ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672

10519 SENATE HEALTH EDUCATION & SOCIAL SERVICES

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3/7/01

SENATE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Introduced:
Referred:

A BILL

FOR AN ACT ENTITLED

"An Act relating to a two-year transition for implementation of the public high school competency examination and to establishing an essential skills examination as a high school graduation requirement; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

INTENT. It is the intent of this Act

(1) to encourage schools and school districts to develop and promote endorsements and awards that document high levels of academic, artistic, or vocational achievement on the part of graduating students;

(2) to implement testing procedures that are reasonable, fair, and in the best interest of students who are being tested; and

(3) that the high school essential skills examination focus on essential and foundational skills in the areas of reading, English, and mathematics that the general

community would expect a student to have or know in order to function at an introductory level in our society.

* **Sec. 2.** AS 14.03.075, added by sec. 1, ch. 58, SLA 1997, is amended to read:

Sec. 14.03.075. **High school essential skills examination** [SECONDARY PUPIL COMPETENCY TESTING]. (a) A **student** [PUPIL] may not be issued a secondary school diploma unless the **student** [PUPIL] passes a **high school essential skills** [COMPETENCY] examination in the areas of reading, English, and mathematics **or receives a waiver from the department**. The department shall determine the form and contents of the examination and shall score completed examinations. [A PUPIL WHO FAILS TO PASS THE EXAMINATION REQUIRED UNDER THIS SUBSECTION AND WHO IS NO LONGER IN ATTENDANCE SHALL RECEIVE A CERTIFICATE OF ATTENDANCE FROM THE SCHOOL DISTRICT INDICATING THE YEARS OF ATTENDANCE AND THAT THE PUPIL HAS NOT PASSED A COMPETENCY EXAMINATION OR RECEIVED A DIPLOMA.]

(b) A **student** [PUPIL] who fails the examination required under this section may be reexamined in a schedule and manner as determined by the Dept. of Educatic ~~. A reexamination may not be offered more often than once every three months and must occur within three years after the date the **student** [PUPIL] is no longer in attendance. A **student** [PUPIL] who passes the reexamination and who meets any other graduation requirements shall receive a diploma from the school district.~~

* **Sec. 3.** AS 14.03.075, added by sec. 1, ch. 58, SLA 1997, is amended by adding new subsections to read:

(c) An examination required under (a) of this section may not be administered during a day in session, and final examination results shall be recorded on each student's transcripts.

(d) A student who is a child with a disability and who does not achieve a passing score on the examination required under (a) of this section is eligible to receive a diploma if the student

(1) completes an alternative assessment program required by the student's individualized education program team or required in the education plan

developed for the student under 29 U.S.C. 794; and

(2) meets other requirements for graduation imposed by the board.

(e) The department shall by regulation establish

(1) uniform standards for

(A) pre-examination study materials;

(B) procedures to be followed during administration of an examination;

(C) awarding a waiver under (a) of this section; and

(2) procedures for recording examination results on a student's transcripts.

(f) In this section,

(1) "child with a disability" has the meaning given "children with disabilities" in AS 14.30.350;

(2) "individualized education program" means a program developed under AS 14.30.278;

(3) "individualized education program team" has the meaning given in AS 14.30.350.

* **Sec. 4.** AS 14.07.165 is amended to read:

Sec. 14.07.165. Duties. The board shall adopt

(1) statewide goals and require each governing body to adopt written goals that are consistent with local needs;

(2) regulations regarding the application for and award of grants under AS 14.03.125;

(3) regulations implementing provisions of AS 14.11.014(b);

(4) regulations requiring approval by the board before a charter school, state boarding school, or a public school may provide domiciliary services;

(5) regulations implementing the high school essential skills examination provisions of AS 14.03.075.

* **Sec. 5.** Section 3, ch. 58, SLA 1997, is amended to read:

Sec. 3. This Act takes effect January 1, **2004** [2002].

* **Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to

read:

APPLICABILITY. The academic standards and requirements required by AS 14.03.075, as amended by secs. 2 and 3 of this Act, apply to students who graduate on or after January 1, 2004.

* **Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION; ACADEMIC STANDARDS FOR PUBLIC HIGH SCHOOL GRADUATION. (a) Beginning January 1, 2002, and ending December 31, 2003, before graduating from public high school, each student is required to

(1) take a competency examination or an alternative assessment approved by the student's individualized education program team in the areas of reading, English, and mathematics; and

(2) meet academic requirements established by the state and the school board of the borough or city school district or regional educational attendance area in which the student is enrolled.

(b) The Department of Education and Early Development shall determine the form and contents of the competency examination and shall score completed examinations. A competency examination may not be administered during a day in session.

(c) A student shall receive an endorsement on the student's diploma and transcript identifying the areas of the examination successfully passed.

* **Sec. 8.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Education and Early Development shall establish by regulation uniform standards for awarding an endorsement required under sec. 7(c) of this Act.

* **Sec. 9.** Sections 2 and 3 of this Act take effect January 1, 2004.

* **Sec. 10.** Section 8 of this Act takes effect immediately under AS 01.10.070(c).

* **Sec. 11.** Except as provided in secs. 9 and 10 of this Act, this Act takes effect January 1, 2002.

ALASKA STATE LEGISLATURE

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Session:
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SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE
SENATOR LYDA GREEN, CHAIR

HIGH SCHOOL GRADUATION QUALIFYING EXAM
Draft Legislation

The draft legislation creates a two-phase approach to solve the current situation where the state is facing the probability that a large number of high school students will fail the High School Graduation Qualifying Exam (HSGQE) and not receive a diploma. This proposal is meant to fortify the legal defensibility of the exam while addressing the needs of special needs students . Another goal is to provide an improved long-term system for testing students and the quality of their education, while also providing an incentive to do well on the exams and in school.

A TWO-PHASE APPROACH:

PHASE I:

A new section is added to the uncodified law of the state of Alaska that reads:
Transition; Academic standards for public high school graduation:

(a) Beginning January 1, 2002, and ending December 31, 2003, before graduating from public high school, each pupil is required to
  (1) take a competency examination or with the approval of the IEP team take an alternative assessment in the areas of reading, English, and mathematics; and
  (2) meet graduation requirements established by the state and the school board of the borough or city school district or regional educational attendance area in which the pupil is enrolled.

(b) The Department of Education and Early Development shall determine the form and contents of the competency examinations and shall score completed examinations.

(c) A pupil shall receive an endorsement on the pupil's diploma and transcripts identifying the areas of examination or assessment successfully passed.

(d) The Department of Education and Early Development shall establish by regulation uniform standards for awarding endorsements required under (c) of this section.

PHASE II:
Amends Sec 14.03.075 to add language to codify the following:

Prior to January 1, 2004, the Department of Education and Early Development shall determine the form and content of a High School Essential Skills Examination (HSESE). The exam will focus on essential and foundational skills and content in the areas of reading, writing and arithmetic/mathematics which the general community would expect a student to have or know in order to function at an introductory level in our society.

Effective January 1, 2004, all students will have to pass the Alaska High School Essential Skills Examination and meet other district requirements in order to be eligible to receive a diploma. Additionally, identified special education students and 504 students (defined under 29 U.S.C. 794) who successfully complete the Alaska High School Essential Skills Examination, or alternative assessment as described and required in a student's individual education plan or 504 plan (developed under 29 U.S.C. 794), and meet other district requirements, shall be eligible to receive a high school diploma. Course of study and exams taken and passed will be reflected on the student's transcript and diploma.

In addition, the department is directed to develop a waiver for students to receive their diploma if they meet other district requirements yet fail the HSESE. The standards for the waiver will be determined by the Department.

ADDITIONALLY, THE LEGISLATION INCLUDES:

1. The department shall develop uniform standards for recording information on the student transcript;
2. A Requirement that the exit exams are NOT administered on a school day, e.g. the exams should be administered on inservice days;
3. That the board develop uniform instruction language for those who administer the HSESE to be used at test time;

INTENT LANGUAGE

Intent Language is added:

The Department of Education and Early Development shall determine procedures that are reasonable, fair and in the best interest of the student. Schools and districts are encouraged to develop and promote endorsements and awards which document high levels of achievement (ex: proficient and advanced), specific or career pathways or preparations (ex: technical, academic, arts, vocational) or significant achievement or accomplishment (ex: artistic, academic, vocational or technical) on the part of students graduating from their school or district.

Background related to special education and 504 (29 U.S.C. 794) students and the attached legislative proposal - Proposed Legislative Language – HSGQE/HSESE

Given that the High School Graduation Qualifying Exam (HSGQE) is revised to focus specifically on essential skills (High School Essential Skills Exam - HSESE) which the general community would expect a individual to have or know in order to function at an introductory level in our society, THEN students with disabilities should be expected to meet the following conditions and terms to receive a high school diploma:

(1) Successfully complete their course of study and district graduation requirements as described and required in District policy and student IEP; and

(2) pass the revised AK HSGQE/AK HSESE or an alternative assessment as described and required in the student's IEP

In short--Students who successfully complete the revised HSGQE/HSESE (or alternative assessment as described and required in the student's IEP), AND meet other district requirements should receive a high school diploma.

(Note: This differs from current law which does not allow a HS diploma for students who do not pass the current HSGQE. Under current law, modifications are not allowed for the HSGQE, and students with disabilities who complete their course of study and their alternative assessment as described or required in their IEP receive only a certificate of attendence.)

The proposed legislative language is intended to allow students with disabilities to participate in the state competency program as follows:

The student's IEP or 504 (29 U.S.C. 794) team will adhere to all applicable federal and state laws and regulations when making decisions relative to that student's participation in the revised HSGQE (HSESE):

There are three pathways related to the revised HSGQE/HSESE for students with disabilities:

- Participation in regular assessments without accommodations or modifications.
- Participation in regular assessments with accommodations or modifications.
- Participation in an alternative assessment prescribed by the IEP or 504 (29 U.S.C. 794) team.

Further discussion regarding rationale and ground rules for IEP notation and decision making:

When a decision by the team is made for the student to participate in regular assessments with accommodations or modifications, then the required accommodations or modifications should be specified in the student's IEP or 504 plan. The IEP or 504 (29 U.S.C. 794) plan should document the reason for the accommodations or modifications.

Accommodations or modifications should not give a student with a disability an unfair advantage, compromise test security, or artificially raise the test score for that student. Accommodations or modifications identified for a student should be those that lessen the affect of the student's disability.

