Speech Therapy**

**Collecting funds.** A roster of Medicaid-eligible students receiving related services must be established. Under the Family Education Rights and Privacy Act and IDEA regulations, consent must be obtained from parents to bill Medicaid. Accurate billing data should be received from service providers.

**Spending funds.** Funds received from Medicaid are deposited into the LEA's separate account for auditing purposes. All Medicaid funds received for services provided to students with disabilities must be spent on special education programs.

Medicaid funds can be spent on any special education program expenditure that is approved in the district's consolidated application. The consolidated application budgets Minimum Foundation Program Aid (State and Local funds) and Federal Title VI-B Funds spent in the LEA's special education program. Funds generated from Vision and Hearing screenings and various EPSDT services for Medicaid-eligible nondisabled students may be spent for other programs. LEAs must submit an annual Medicaid financial report of expenditures from the separate account each fiscal year. State and local expenditures must be maintained at
previous levels, despite the amount of Medicaid funds generated.

State match. A 25% state match is required for all funds received from Medicaid. Each fiscal quarter, the Arkansas Department of Education, Special Education, sends statements to participating school districts indicating the state match due. The 25% match is paid to the Arkansas Department of Education, which reimburses Medicaid. The 25% match must be paid from state or local funds, not federal funds. The matching payments can be used toward meeting special education required expenditures from state and local funds. Funds received from Medicaid during the current fiscal year can be carried over to the next fiscal year but must be spent by June 30.

Audits. A W-4 form or a copy of the Purchased Services Contract must be on file in the office of the enrolled Medicaid provider of therapy/pathology services. For audit purposes, the Medicaid provider must retain a copy of the most recent W-2 or 1099 form issued to the therapist/pathologist.

Barriers to Medicaid Reimbursement

Perceptions of the LEA. In Arkansas, school districts have been somewhat hesitant to begin Medicaid billing. Feild, et al. (1991) cited reasons given by LEAs such as, "too complicated," "takes too long to get money," "parents won't cooperate with providing Medicaid information" and "What is Medicaid?"

Smokoski (1991) directed Colorado's Medicaid billing pilot project. He listed six reasons special education directors expressed for not participating in the study. Three reasons directly relate to possibly losing money: possibility that Medicaid reimbursement may not generate enough funds to compensate personnel administering the program,
that districts could invest more money in the program than would be recovered, and that any increased revenues could result in decreased state funding for special education. The remaining reasons deal with systems factors including the complexity of the billing process, that districts have no control over which children are Medicaid-eligible, and finally, uncertainty of the district actually benefiting from billing Medicaid.

Kreb (1990) outlined barriers incurred by early intervention program coordinators when accessing Medicaid funding for related services. Some barriers noted were artificial, attitudinal constructs expressed by service providers and administrators. Such barriers included: "no cost to parents" is a misunderstood concept, accessing funds could possibly create a "run on the Medicaid bank," Medicaid is a "pot of gold." She also noted that program administrators must be creative, persevere, and cooperate with other agencies to be successful when attempting to access Medicaid.

Perceptions of the SEA. Additional barriers at the state level were listed by Ahearn (1993). She found states were encountering difficulties working with Federal regional HCFA offices. States reported HCFAs' inconsistency in interpreting Medicaid regulations, and difficulty in getting HCFA to understand and accept the variety of services delivered by schools. The interagency collaboration and management necessary to prohibit service duplication can be difficult for school districts to implement and maintain. Finally, she cited the variety of administrative structures such as intermediate educational units and cooperatives or special school districts that may pose complications when implementing Medicaid reimbursement programs.
Perceptions of others. Farrow and Joe (1992) listed yet another barrier to Medicaid use by school districts: Medicaid officials. Discouragement of Medicaid expansion may come from federal officials who fear increased federal costs. Discouragement may also come from state Medicaid administrators who may be reluctant to reimburse school related services, even if there are no new state costs.

Joy Rogers' book, Third Party Billing for Special Education: Panacea or Mirage (1993) is a comprehensive work on the problems of third party billing. The book's content deals mainly with billing private insurance but many barriers to billing private insurance overlap Medicaid, too. She lists several barriers to third party billing: frequent changes in state regulations, legislatures may possibly prohibit school billing, "medicalization of educational services" so they are billable, segregation of students so billable services can be provided, and that students may not make enough documented progress to leave special education's "billable" settings.

Status of States Currently Billing

By 1997, 46 states were billing Medicaid for related services (ASHA, 1997). Following is the status of some states that began billing from 1989 to 1991.

New Hampshire public schools began Medicaid billing in August of 1991 (Radigan, 1992). The average recovery per student was $345. The highest reimbursement category was speech, language and hearing (43%). Concerns noted by school districts included identifying Medicaid-eligible students, managing the program with existing support staff and recovering dollars for all billable services.