Districts and sites can report on site and district report cards such information as the numbers of students graduating each year and the numbers of students who graduated with modifications or alternative assessments and the types of modifications and alternative assessments allowed or used. To protect individual student privacy this information can be reported without reference to specific student names. These reports can provide information to be used in system reviewsfor accountability and improvement efforts by such entities as the districts and sites themselves, AK Department of Education and Early Development, State School Board, the public, Legislature, etc.

"Target and Taught Skills and Content" versus "Essential Skills and Content"

For each of the skills or content in a discipline or field of study, we can ask the question – is this something we want our students to know and be able to do.... The answers to this question provide direction and content for our schools' curriculum and instruction. Those skills and content are identified and described by content and performance standards. The *Alaska State Performance Standards* list and describe what we want our students to know and be able to do in reading, writing and math. The *Alaska State Performance Standards* identify the targeted and taught skills and content in our schools. The *Alaska State Performance Standards* are a guide to good instruction and solid curriculum.

The "Essential Skills and Content" is a sub set of the targeted skills and content. These are the skills and knowledge that a person would need to have or know to function at a basic or introductory level in our society.

To determine if a given performance standard or exam question reflected an **essential** skill or content," a committee of community members, business people, and educators asked the following question: would you deny a diploma to a person if he or she did not have that skill or know that content?

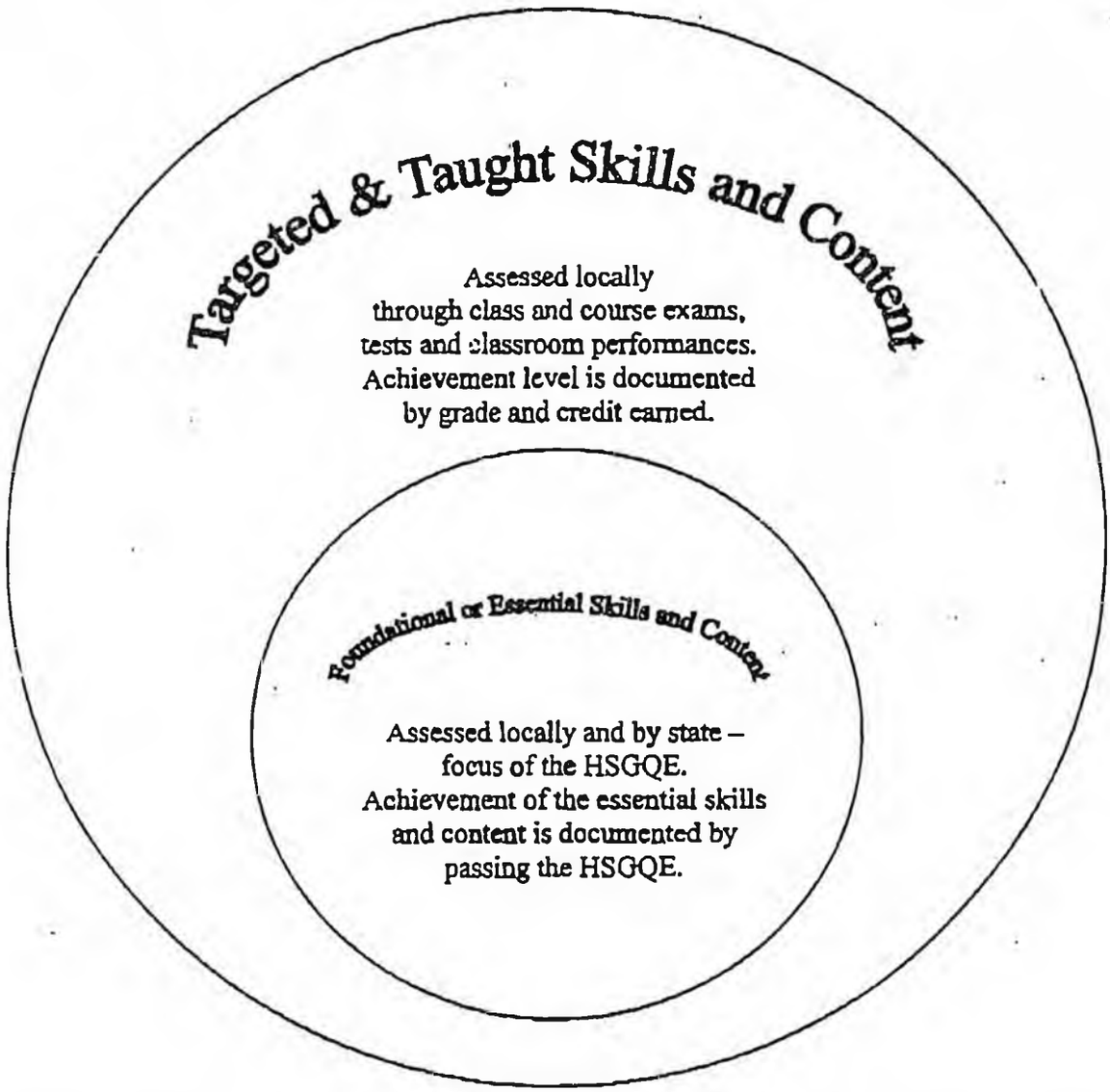
These are two different questions (1) what do we want our students to know, be able to do? (2) would you deny a diploma to a student if he or she did not have that skill or know that content?

These two questions are being confused with each other in the current AK HSGQE debate.

The following diagram provides an overview of the relationship of the targeted skills and content (described by the performance standards) and the foundational / essential skills and content.

Essential Skills as a sub set of the Targeted and Taught Curriculum

State performance standards list and describe the "targeted and taught skills and content" in reading, writing and math. These standards describe what we "want our students to know and be able to do." The state performance standards are a guide to good instruction and solid curriculum.



The "Essential Skills and Content" is a sub set of the targeted skills and content. These are the skills and knowledge that a person would need to have or know to function at a basic or introductory level in our society.

To determine if a given performance standard or exam question reflected an **essential** skill or content," the committee asked the following question: would you deny a diploma to a person if he or she did not have that skill or know that content?

Kennedy & Co. LLC

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March 6, 2001

To: Senate Health, Education and Social Services Committee

Re: high school graduation qualifying exam

We wish to enter this formal testimony regarding the proposed changes to the high school graduation qualifying exam. We regret that we will be unable to attend the teleconference tomorrow (3/7/01) at 1:30.

We strongly favored the original legislation but realize with our litigious society changes are needed.

We have read the draft of proposed changes and concur with them. Senator Green, you and the committee should be commended for championing a more workable standard for all high school seniors. We strongly disagree with the Governor's recommendation to defer the high school graduation qualifying exam until 2006. We like the timetable being implemented now.

It is unfortunate that testing is required at all. However, "what gets measured gets done." A member of the high school education labor union (i.e. teacher) lamented to me yesterday that it is a hassle to administer the exam. We say "Tough!"

My third grade daughter, Rachel, sat for the exam last week. It was a focused and worthwhile challenge for my 9 year old. My son, David, sat for the third grade test last year. His strong benchmark scores qualified him for the ExtraLearning Program (ELP) at Cottonwood Creek Elementary School.

The private sector (i.e. the customers of the educating government) demanded the high school graduation qualifying exam. We the customer finally obtain fundamental,quality education. The teachers and school system are held accountable.

We recommend adoption of the proposed changes from your committee.

Sincerely,

Dan F. Kennedy, CPA MBA
Kennedy & Co. LLC - certified public accountants, Wasilla, Alaska

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 3/9/01

FURTHER: Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3-19-01

Health, Education and Social Services Committee considered SENATE BILL NO. 133

PUBLIC SCHOOL EXIT EXAM

"An Act relating to a two-year transition for implementation of the public high school competency examination and to establishing an essential skills examination as a high school graduation requirement; and providing for an effective date."

and recommends:

Senate Bill:
[ ] same title
[✓] new title
House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR #_____

[✓] be **replaced** with____ **CS** SB 133 (HES)

[ ] adopt **previous** ____ **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#
FN forthcoming				

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
Drew D. Jensen	✓			
Gary Wilson	✓			
Dan Wall	✓			
Betty Adams	✓			
CHAIR: Lydia Mees	✓			

MEDI-CAID DIREC-TIONS 4-09-01

TONY KNOWLES, GOVERNOR
State of Alaska

GOVERNOR'S COUNCIL ON DISABILITIES AND SPECIAL EDUCATION

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EDUCAID

A Report of the Governor's Council on Disabilities and Special Education's Position Regarding the Use of Medicaid Funds to Reimburse School Districts for the Costs of Special Education and Related Services to Medicaid Eligible Students

Prepared for the Governor's Council on Disabilities and Special Education by The Research Group, Inc.

January, 1997

Table of Contents

Purpose

The purpose of this report is to summarize the position, concerns and recommendations of the Governor's Council on Disabilities and Special Education regarding the use of Medicaid funds to reimburse school districts for health-related costs of Special Education to Medicaid eligible students. While this practice is presently conducted in a number of states, it is not policy in Alaska.

The Council began its review of this approach in August of 1996. After initial discussions the Council contracted Sandra Peterson of Portland-based Healthcare Business Education to conduct a review of other state policies and experiences with using Medicaid funds to pay school districts and to make recommendations to the Council on how this approach might be implemented in Alaska. In particular Peterson notes in her report the quite different approach that this funding policy represents:

> As a background to understanding the task, one must recognize that the concept of Medicaid reimbursement for students with developmental disabilities is somewhat antithetical to traditional medical assistance programs. The most prevalent barrier is the lack of knowledge and understanding about what Medicaid can and cannot fund and about what schools, through special education, can and cannot do. The complexities of each area usually wear out even the most well-intentioned program planners when it comes to designing funding systems for children with special needs. (Peterson Report)

That report is submitted under separate cover.

Peterson's work was presented in draft form for initial comment to a five member work group of the Council, also attended by representatives from the Department of Education and the Division of Medical Assistance. On October 9, 1996, this work group reviewed 1) the background to the process; 2) other states' experiences with this funding approach; 3) anticipated barriers to enacting this policy; and 4) recommendations for implementation of the policy approach. Their information was forwarded to the Council along with a draft policy recommendation for review and action.

The Council's Position

The Council is guided by the primary goal of improve the level of services for of all Special Education students. If certain conditions were met, the Council believes that this method of Medicaid billing could help to meet this goal. If properly implemented, the benefits that could be gained are increased revenues, elimination of duplication in service delivery and student testing, and coordination of resources.

While improving these services, however, we cannot accept a loss of Medicaid funding for other programs.

It is the position of the Council, that current levels of state funding to schools for Special Education students **must not be reduced** as a result of using a Medicaid billing method. In addition, revenue produced by this new system **must be used by schools solely for the improvement of services to Special Education students.**

In at least 27 other states, school districts use this method of billing to fund services to Medicaid eligible students. However to avoid some of the barriers experienced by other states, the Council's recommendations must guide the implementation of Educaid in Alaska.

Although there are potential benefits for students in special education by creating a Medicaid billing program for health services, it will take a substantial effort to resolve the many and varied issues that such a program will generate.

It is the opinion of the Governor's Council on Disabilities and Special Education that the implementation of Educaid would supplement present levels of funding and provide needed improvement to services benefiting Special Education students.... revenue produced by this new system must be used by schools solely for the improvement of services to Special Education students.

Implementation Requirements

•To be consistent with the Council's goal of enhancing funds to Special Education students, federal supplanting issues must be evaluated.

There are regulations affecting how federal Medicaid funds may be displaced. If the program is adopted, it will be tempting to reduce state funding to districts.

Educaid should not be implemented if other Medicaid funds are lost as a result, or if state funds are reallocated away from Special Education students.

• A student's Individual Education Plan (IEP) should describe the basic health services that would be reimbursed through this program. These include, but are not limited to, physical, occupational and speech therapy, skills orientation and mobility for blind, deaf and developmentally delayed (excluding academically delayed), visual and audiological treatment, and mental health evaluation and treatment. Independent school-based, family-centered, care coordination must be developed along with these services, but could be included either as a school district administrative cost or a direct service consistent with present DMA practices.

The Council also believes that it will be necessary to require service coordination **through an independent school-based, family-centered care coordination plan for students.**

Other covered services and support activity directly related to the IEP could be reimbursed through this program such as costs for transportation and transportation aides, screenings and evaluations to determine eligibility, health care aides, nursing services and

delegated nursing tasks, and direct expenditures for outside medical evaluations.

• Medicaid funded services to individual students and other Medicaid recipients must be maintained.

It is understood that TEFRA (Tax Equity and Fiscal Reconciliation Act of 1982) recipients have a capped limit. In general, TEFRA payments have never exceeded the cap in a school-based Medicaid program. This, however, should be planned for and monitored. There should also be a full discussion of the potential impact of this funding approach on Medicaid funding for all eligible persons.

• Although exceptions should be made for those districts that demonstrate that it can't be implemented in a cost efficient manner, the program should be required for all dist.

The Council recognizes the unique concerns of both rural and urban districts. Consequently, we would recommend that a series of positive incentives be developed to ensure participation by as many districts as possible. It is estimated that three years would be required for full program implementation.

Maximum participation of individual students will increase funds to Special Education programs as a whole. The experience in Oregon and other states shows us that a **voluntary program suffers from higher costs, duplication and inefficien** when districts choose to join the program at different times. Alongside the implementation of this program, existing revenue streams to local districts must continue at current levels to create a net gain in services to Special Education students.

In order to streamline procedures and to eliminate errors in billing, the Division of Medical Assistance (DMA) should develop a **database of students who are Medicaid eligible.** The Council is concerned that some parents may have a culturally-based reluctance to identify

their children as Medicaid eligible in a school environment. This issue must be addressed before the system is put in place and information describing the program should be developed and made available to the public before the program starts.

• *The program should be administered by the Division of Medical Assistance (DMA), under the direction of a steering committee composed of members from the DMA, the Department of Education (DOE) and Regional School-Based Billing Centers (RSBBC). A project leader should provide organizational administrative support.*

The committee would oversee the project leader, be responsible for program evaluation, and collaborate among all agencies serving children with special needs. The project leader should be under the direction of the DMA but must possess a working knowledge of the Special Education environment.

• *Establish guidelines for the operation of Regional School-Based Billing Centers.*

The establishment of Regional School-Based Billing Centers, should take advantage of current regional service hubs to minimize costs. These centers would gather data directly and report to the Department of Education and the Division of Medical Assistance. These agencies would then collect, process and share reports with one another and the Governor's Council.

The Council has identified a number of ways to facilitate the gathering of accurate student data. In particular, the State should establish a unique confidential identification number for each student that would follow him or her, rather than remaining at the child's district. This would enable the regional centers to maintain up-to-date lists of Special Education students, and those students with screenings planned. The DMA could use these lists to determine student eligibility for Medicaid reimbursement.

• DMA, through the project leader, should be responsible for monitoring Medicaid activity and reporting levels through Medical Manag :ment Information System (MMIS) reports.

MMIS reports would be used to identify overlapping services and to assess comprehensive funding levels. This information would be provided to the Council for use in making recommendations for managing services more efficiently and effectively.

• An evaluation component should be included to assess the success of this approach.

Evaluation would be the responsibility of the committee and its staff or contracted agent. Peer review committees could be used to perform audits as present DMA and DOE staff and audit schedules are not sufficient to ensure regular review of participants. The DOE would continue to be responsible for school district compliance with Special Education law.

• Speech/language therapists should be certified to American Speech and Hearing Association (ASHA) standards.

While a number of Alaska school districts presently encourage ASHA certification for speech/language instructors, this requirement would have to be met by at least one person working with each school district. ASHA certification could be offered through the University of Alaska, but ongoing training for this professional certification must also be provided. Contracting agents such as the Southeast Regional Resource Center (SERRC), which provides speech/language services to smaller districts, would have to maintain these same training standards.

- *Support staff must have introductory and ongoing training in Medicaid reporting and documentation requirements.*

There are also a number of non-reimbursable costs associated with learning proper reporting procedures for school staff that will be involved in submitting claims. These non-reimbursable costs and training needs would be charged to the districts as staff development costs. These training needs would be ongoing.

- *Costs to provide education of staff and the processing of data from the service provider to the DMA should be shared by districts that benefit from Medicaid reimbursement.*

Even as districts share the costs it should be remembered that State funds to Special Education students must be enhanced by this new program and not reallocated to other areas.

- *Uniform software should be acquired that can import data bases and generate reports for school administrators.*

Efficient data management and analysis is impossible without this technology. Present DMA technology is not sufficient. There would also be minimal hardware requirements for regional billing centers.

- *The DMA should recognize a new class of providers that would meet the needs of this program such as school districts and regional billing centers.*

Without this provider designation, Medicaid payments to the districts would not be possible. Smaller districts contract for speech/language services rather than maintain a person on staff. To allow these districts to meet the minimum requirements of this program, independent contractors, such as SERRC, should be granted status as an Interagency Service Provider.

Potential Concerns

The Council has identified a number of barriers which must be overcome before Educaid is implemented. The concerns fall into two general categories: 1) funding of Educaid; and 2) barriers encountered by other states, which potentially exist in Alaska, as described in the Peterson report.

A list of these concerns follows. These barriers are also addressed within the discussion of the implementation recommendations.

- ***Ensuring that Medicaid funds do not displace public education foundation formula funds.***

It is the Council's position that Medicaid payments to school districts should not supplant existing funding to districts.

- ***Gaining legislative approval to authorize implementation costs and DMA activities (including new provider type).***

Legislative action will require a comprehensive assessment of cost of implementation and ongoing services and training. The need for school-based, family-centered care coordination must also be addressed.

- ***Establishing an economical and accountable system that coordinates the health care and educational agencies that assist the Special Education student.***

A new accounting system of students served through this program could bring together all the players, reduce duplication and even reduce the number of assessments for children. Authority for this program must also be established.

• *Gaining Health Care Financing Administration (HCFA) state plan approval.*

A comprehensive list of exceptions would need to be developed in conjunction with discussions with HCFA. These hurdles would be addressed as they came up.

• *Determining Medicaid eligibility in a manner which is efficient and relevant for school districts and other billing centers.*

This is addressed in the recommendations, and includes establishing a confidential student number, and acquiring new database software. Special attention should be paid to the cultural context of service delivery, and the feasibility of this method of Medicaid payment in smaller districts.

• *Gaining appropriate credentials for school district professional staff.*

This is addressed in the recommendations, which suggest certifying all speech/language therapists to ASHA standards. This could be achieved through the establishment of a program at the University of Alaska.

• *Changing the Division of Medical Assistance (DMA) claims processing system to include school districts and potentially a new provider type.*

Costs of changes to program language, manuals as well as costs to train parents, other agencies and DMA staff about billing requirements, are not reimbursable and must be determined. There may also be a need to change present legislative and regulatory authorization for provider types.

Summary

It is the position of the Governor's Council on Disabilities and Special Education that the primary goal of Educaid is to optimize services to all Special Education students.

The Council would only support using Medicaid funds to reimburse school districts for health-related costs of Special Education for Medicaid eligible students if the implementation requirements are met and the Council's potential concerns are addressed.

Educaid must not be undertaken if it results in a loss of health services or long term care that is now provided by Medicaid dollars to people with disabilities and other served populations.

Action should only be taken if revenues produced by this new billing system are all directed back into Special Education.

H ealthcare

B usiness

E ducation

December 15, 1996

David Maltman, Executive Director
Governor's Council on Disabilities and Special Education
P. O. Box 240249
Anchorage, AK 99524-0249

Sj: Revisions to Report of October 16, 1996 and Response to Dave Williams' letter of November 13, 1996

Dear David:

The following is a response to my review of the Council Meeting of October 30, a review of the DRAFT recommendations dated November 15 and Dave Williams' letter of November 13, 1996. I apologize that I was unable to review these materials and provide a response earlier. Since my contract deadline was October 16, I took another project that began the morning of November 4 and have been mostly out of the office since that time. We also had the traditional Alaskan experience of having our flight out of Anchorage cancelled due to ice and spent most of the night in the airport--not arriving in Salem until late Friday afternoon. This threw my report and recovery time into the following week.

In addition to the changes to the report, this memo, hopefully, addresses most of Dave Williams' concerns as well. I appreciate your sharing his memo. It was pretty apparent from the October 30 discussion that my desire to be objective was somehow not conveying the message that the council should be impressed by the many practicalities of implementing this program. In light of the revenue projections, the degree of effort on the part of the schools and the DMA was minimized. The meeting was extremely useful and the process gave me a greater understanding of your environment and decision-making process.