Connecticut schools are legally mandated to bill Medicaid for
related services. Unfortunately, schools have little fiscal incentive to access the system. The state's school districts receive funds from the local board of supervisors and actually have little control of their budgets. Medicaid funds received from billing do not go directly to the LEA, and billing Medicaid may not increase funds for programs that generate Medicaid reimbursement in the first place. Connecticut's Federal Matching Assistance Percentage is low at 50%. Currently few districts are actually billing (P. Shaunessey, personal communication, August 16, 1993).

West Virginia Code 18-2-5b mandated the public schools to bill Medicaid. The state has a high Federal Matching Assistance Percentage of 76.61%. Interagency agreements have been established between the Departments of Education and Human Services. Officials from both agencies have aggressively pursued Medicaid funding for related services (T. Smith, personal communication, June 20, 1992).
CHAPTER 3

METHODOLOGY

Population

Arkansas has three different systems under which school districts are organized into LEAs operating special education programs: education service cooperatives, lead district cooperatives, and school districts. Each type of unit has a special education supervisor who is responsible for the special education budget. The supervisor is also responsible for overseeing spending of Medicaid funds, if the LEA is billing for services. Currently there are 16 education service cooperatives, 44 lead district cooperatives, and 49 school districts who employ a total of 109 LEA supervisors. All 109 supervisors were surveyed for this study. Eighty-seven supervisors returned the survey (80%).

Research Design

A survey was used in this study. A memorandum was sent with the questionnaire explaining the research project. A self-addressed stamped envelope was sent with it. Prior to the mail out, the survey was discussed with the executive board of the Arkansas Association of Special Education Administrators. Area Representatives were asked to encourage members of their region to complete and return the survey. Telephone follow-up interviews were used to assure a sufficient response rate.

All LEA supervisors were asked to complete the questionnaire regarding Medicaid billing. The survey included three major parts. The first section asked basic demographic information including type of LEA
and the number of school districts supervised. All supervisors were asked to complete this portion of the survey. Supervisors who currently bill Medicaid were asked to respond to the second section of the questionnaire. These 13 questions sought information about LEAs’ billing history, services generating billing, processing billing, and problems they have experienced. The last question in this section solicited suggestions for improving Medicaid billing. The third section of the survey was completed by supervisors of nonbilling LEAs. These supervisors were asked to rate a series of possible reasons LEAs do not bill as each pertained to their decision. They were also asked to list and rate any other reasons why they do not bill Medicaid.

**Measurement**

The survey was developed by interviewing LEA supervisors and Medicaid billing clerks, and reviewing the related literature. Some articles in the literature had surveys designed to collect data at the SEA level (Dugger et al., 1993; Radigan, 1992; Smokoski et al., 1991; Ross, 1980). Other articles outlined areas that should be examined before a billing system is set up (Bergman, 1993; Rogers, 1993; Field et al., 1991; Kastoff, 1991; Kreb, 1990, 1991; Weber, 1991; West Virginia Department of Education, 1990; Gerry, 1989). These were used to design the list of barriers LEAs face when billing in question 17 and the reasons LEAs have for not billing in question 19. The survey has both multiple choice and open-ended questions. The multiple choice responses were placed into a spreadsheet for calculation of descriptive statistics. Open ended questions were reviewed by the researcher.

A group of 15 professionals outside the sample population field tested the survey instrument for reliability and content validity. The
field test group was composed of four former LEA supervisors, the head administrator of Grants and Data Management at the Arkansas Department of Education, Division of Special Education, two Medicaid billing clerks, two superintendents, a state area supervisor, two early childhood coordinators, three members of the Department of Pediatrics at the University of Arkansas for Medical Sciences. All members of the group were familiar with Medicaid billing. The questionnaire was readministered to the same group 10 days later to measure its reliability. None of the field test group indicated confusion with the questions or choices in the instrument or gave different answers on the second administration. One administrator suggested collecting information on LEAs’ Medicaid receipts from the Arkansas Department of Education, so the question asking about Medicaid receipts was dropped in favor of receiving this data from the Department of Education. The field test results showed that the survey instrument was consistent in measurement, and the information it conveyed was reliable.

**Analysis**

Descriptive analysis was used to classify billing methods used by LEAs and identify factors facilitating a billing method. The relevant variables can be used in a model to match LEAs with appropriate billing mechanisms.

**Significance**

The results of this study will provide LEAs, the Arkansas Departments of Education and Human Services and billing services with data needed to judge the effects of current Medicaid reimbursement systems. Nonbilling districts may use the study’s information to select a billing method and begin accessing Medicaid.
A handbook will be produced from the results. Its purpose will be to assist LEAs in choosing an appropriate billing alternative. The results also will be presented at state and national meetings of the Council for Exceptional Children and at the meeting of the Arkansas Association of School Administrators. The study's results will aid the Arkansas Department of Education and LEAs in policy formation and the design and implementation of billing policies and procedures.

The information should be useful to the General Assembly's legislative study committees if mandated billing is ever considered for Arkansas school districts (P. Shaunessey, personal communication, August 16, 1993). Data acquired from the study should provide a rationale to continue funding school-linked health care services, including related services listed in IEPs, as the national debate on health care reform continues.