The revised calculations reflecting input provided by the Council show the cost projections will be somewhat higher--implementation costs are now estimated to run $471,750 and annual operating costs will run $867,600. These expensed amounts would result in $1.8 million net to the state the first year-- assuming the best-case scenario in overcoming barriers and gaining necessary approvals. The start-up costs could be recovered over the first three years. Many variables come into play, however, and it is impossible to know how delays in the implementation tasks identified in the report would affect the cost. Major changes to the report start on page 37 where I also reformatted the cost summary in order to more easily see the breakout. Other changes are spread throughout the document. I believe I addressed all the concerns of the Council, particularly the Council's reasons to pursue Medicaid funding as indicated on page 10.

The State of Alaska, no doubt, has the potential to realize and benefit from implementing a Medicaid billing program for school special education health services. This potential was

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not fully address the many and varied immeasurable issues that will surface and require substantial effort to work through to resolution--not all issues will be resolved to an acceptable end--and, considering the major tasks, I am doubtful that the potential can be realized.

An observation about the meeting:

Several in attendance stated they had scanned, but had not completely read, the report. As is somewhat typical, discussions focused primarily on revenue projections and costs of implementing the program. Full discussion of pros and cons was not possible because many at the table had not had the opportunity to read and reflect on the operating and administration issues. The only school administrator who would likely be directly involved in implementing the program at the school level was Dave Thomas who was essentially silent throughout the discussion.

Weighing the risk, district by district:

One reality that could not be reflected in the cost projections was and is the uncertainty that the level of effort will result in a proportional level of return by each district. Participating is a risk. Part of the reason is that the decision to participate must be based on limited information. The break-even point depends on a number of variables--which will not be known until a district actually is already committed to the task.

In order to systematically calculate rate projections, the numbers spreadsheet per district were prepared according to the estimates provided by the DMA and the information provided by Juneau School District. These did not include frequency actuals even within the Juneau School District. Since Juneau gathered its own information, one cannot be certain that the IEP's were written in a Medicaid-approved format that clearly identified the frequency of services. Nor were the numbers fixed or steady. And, the method of determining service levels within Juneau School District will differ somewhat from what can accurately be anticipated in other districts. The numbers were based on identified IEP services--more detailed criteria will result from the process of gaining HCFA approval. This means that in reality, a district may gear up for participation thinking they will be able to bill for 20-30 children when, in fact, only 6-7 are receiving services that qualify. On the other hand, the reverse could also result. The report attempts to identify the many variables and the policy approved by HCFA in other states in order to lay a foundation for what the potential is in the State of Alaska. The Council should be prepared to present districts with the risks and the unknowns as well as the benefits.

New information:

Another point that needs to be emphasized about relying on straight projections in a sea of variables is that serving Medicaid children implies that one knows which students are Medicaid eligible. We discussed this issue but there is new information. This fall Oregon undertook a study (unknown prior to the Alaska report) to verify eligibility based on the best efforts of both agencies. In 1993, the Medicaid program developed an "upload-download" system to provide schools the capability to upload their student data directly into Oregon Medicaid files to verify eligibility. The cost to Oregon Medicaid was approximately $5,000 in systems staff time; the equipment was already in place. The accuracy of this upload-download process had not been thoroughly tested between the two entities until now. This process replaced the need for districts to pay $100 each month to have a leased line with on-line access to Medicaid eligibility screens. However, when verified, Oregon learned that discrepancies in the information gathered by Medicaid and the information gathered by districts resulted in a 25% - 32% "false not-eligible" report. This means that

t resolved discrepancies between provider-payer in names, date of birth and Social Security numbers ran between 25%-32%. To research these numbers is extremely time consuming and often futile. Unless Social Security numbers are captured accurately and used to verify eligibility, school providers are not likely to be able to know all students who are eligible. And, unless names are exactly matched, eligibility verification is often a negative. Federal law requires verification to be matched on two out of three pieces of identification furnished by the provider, no less. The Alaska report assumed full identification of all Medicaid eligible children. The recent Oregon study indicates as much as 32% of the Medicaid population will not be learned and, therefore, reimbursement will not be possible.

Just because you can, doesn't mean you should.

The report to the Governor's Council included identification of issues and steps involved in evaluating the potential. Obstacles that arose in the development of the program in other states were identified. Resolutions were spelled out to demonstrate how issues that were challenging were overcome. This should not be interpreted by the Council that all resolutions were worth the effort or expense-only that problems were solved and how they were solved. No two states are alike. Alaska faces most of these same obstacles that will require effort to resolve. In addition, Alaska faces other obstacles which no other state has faced--such as that SERRC has no legitimate standing as an educational entity. This obstacle, if not satisfactorily resolved, affects the potential considerably.

An issue that was not part of the report or discussion but apparently was a factor for Council consideration:

A billing company reported that Alaska schools could retroactively bill Medicaid for two years prior to the start up of the program. The state which was allowed to back bill for two years was permitted to do so because HCFA made a technical error and delayed in responding to a request. Retroactive billing would only be possible if the districts had systematically documented services according to Medicaid requirements. States which allow back-billing would only legitimately do so because services had been provided and documented but, for technical reasons, billing had been delayed. Each state defines the period of timely claims submission--up to one year from the date of service--which is a federal Medicaid limitation.

Documentation and reporting service levels must occur at the time the service is delivered. To retroactively compile data to submit claims is like reconstructing "tax deductible record-keeping after you know you're going to be audited." It is bad practice and extremely risky. If states had been compiling data all along but withholding claims upon approval to submit, billing retroactively would be possible. However, to retroactively fabricate records in order to gain Medicaid reimbursement is highly inappropriate and not recommended. Because other states reportedly back-billed for a time period does not mean it is allowed or authorized. In fact, an audit is more likely today than five years ago when school billing was a new issue.

Some district staff believe services are clearly documented now and so would not require additional or different documentation. While documentation is not radically different from special education documentation, it is different. Medicaid documentation requires attention to times, dates and description of services, not lesson plans and attendance as is more common in the school setting. It is unlikely that a school administrator could confirm that their documentation procedures would meet Medicaid standards when those standards are not commonly known, nor, in most cases have they been discussed within the state. In

any case, Alaska state law only allows Medicaid providers to retroactively bill six months from the date of service. This requirement must be equally applied to all provider categories.

While the State of Alaska clearly has an opportunity to draw federal funds by developing a state Medicaid billing program for school providers, this opportunity must be carefully assessed not only on the financial potential, but also on the practicality of the issues, considering that only a certain right combination will make the opportunity worth the effort. Juneau, for example, with revenue projections of $163,000 per school year, has some of the greatest logistical advantage. Even so, implementation costs for Juneau will be nearly equal to the Anchorage district that has a far greater reimbursement potential--about $1 million each school year.

Other issues yet to be considered:

1. Costs related to the district undergoing a Medicaid audit are unknown and, cannot be projected since variables include the audit findings. Some audits end at the first review of the records; others end only after a lengthy due process that may result in findings considered fraudulent according to Medicaid regulations. This cannot be known.

2. Union issues regarding change in workload or job descriptions that surfaced in other states may become an issue and result in legal costs as well as administrator's and staff time and commitment. Since this is unknown and cannot be anticipated, it cannot be included in cost projections.

3. State matching funds are required to be paid by schools themselves. While the Council acknowledged this was necessary, <u>how</u> the fund transactions would occur was not addressed. In Oregon, for example, the dollars were originally matched from the "Handicapped Child Fund." After the first three years, that funding source dried up. The "state" then withheld funds from its allocation of school funding support based on accountings of payments made to districts by the Office of Medical Assistance Programs. Due to restructuring school funding, a Secretary of State audit found that practice no longer acceptable.

   Alaska also pays for most school service from its foundation dollars--state dollars. If the money cannot be withheld at that point, the DMA would have to generate a billing to each school, based on enrollment information against which claims are paid, each month or quarter, to reimburse the DMA for use of its state matching funds. This can become complex for DMA to track and bill because each district is likely to be enrolled under the regional billing center. Billing each district also requires districts to track and report federal funds separately. It may also be a contractual issue between the DMA and its intermediary, First Health.

4. The report did not directly deal with how the funds were to be used because this was the responsibility of the Governor's Council. It was clear that members of the Governor's Council and the school districts that generate the revenue wanted to assure that Medicaid dollars be used to provide services that otherwise would not be provided. From review of the draft of the Governor's Council recommendations, use of funds is not identified specifically. The concern is that if these dollars are not earmarked and trackable to specific services or a range of

services, they will be cyphoned off by others--even at the legislative level. This would leave the school districts with the burden of generating revenue that does not guarantee that those responsible for the work will reap the desired benefit. To allow the incentive to be lost through oversight or assumption would prescribe doom to the potential revenue.

Since the Governor's Council Draft Report indicates a strong value placed on family-centered care coordination, perhaps funds could be used for care coordination. To buy more of the same kinds of services as indicated in the Council's recommendations implies the services are not currently provided, which cannot generally be assumed. (Several districts in Oregon purchased laptop computers with their Medicaid funds--to provide more efficient documentation and reporting capabilities of staff.)

The unique circumstances under which Alaska must implement the proposed billing program mean the outcome will be different from any other state's program or experience. In some ways, the path will be smoother because of the pioneering efforts. In other ways, the path will be rougher because of the timing of Alaska's effort--HCFA has learned from other's efforts and addressed policy issues that will be more restrictive. In the future, as HCFA and State staff members turn over and as Medicaid budgets tighten, new regulations may be imposed. School providers are clearly at the mercy of another agency over which they have no control. In order to bill into the Medicaid program successfully, streamlined procedures and methods of verifying eligibility and the capacity to interact successfully with the state's claims processing contractor are necessities. Anything short of a full commitment from both agencies' leadership should signal decisionmakers that frequent confrontation and problem-solving will become necessary.

Culturally-based sensitivity discussion

Another concern expressed by the Governor's Council was the sensitivity to culturally-based reluctance to identify children as Medicaid-eligible. In the effort to learn which children are billable and which are not, even dedicated staff who are especially considerate and sensitive can inadvertently offend or call attention to the billing effort. This risk is real. While confidentiality is always a concern and to be respected, in the sometimes frantic effort of seeking reimbursement for services, the practicality of "needing to know" often means a lessening of sensitivity--much like the need for modesty that often gets pushed aside in the medical setting in an effort to provide needed medical treatment. The environment of serving children in general, and particularly, children with special needs at a time when resources are extremely limited increases the likelihood that Medicaid eligibility will become known--often against the wishes of those involved.

Comprehensive compliance auditing discussion

The last issue that was not included in the original report also surfaced at the Governor's Council. The orignal assumption was that the State Department of Education currently provides comprehensive special education compliance reviews every three years. From the discussion at the October 30, 1996 meeting, staff shortages mean that the frequency and depth of DOE compliance auditing may be unpredictable. Medicaid audits and special education audits review different regulatory issues and, so, cannot be provided by the same staff. But, the regulations are premised on "individual" needs and the Medicaid program relies on the special education process to define the steps and provide the documentation.

If there are compliance issues within special education, there will also likely be compliance issues within Medicaid. This is of great concern to the author of the report since the

recommendation assumed reliable compliance audits within the special education environment.

As one involved in the daily operations of a Medicaid billing program that supports services to children with special needs, I am aware, more than most, of the effort and expertise needed to keep this kind of program on a positive track. Over the past six months I have been observing Alaska's potential in its own environment. I see a desire to move forward with this effort but the necessary expertise does not seem to be available. As indicated in the report: Alaska needs to develop its own expertise. Those who are capable must have strong Medicaid and Special Ed background in order to develop a viable school billing program. No available leadership has surfaced. Capable, yes; available, no. This effort is major and responsibilities to get the program up and running cannot be included with other responsibilities--at least at the start-up. It will require a single-focused effort by highly organized and skilled persons. Considering that during the process of researching the potential and the follow-up to the council meeting, literally everyone contacted within DOE, DMA and the schools seemed overwhelmed with current responsibilities. For example, three phone calls to one key administrator for information were not returned. This environment will make it impossible for anyone to be successful.

If you have any questions or comments, please call me to discuss it. Thank you for your support and the opportunity to assist the State of Alaska with the research and process of Medicaid billing. I hope things are going well for you and the Council and that you will be able to complete your recommendation process soon. I wish you and your capable staff a wonderful holiday season!

Sincerely,

Sandra Peterson

Sandra Peterson
(800) 378-3563

cc: Dave Williams, DMA

REPORT FOR:

The GOVERNOR'S COUNCIL ON DISABILITIES
AND SPECIAL EDUCATION

REVIEW AND ANALYSIS:

EVALUATING THE POTENTIAL FOR THE STATE OF ALASKA TO PURSUE MEDICAID FUNDING FOR HEALTH-RELATED SPECIAL EDUCATION SERVICES

October 16, 1996

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TABLE OF CONTENTS

I. ACKNOWLEDGEMENTS

Thank you to the individuals and agencies who generously contributed their time, effort and resources to gather information and data which helped in developing the recommendations and evaluating the potential for the State of Alaska.

Special thanks to those individuals listed below:

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Robyn Rehmann	Special Education Director, Anchorage School District
John Stamm	Supervisor for Related Services, Anchorage School District
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Millie Ryan	Governor's Council on Disabilities and Special Education
Bob Tanna	HCFA, Regional X, Medicaid Provider Requirements, Seattle, Washington
John Hart	University of Alaska, Continuing Education
Brian Saylor	University of Alaska Anchorage

II. INTRODUCTION: HOW THIS REPORT IS ORGANIZED

This report includes several separate sections which are intended to provide background and information critical to understanding the issues around the potential to pursue Medicaid funding to reimburse school districts for health-related special education services. It is intended to be a basis on which the Governor's Council on Disabilities and Special Education can make a decision.

EXECUTIVE SUMMARY

This section provides a brief summary of the issues to be addressed around implementing an efficient Medicaid School-Based Health Services Program in the state of Alaska, the rationale for the recommended approach and the barriers to be overcome as well as a brief description of the economic and fiscal impacts.

PROCESS FOR DEVELOPMENT OF RECOMMENDATIONS

This section describes the process which was used to develop the report. This includes the various information sources both in the state as well as outside the state that were instrumental in gathering input for this report. This also includes a section about the contractor's background and experience in the subject areas.

SUMMARY OF RECOMMENDATIONS AND BARRIERS

This section lists each of the key issues and the barriers that had to be considered in the development of the report and the recommendation associated with each of these issues. More detailed discussions of the issues and recommendations are provided later in this report.

BACKGROUND AND ENVIRONMENT

This section provides general information on the current state and federal laws relating to Medicaid funding for health-related Special Education services. The basic rationale for pursuing this funding source and the experience of other states are also discussed.

REVIEW OF MEDICAID REIMBURSEMENT REQUIREMENTS

This section builds on information provided in a publication entitled, "EPSDT School-Based Children's Medical Services Program" produced in June 1993 by the State of Alaska, Department of Health and Social Services, Division of Medical Assistance and a Proposal entitled "Medicaid School-Based Health Services" by the State of Alaska, Department of Health and

Human Services, Division of Medical Assistance dated September 21, 1993. This background of Medicaid and Special Education requirements is intended to provide the Characteristics of an efficient program that meet Medicaid and Special Education criteria.

IMPLEMENTATION ACTIVITIES

This section includes implementation activities of enrolling school districts as Medicaid providers using information provided by the Division of Medical Assistance and two sample school districts. It also includes the implementation activities of the Department of Education and the Division of Medical Assistance as well as describes other implementation activities of the Alaska State Legislature and DMA State Plan Amendments and Federal Waiver requests that may become necessary if the program is implemented.

THE KNOWLEDGE BASE: ANALYSIS

This section includes a summary of key data which has been gathered by the contractor regarding numbers of children who are receiving services in the school environment under special education . This summary includes an analysis of the scope, frequency and level of services which may result in reimbursement for the school districts. It includes data from the Alaska census and the Alaska DOE special education census reports required by federal law. It also includes MMIS reports from the Alaska Division of Medical Assistance as well as selected school district statistics.

ISSUE DISCUSSIONS: EVALUATING THE POTENTIAL

This section presents a series of issue discussions regarding the key questions that must be addressed before the Governor's Council on Disabilities and Special Education can make a decision. This basic format includes discussion issues which surfaced in other states during the development of their School-Based Health Services program. It also includes discussion of unique issues which surfaced as a result of research and analysis while developing this report. It also includes principles and criteria for an evaluation plan.

FISCAL IMPACT SUMMARY

This section includes a brief summary of the fiscal impact on the State of Alaska if a Medicaid-funded School-Based Health Services program were implemented. This summary was prepared by an independent consulting firm.

III. EXECUTIVE SUMMARY

This section provides a brief summary of the issues to be addressed around implementing an efficient Medicaid School-Based Health Services Program in the state of Alaska, the rationale for the recommended approach and the barriers to be overcome as well as a brief description of the economic and fiscal impacts.

The report reviews and analyzes the costs and benefits of enrolling school districts to bill Medicaid for special education health-related services. The report is intended to assist the Governor's Council on Disabilities and Special Education in its decision to pursue Medicaid reimbursement to provide more services to children with special needs. Cost projections are conservative so as not to overstate the potential revenue and expenses of implementation and operation that offset revenue are also provided.

The several barriers the State would have to overcome include political barriers at the state level--barriers which would allow districts to keep the funds they generate--as well as Medicaid regulations that will require waivers in order for an efficient system to be implemented. Several technological barriers also exist: (1) development of a Medicaid eligibility verification system that is efficient for school districts and (2) revision of the Division of Medical Assistance Medical Management Information System. Any one of the identified barriers that cannot be overcome could result in the project's failure.

The recommendations, if implemented, will result in a cost-effective system that allows districts to benefit from billing Medicaid. Without careful system design, full participation by districts, legislative support, recommended waivers approval and without utilizing the rehabilitation model instead of the traditional medical model, however, the resulting reimbursement system could create a cumbersome mechanism with limited benefits and little return for the level of effort required. The potential for new revenue cannot be realized without full effort and support from the state's leadership.

The basic strategy in developing an efficient and effective system was to build the program around the federal special education legal requirements that districts must follow. This strategy reduced the cumbersome processes which control service levels for traditional Medicaid programs and built upon existing federal laws, service delivery within the special education environment and fine-tuned the existing Medicaid reimbursement system.

The design included mandating full participation for all districts for which it is reasonable. The design of the mandate included incentives which assured districts keep the funds they generate and can determine use of funds in a fair and appropriate manner. The program implementation included a

start date of Fall of 1997 and a three-year time frame to allow for development of staff, policy and procedures and necessary legislative and federal approval.

Process for Development of Recommendations

The process for developing the recommendations began with gathering and reviewing information about Alaska's Medicaid programs. Medicaid programs background information was provided by the Department of Health and Social Services, Division of Medical Assistance who also provided information about the proposed school-based health program and the current time study program funded by Medicaid. Background information was reviewed and discussed with DMA staff.

Information was also gathered from 27 other state school-based Medicaid program managers to determine what their issues and experience in billing Medicaid have been.

The contractor drew on extensive experience with the School-Based Health Services Billing Program in the state of Oregon where over $10 million in Medicaid funds have been generated in 1996 for school districts through this program. Using this program format as a model for the potential, the contractor began to identify the essential requirements necessary for a viable Medicaid program in the special education setting in the state of Alaska.

In developing program parameters, recommendations were limited to Medicaid reimbursement for health-related services to student's with IEPs and to those services delivered by appropriately credentialed school staff. As each Medicaid requirement was identified, research was conducted which provided information about the ability of the school districts in Alaska to meet the Medicaid requirements. Options and variables were considered. Some alternatives were discusssed with federal Medicaid regulators in Region X of the Health Care Financing Administration. And, the Code of Federal Regulations provided guidelines to options when other specitic requirements were found to be unmet.

When findings indicated no alternatives were available, for example, when it was clear that some school providers were not appropriately credentialled to be reimbursed by Medicaid, options were explored for these providers to gain the appropriate credential.

Data provided by the Division of Medical Assistance which calculated Medicaid-eligible populations by school district was used to identify statewide potential. DMA data was used to match even more specific data provided by the Juneau School District. This data represented actual numbers of children served in each category as well as the actual numbers of children receiving billable services. This information, combined with other information from the Oregon model, provided the basis for the statistical calculations.

The potential revenue calculated was a conservative reimbursement amount based on the cost to deliver the service. The next step was to adjust revenue projections to reflect the way services are provided in various locations within the state. This net revenue was then projected over a three-year period which provided a basis for certain other recommendations.

ABOUT THE CONTRACTOR...

As an employee of the Oregon Office of Medical Assistance Programs from 1981 through September, 1995, Sandra Peterson was project coordinator for the Oregon School-Based Billing Program which was developed soon after federal legislation permitted states to pursue Medicaid funding for health-related special education services. Sandra spent two years at the Oregon Department of Education developing guidelines , evaluating service activity and training and presenting program details to professional, administrative and clerical staff.

After implementation of this new Medicaid program, Sandra returned to OMAP to develop and implement a new Automated Information System, coordinate provider information and manage provider services staff prior to and during implementation of Phase I and II of the Oregon Health Plan. She left the State of Oregon in September of 1995 and currently contracts with health-care provider organizations who primarily serve the various Medicaid populations--mental health, Indian health, public health departments and school districts--to advise on Medicaid policy, technical issues, (electronic telecommunications for claim and eligibility verification) and provide organizational leadership.

In October 1995 she became the Executive Director of the Education-Based Medicaid Corporation, a non-profit corporation of school districts for whom she provides organization leadership, technical assistance and consultation on matters of billing Medicaid.

Summary of Recommendations for Implementing an Alaska Special Education/Medicaid Billing Program

ISSUE	RECOMMENDATION
Administration Where should responsibility for administration of the program be placed?	The Division of Medical Assistance and an interagency advisory group composed of members from DMA, the Department of Education (DOE) and Regional School-Based Billing Centers should administer the program. This group should enlist the services of a project leader who provides organizational administrative support. Besides providing project leadership for school districts that bill for Medicaid reimbursement, the primary objectives of this advisory group should be to promote effective collaboration among all agencies serving children with special needs.
Infrastructure What is the most efficient and least costly infrastructure needed to administer the billing program?	The Division of Medical Assistance should contract directly with Regional School-Based Billing Service Centers. These Centers would gather service data from districts and report data to DOE and DMA (MMIS) who would then collect, process and share reports with one another and the Governor's Council.
Coordination How would implementation activities be coordinated?	The interagency advisory group should determine activities of the project director who would lead districts through the process according to a workplan. Three years would be required for full program implementation.

Covered Services

What services should be included in the billing program?

Basic Health Services should include physical, occupational and speech therapy, skills orientation for blind, deaf and developmentally delayed (except academic) visual and audiological treatment, certain mental health treatments.

Screenings and evaluations to determine eligibility for special education and health care aides, nursing services and delegated nursing tasks, and direct expenditures for outside medical evaluations should also be included.

Transportation costs to the covered services and support activity directly related to those services identified on a student's Individual Education Plan which have been determined according to federal rules and regulations should be covered as reimbursable.

Training

What training would be required for districts?

Requirements to meet Medicaid standards include learning how to report and document information. Support staff must also learn technical billing procedures. These procedures are all new to the school districts. Inservice workshops for orientation as well as ongoing training would be required.

Continuing education for service providers who need to meet Medicaid provider standards in order to bill for services would also need to be made available.

School District Participation

Should a school-based Medicaid billing program be mandated or optional for districts?

Based on qualifying criteria, school districts should be required to participate in Medicaid reimbursement so consistent and reliable procedures can be developed. Without full participation, resources cannot be adequately managed.

Verifying Medicaid Eligibility

How would school districts verify which students were Medicaid eligible?

DMA would have to develop a way to provide a database match of students who are Medicaid eligible. Monthly verification by name, date of birth (DOB) or Social Security Number (SSN) is necessary to identify on which children to submit a claim.

Monitoring

Who would monitor the overall services to Medicaid children?

DMA, through Billing Center/District Peer Review Committees, should be responsible for monitoring Medicaid billing activities and reporting service levels. MMIS reports can provide a basis for analysis. Peer review Committees could utilize MMIS reports and make policy recommendations as well as provide educational audits to districts. Analysis could also identify overlapping service areas. The Governor's Council on Disabilities and Special Education should then be able to make recommendations to the Governor for managing services more efficiently or effectively.

Duplicate services

Can duplicate services be measured?

One way to gather data (which the state currently does not have) is to bill school health-related services through DMA's Medical Management Information System.

Collecting data from several agencies through the same system would allow management reports to display data that can be analyzed for duplication of services.

Primary Reason to Bill Medicaid

What is the primary reason to pursue Medicaid funding?

The overriding reason to pursue Medicaid funding would be to improve programs and services provided to special needs children served by the several agencies and funding sources. Services may be expanded to children who need treatment but may not qualify under the current criteria. Care coordination services not currently provided to families may also be provided by districts with Medicaid revenue.

MMIS can also provide detailed service information critical to efficiently and effectively manage services to children with special needs throughout the state of Alaska.

Revenue

What "costs" could be shared or what revenue could be anticipated from federal Medicaid matching funds?

Costs to provide education of staff and the cost of processing the data from the service provider to DMA should be shared by districts that benefit from Medicaid reimbursement.

Revenue based on costs of providing services would grow as more districts became organized to gather information and as more speech teachers became ASHA certified. Projected annual revenue is provided in the body of the report.

New dollars into the state

What amount of revenue can be expected to be generated from the federal matching funds by billing Medicaid for health-related services provided in the school setting?

For each Medicaid dollar generated, 50% is from federal taxes. Theoretically, because reimbursement levels are based on the cost to deliver the service, no "profit" or excess is built in. Reducing funding at any level based on Medicaid reimbursement would result in decreased dollars for district to provide services and programs.

Before state decisionmakers consider reducing legislative funding appropriations

	due to Medicaid billing, compliance with federal supplanting issues neet to be fully evaluated. Another consideration: One district may be able to recover Medicaid dollars because they have a high percentage of students who are Medicaid eligible. Other districts may have none. To reduce funding across the board could unfairly penalize districts who have no Medicaid reimbursement potential.
Stability of Medicaid Eligibility How stable is the Medicaid population who may also be receiving reimbursable health-related services?	Many variables control who is Medicaid eligible. On any given month, one third of the Medicaid population or information may change: eligibility status, name or address etc. Other variables contributing to reimbursement instability include unpredictable rates of reimbursement, federal cooperation, covered conditions, services and service levels. Special eduation criteria can also experience changes, such as expansion of needed services or reduced identification of students. Alaska is currently at an above-average level of special education identification at 13% statewide. This percentage is more likely to move downward toward the national average of 11% of the state student population base. (Reported by Average Daily Membership-ADM)
Timing When could the state realistically expect to begin operating a Medicaid billing program in schools?	School year 1997-98 is the earliest a program could begin. Implementation activities will take a year--assuming major barriers are overcome.

Because Medicaid funding criteria and levels are likely to change at the federal level, the "window of opportunity" for the state of Alaska to develop this kind of program will not likely extend past 1997.

Technology

What technology is needed to communicate and manage data efficiently?

The DMA has free software that electronically communicates claims data from providers to DMA. While this would be adequate for submitting claims data in order for MMIS to make a payment decision, it would be necessary to develop software that can import data bases and generate reports to school administrators.

Efficient data management and analysis is impossible without this technology.

Hardware requirements would be minimal and necessary only for the billing centers.

Summary of Barriers to Implementing a Medicaid Billing System to Gain Reimbursement for Special Education Health-Related Services

What are the barriers in implementing a Medicaid School-Based Health Services Program?

Certain barriers which must be overcome are significant, but not insurmountable. As a background to understanding the task, one must recognize that the concept of Medicaid reimbursement for students with developmental disabilities is somewhat antithetical to traditional medical assistance programs. The most prevalent barrier is the lack of knowledge and understanding about what Medicaid can and cannot fund and about what schools, through special education, can and cannot do. The complexities of each area usually wear out even the most well-intentioned program planners when it comes to designing funding systems for children with special needs. The following explanation attempts to provide some perspective:

Historically, federal and state Medicaid policies and procedures have been designed to fund only the levels of service that are medically necessary--services which have traditionally restored a patient to an acceptable level of "health." This means the general policies, the claims processing systems and the control procedures are designed to prevent funding for all but the minimal level of "necessary services."

Medicaid programs do not, generally, develop policy to provide services aimed at achieving age-appropriate function for children. A school reimbursement program which funds services for children with developmental disabilities (and whose treatment may be seen as experimental in the traditional sense) is, therefore, contrary to the basic design of most medical assistance programs nationwide. These same programs also assume that services will be delivered in a traditional medical setting such as a hospital or a clinic. School buildings, as a medical setting, is not on the list of acceptable medical settings in federal Medicaid regulations. Nor do regulations recognize the need to deliver health services to a child who might be traveling on a bus from home to school. The comparable medical setting, of course, is an ambulance. These new settings for service delivery don't fit conveniently in either the Medicaid tradition or in the education tradition. Nor do regulations recognize the need to deliver service "in the least restrictive environment" which is a federal mandate in the educational setting.

There is also ongoing debate about what the individual needs of the child with disabilities are. Medicaid policy may take one stance; special education, another: For example, consider the ventilator-dependendent child who requests Medicaid funding for a portable ventilator: in some states, Medicaid policy covers a stationery ventilator, but considers a portable ventilator "not medically necessary"--or "for convenience only and frivolous"--even if it is less costly. This lack of recognizing that, today, children with disabilities go to school and they need portable equipment is another barrier.

Inflexible policies are slow to change because the historical standard is based on a traditional medical setting where the patient is transported to the service. That same concept, however, is also why Medicaid reimburses for transportation of a student to a covered Medicaid service. In the school setting, that means if the IEP requires transportation (school bus) in order for the child to get the occupational therapy provided by the District OT, then mileage could be reimbursed by Medicaid.

Another Medicaid policy resulting from the traditional medical setting is the barrier which describes what the relationship must be between the provider agency (the school district) and the health-caregiver. According to Medicaid, the relationship between a provider agency and the caregivers must primarily be employer-employee and not contractual. This regulation makes it difficult for a small district to be recognized by Medicaid as a provider agency because small districts often contract for their health-related services. These few examples are reasons why it is difficult to fund services in the school setting with Medicaid.

On the special education policy level, specific health-related services are mandated by federal legislation. Procedures are strictly defined, including set timelines for referrals, evaluations, decision-making teams to determine special education eligibility, decision-making teams to determine services to be delivered etc. State Departments of Education monitor school districts for compliance with these federal policies and procedures. When the process has been followed but services cannot be agreed upon, the grievance process or court system may decide which services a school will provide. While many services are provided under the special education mandate, many other services are limited by the same mandate. The limits are not understood by many decisionmakers. To quote from a March 1996 study on "IMPACTS OF STATE MEDICAID DEMONSTRATION WAIVER PROGRAMS ON CHILDREN" by Harriette B. Fox and Margaret A. McManus:

> ". . .benefits are limited for developmental or habilitative services, most importantly ancillary therapies, although these services may be covered by the OHP (Oregon Health Plan) when furnished through the schools."

While this statement may be explained as a poor choice of words, it is a common assumption, both within and outside the medical community, that when benefits are limited for developmental or habilitative services by lack of health-care funding, referring a child with disabilities to the local public school system will result in the necessary therapy for that child's condition at no cost and regardless of the child's needs.

The reality is that schools are mandated, under special education regulations, to provide health-related services, including therapies, <u>for those students who qualify through special education in order for that student to benefit from his education.</u> And, no

more. Some children need more therapy services than those mandated under special education legislation.

With the above background which discusses a knowledge barrier that extends beyond the state of Alaska, the following outlines the specific barriers the state of Alaska would need to overcome to implement a successful Medicaid funding program within the school district setting:

1. Determining Medicaid eligibility in a manner which is efficient for school districts. There are nearly 125,000 children in the Alaska Public School System; schools need to know which students are Medicaid eligible at the time of service.

2. Gaining ASHA certification for district speech/language teachers. Teachers may have a masters level speech/language degree, but not ASHA certification--a Medicaid requirement. Other "medical" credentialing requirements may also apply.

3. Gaining HCFA state plan approval for issues that appear to violate HCFA requirements. Examples: allowing SERRC to become enrolled as a school provider when SERRC is not recognized by the state DOE as a school entity; approval of a TPL waiver (third party liability requirement)

4. Changing the DMA claims processing system to include a new provider type: school districts.

5. Gaining legislative approval to authorize implementation costs and DMA activities to include permitting a new provider type.

6. Risking loss of other Medicaid funded services. Ongoing monitoring would be required to assure there is no unintended negative impact on programs or on children with special needs. Examples: the TEFRA option and the Medicaid-funded time study for administrative services.

7. Establishing an efficient, economical and accountable system for two program areas--education and health care--that already have strict federal mandates but have little control over the needs of the population served.

IV. BACKGROUND AND ENVIRONMENT

This section provides general information on the current state and federal laws relating to Medicaid funding for health-related Special Education services. The basic rationale for pursuing this funding source and the experience of other states are also discussed.

Discussion of Federally Authorized Programs for Children with Disabilities

To understand both the Medicaid and the Special Education environment, it is necessary to describe the several federally authorized programs which apply to this examination of funding services to children with disabilities. When programs are optional for states, this examination will indicate state options by underscoring the text. Otherwise, the assumption should be that the programs are federally mandated. Alaskan agencies responsible for administering federal programs are indicated.

The following discussion of federal programs is necessary to fully examine the question and to lay the foundation for the Council in its decision-making process.

A.1. Medicaid

Medicaid, a federal/state funding mechanism, was established in 1965 by Title XIX of the Social Security Act to provide medical assistance for selected groups of low-income individuals and families. The states have considerable flexibility in structuring their Medicaid programs.

Within broad federal guidelines, each state Medicaid agency determine:

- who is eligible
- types, amounts and duration of the services covered
- sets the rates of reimbursement for services.

As a result, Medicaid varies considerably from state to state.

Responsible Agency: In the state of Alaska, the single state Medicaid agency is the Department of Health and Social Services, Division of Medical Assistance.

According to the Annual Report FY95 of the Division of Medical Assistance, 55,202 children from birth through 20 years of age were Medicaid eligible and enrolled for the Healthy Kids Program which is the name of Alaska's EPSDT Program.

A.1. a. EPSDT Program

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is the child-specific federally required component of the Medicaid program. All Medicaid-eligible children are entitled to services under EPSDT.

The EPSDT program covers

- periodic screening to detect physical, mental, vision, hearing and dental problems.
- treatment (including hearing aids and eyeglasses) and dental care (including preventive, restorative and emergency care, and, when necessary to correct a disabling condition, orthodontics.)

States must pay for partial or full health assessments between regularly scheduled screens if a child is suspected by anyone (parent, educator, developmental or health professional) of having developed any type of problem, whether new or whether a pre-existing condition that has worsened.

A.1.b. Capturing EPSDT data in Alaska

Processing claims through the DMA's Medical Management Information System (MMIS) allows the state to report the screenings, evaluations and treatment for children served through Medicaid funding. DMA reports that certain EPSDT information is missing due to the encounter reporting methods of the Indian Health Service (IHS) facilities. DMA reports cannot differentiate among the various services provided from IHS facilities.

A.1.c. Children with Complex Medical Conditions in Alaska

Statistics from the Division of Medical Assistance Annual Report FY95 show that there were 35 Children with Complex Medical Conditions under their Medicaid Home and Community-Based Care Program. Medicaid-covered services received by these children totaled $1,333,942 in expenditures for FY 95.

In addition, the state of Alaska participates in an optional federal Medicaid eligibility program known as the TEFRA Option (from the Tax Equity and Fiscal Reconciliation Act of 1982) or also known as the "Katie Beckett" provision. Under this provision, states can extend Medicaid to certain children with disabilities who live at home. The term "Katie Beckett provision" derives from the case of a ventilator-dependent child who could have been cared for at home but remained institutionalized only because the income and resource rules made her ineligible for SSI and therefore ineligible

for Medicaid. Children must meet the SSI definition of disability and must require the level of care that is available in a hospital or a nursing home but which can also be appropriately provided outside the facility.

To qualify for the TEFRA option under Medicaid, a child must meet all the following criteria:

- be 18 years of age or younger
- have a qualifying disability as defined under federal law
- meet the institutional level of care requirement
- have a plan of care with cost equal to or less than that which would be required to maintain the child in an institution.
- child must live in her natural home

The Division of Medical Assistance funded services to 172 children under the TEFRA option during FY 95. Total TEFRA Medicaid expenditures for FY 95 were $1,238,552.

A.2. The SSI Program (for children with disabilities)

The Supplemental Security Income (SSI) prgram for children is a federal benefit program for children with chronic illness (of significant health impairment) and disability. SSI is a federal cash-assistance program funded and administered by the federal government through the Social Security Administration (SSA). Its purpose is to guarantee a minimum level of income to children who are blind or disabled. Children who receive SSI benefits have severe chronic health problems which last 12 continuous months or are expected to result in death, are disabled or blind and have limited income and assets. These benefits are important to families whose children have diverse, extraordinary needs. In addition, SSI eligibility can provide an avenue to health-care insurance through Medicaid.

Medicaid covers many of the health-care expenses that mount up quickly for children with chronic illness or disabilities. In 31 states children eligible for SSI are automatically enrolled in Medicaid. In another seven states, including Alaska, children who are eligible for SSI are eligible for Medicaid, but are required to apply for Medicaid and SSI benefits separately.

Responsible agency: In the state of Alaska, eligibility determination for children with disabilities is the Division of Vocational Rehabilitation Disability Determination Unit.

A.2.a. Eligibility Criteria Changes Affecting Children receiving SSI

A provision of the July 17, 1996 Welfare Reform Legislation eliminated the Individual Functional Assessment (IFA) tool as a basis to determine eligibility. Many children with disabilities were determined eligible for SSI

using this assessment tool. New criteria is now being developed to reevaluate those children. It is unknown how many children in Alaska will be affected by this change in federal legislation. Early projections, nationally, however, indicate the overall drop in eligibility to be small--at the 5% or less level.

A.3. Special Education

Special education and related services are designed to meet the unique needs of a child with a disability, in conformance with each child's individual education plan. Such services include, but are not limited to , specially designed instruction, transportation and such developmental, corrective and other supportive services as required to assist a disabled child to benefit from special education, including speech pathology and audiology, psychological services, physical and occupational therapy, recreation and medical and counseling services. Medical services are for diagnostic and evaluation purposes only.

Responsible agency: Special Education in Alaska is administered by the Alaska Department of Education.

A.4. Early Intervention

Part H of the Individuals with Disabilities Education Act provides assistance to states to develop and implement statewide, comprehensive, coordinated, multidisciplinary, interagency programs of early intervention services for infants and toddlers with developmental delays and their families.

Children from birth through 2 who are experiencing developmental delays in cognitive development, physical development, language and speech development, psychosocial development and/or self-help skills, or those who have a diagnosed physical or mental condition which has a high probability of resulting in developmental delay are eligible. At state discretion, eligible children may also include those from birth through 2 who are at risk of having substantial developmental delays if early intervention services are not provided. Families of eligible children are also eligible for services.

Covered services include those designed to meet the developmental needs of infants or toddlers with disabling conditions in conformity with an individualized family service plan (IFSP).

Such services include those provided by qualified speech and language pathologists and audiologists, occupational therapists, physical therapists, psychologists, social workers, nurses and physicians in conformity with an individualized family service plan.

Responsible agency: In Alaska, the Department of Health and Social Services, Maternal Child Health (MCH) is responsible for the Infant Learning Program and is the lead agency for the Early Intervention Program.

INTRODUCTION:

While thirty-eight states report they have a Medicaid program to reimburse school districts for health-related services prescribed on the Individual Education Plan for each Medicaid-eligible child, the programs vary widely and participation and success are mixed. Some Medicaid programs require (1) each employee (who is medically credentialled) to enroll as a Medicaid provider, (2) a physician referral for each service and (3) require school districts to bill all private health insurance before pursuing Medicaid as a funding resource. Each of these requirements precludes school districts from successfully participating in a billing program since these requirements run counter to the operations of an education program. In some cases, there is a direct violation of ethics: for example, a public school system must provide a "free and appropriate public education" and can be legally at risk if they use a child's private health insurance.

Since the contractor's experience was primarily in Oregon where great care was taken to utilize the strengths of the Medicaid requirements through the EPSDT program and to develop a program that respects the federal-defined special education process, twenty-seven other states were contacted to capture and highlight what was working and what was not working throughout the nation.

A summary of the responses from other states follows:

<u>What are the primary reasons school districts do not bill for school-based services through the School Reimbursement Medicaid Program:</u>

Sixteen out of 27 states reporting identified paperwork as primary reason school districts have not wanted to participate in the Medicaid billing program.

Nine out of 27 states reporting identified concerns about Medicaid funding as reasons school districts have not wanted to bill Medicaid.

•Florida reports that 1) school districts are not participating because it is not profitable, 2) districts must bill only direct costs so the incentive to participate is low, 3) speech therapists do not meet federal provider requirements and 4) most services are considered educational and are not Medicaid reimbursable.

•Nevada schools don't pursue Medicaid funding because only the large districts can benefit and they believe it is too difficult for small districts to pursue reimbursement.

•Illinois schools have aggressively tried to build a Medicaid reimbursement program for several years, however, they report that many districts do not participate because Medicaid regulations make it difficult for them to enroll as providers.

•New Mexico schools are not only concerned about the impact of additional federal requirements they are subjected to by billing Medicaid but they are also concerned about the perceived complexity of the billing process.

Not all states have the same concerns:
•For example, the state of Nebraska requires participation by public schools if they provide therapy to any Special Education students. The Nebraska Governor has contracted with a billing service that promotes districts to bill for all services in order to maximize the federal draw. Nebraska learned, however, that many of the school districts have no special education students who receive occupational therapy, physical therapy or speech therapy; some speech therapists are not qualifiable by Medicaid, and some schools have no Medicaid-eligible students that do not have other insurance. This means the district must pursue the private insurance first before billing Medicaid. If they do not pursue all other resources, then they cannot bill Medicaid for the services.

What services do most states include in their Medicaid School-Based Programs?

•Twenty-two out of 27 states can bill for therapy services; 11 out of 27 can bill for EPSDT screenings and subsequent evaluations. Other services, like nursing varies from state to state.

Do any states allow school districts to bill for nursing services?

•Direct nursing services can be billed in14 out of 27 states with the state of Missouri only allowing services provided by a nurse practitioner to be billed. This is because in Missouri, RNs and LPNs do not have provider standing with Medicaid. As in most Medicaid programs, RNs and LPNs can bill only for private duty nursing.

Do any states mandate that schools bill Medicaid for IEP services?

•Idaho and Utah mandate schools bill Medicaid for IEP services. They have also mandated that all of the revenue goes to the state budget. Incentives to participate are low and Idaho Medicaid is considering changing the current

distribution of Medicaid reimbursement for IEP serves to allow schools to retain more of the funds.

Consultation with Oregon School Providers

•An informal telephone poll of Oregon school districts asked service providers if they had a choice to bill or not to bill Medicaid. Districts were also asked what their biggest initial hurdle was. Results follow:

Eighteen out of 20 said they would chose to bill Medicaid because the revenue was seen as beneficial to the district and the students served. The biggest hurdle was licensing or obtaining ASHA certification for speech therapists who were not properly credentialled for Medicaid reimbursement.

Comments: Documentation practices required by Medicaid have raised the standards of special education reporting. These increased standards have been beneficial to the district, to communication between service provider and has improved recordkeeping practices of student health-care special education records.

Improvements in documentation practices have led to better continuity of care when students move out of the district or are required to be treated by another service provider.

Speech pathologists who had to return to class to continue their education in order to become qualified to bill Medicaid report that their level of professionalism has improved significantly. They report they are more marketable for employment in another setting such as a hospital, rehabilitation center or nursing home and they take pride in their elevated standing among other special education professionals.

Overall, there were 397 speech therapists in Oregon schools in 1991; approximately 60% had to upgrade their Teacher's Standards and Practice Commission credentials to either American Speech and Hearing Association (ASHA*) certification or Oregon State Licensure. To date approximately all but 15% have accomplished this standard over the past five years.

Nearly all districts report they have rewritten job requirements for speech pathologists to include state licensure, Clinical Fellowship Year (CFY), or ASHA CCC as a condition of employment. Not all districts, however, require ASHA certification.

Most districts initially paid for the licensure process and the annual license fee for the first five years. The cost to districts to educate and certify their speech pathologists averaged $4,000 in one Education Service District. Costs have varied from district to district because some service providers needed

more additional education than others. Now, most all districts require employees to pay for professional licenses. Continuing education, however, is generally an employee benefit within the educational community.

ASHA Certificate of Clinical Competence

The American Speech and Hearing Association (ASHA) is considered by most speech pathologists to be a highly influential professional organization. The author participated in a national ASHA conference in Baltimore, Maryland in May of 1991 when the mood of the organization was extremely hostile to the concept of school districts billing Medicaid for services provided through special education programs. They feared the dollars taken by schools would diminish the pool of dollars going to private providers.

Today, the American Speech and Hearing Association embraces this school billing effort in part because school provider membership has brought increased financial and political support to the organization and has raised the awareness of public educators of the importance of professional medical credentialling.

ASHA has revised its standards and methods of obtaining certification to meet the need of speech pathologists who had to be able to maintain employment while obtaining ASHA certification. It is now possible to obtain ASHA certification without taking a leave of absence to return to school. Many universities have developed programs for speech pathologists who desire to obtain ASHA certification. There are three university programs in Oregon, and several in other Northwest states; however, there are currently none in the state of Alaska.

Those districts in Oregon that required speech pathologists to obtain certification felt the greatest benefit has been to the infants, children and youth who have a superior quality of therapy with the higher standards.

The Union ESD Special Education Director, when asked if he would force his speech staff to upgrade to ASHA standards, said, "absolutely. It was one of the best things I ever did for kids." Even though the ESD's outlay for the 20 speech pathologists employed by the ESD was $80,000, the Director said it was a wise staff development investment. The new standard impacted speech pathologists statewide. The author spoke with no one who said they wouldn't upgrade their speech staff standards. All interviewed said the result has been positive in every way--although the process was sometimes painful.

V. REVIEW OF MEDICAID REIMBURSEMENT REQUIREMENTS

This section builds upon information which was provided in a publication entitled, "EPSDT School-Based Children's Medical Services Program" produced in June 1993 by the State of Alaska, Department of Health and Social Services, Division of Medical Assistance and a Proposal entitled "Medicaid School-Based Health Services" by the State of Alaska, Department of Health and Human Services, Division of Medical Assistance dated September 21, 1993. This update is intended to provide the Characteristics of an efficient program that meet Medicaid and Special Education criteria.

MEDICAID REIMBURSEMENT REQUIREMENTS

A fundamental Medicaid requirement is that the provider of services must verify eligibility prior to delivering a service.

However, the current method of phone verification would not work efficiently for either the Division of Medical Assistance or for school districts. To request phone verification monthly on over 15,000 children would be highly impractical and costly.

The school setting is unlike other health-care provider settings in that the physician or hospital provider usually has benefit of the patient providing the Medicaid-coverage ID card. In the school setting, it is impractical and discriminatory to ask a child to produce proof of Medicaid-eligibility.

A school district may know how many students are Medicaid eligible, but they don't know which students are Medicaid eligible.

Which service activity can be reported for Medicaid reimbursement?

Education-based reimbursement for special education health (medical) services is still a new concept nationwide. It requires a careful examination of what service activity can be reported to qualify for Medicaid reimbursement. No two states have approached the issue the same and no two states have the same program or procedures.

The success rate of education-based health-related service coverage varies widely state by state. In some states the Medicaid agencies have maintained a traditional-medical setting approach and have required schools to become Medicare-institutional certified following hospital criteria. Other state Medicaid agencies have attempted to consider the educational setting and the federal requirements of both the education setting and the medical setting. The federal regulations coming from the Office of Special Education and the Health Care Financing Administration are the source documents for fully exploring the marriage of these health care delivery settings.

In Alaska, the Division of Medical Assistance would need to fully understand how the services are delivered in the special education setting in order to write policy that makes sense to health-care providers who will report and document services provided. Which activites and what activity level should be reported for Medicaid reimbursement must be fully explained to the school providers whose instructions and objectives to date have been to help the students benefit from their education--not to meet medical objectives. Some service activity is obviously medical; other service activity is obviously educational; other service activity needs to be examined by both educators and DMA to explore the potential. This is a new setting for health-care delivery. There is little precedence. Knowledgeable persons who take time to observe, learn and apply basic Medicaid regulations can define a program to meet the needs of the service providers in the eduational setting. It is no small task, however. It will take several years to fully develop policy.

Two examples: (1) Traumatic Brain Injury (TBI) was not considered a special education classification a few years ago. (2) Children diagnosed as Autistic is also included special education eligibility classification. Both categories of children require extensive medical intervention. The TBI child has more clearly defined medical needs than the child who has been diagnosed as autistic. Autism, however, is a medical diagnosis. Some medical treatment programs are covered by Medicaid under a more-traditional mental health rehabilitation category.

For the autistic child, the debate about what treatment is educational and what treatment is medical is a national debate. Nationally, there is also little agreemen' about what is or what is not effective treatment for children diagnosed as autistic. And, many decisions about what treatment is necessary is being decided in the court system--not by educators or by the medical community. Whatever policy is developed about services delivered to these populations today will undoubtedly change as more knowledge about effective treatment for these children is gained.

Technology forces Medicaid reimbursement in other-than-medical settings.

As in the past, medical technology advancements permit more children to live in the home and community setting where services must be delivered. Precisely which services will be billable to Medicaid and which will not be billable cannot be determined by a general policy. Observation and analysis by a knowledgeable Medicaid policy person will be required in order to develop specific guidelines to education-based service providers that can withstand a Medicaid audit.

New policy and providers prompts ongoing Medicaid analysis.

The providers of services cannot unilaterally determine which of the services services they provide are billable. Likewise, a Medicaid policy person cannot write policy that is so vague as to mislead providers to report any service activity for Medicaid reimbursement. This approach to opening Medicaid funding is irresponsible. One cannot expect a claims payment system to deny claims for inappropriate services when the service categories are broadly defined. On the other hand, the claims payment system (called the Medical Management Information System--MMIS) that actually pays the claim is set to pay according to editing criteria. It would be just as irresponsible to define each procedure so specifically that the procedures must be coded to the degree of the medical community. These universally-adopted procedures have taken decades to define in the physician and hospital settings.

"Who" delivers the service is critical to Medicaid reimbursement.

To further complicate the "what's covered and what's not" issue, services are not delivered the same throughout the state. Urban areas have more access to medically-qualified staff who give more direct service; rural areas are often remote from the medically-qualified staff who may only deliver direct services to students once a month or even more sporadically. The problem of having access to medical providers in rural settings is universal throughout the United States, not just in Alaska. However, it is of greater significance to Alaska because of the remoteness and size and the lack of transportation infrastructure that makes these rural communities dependent on others to provide services.

Urban areas usually employ more direct service providers; rural areas and villages usually contract for service providers who are paid daily to evaluate, treat the student and monitor services delivered by para-professionals who do not qualify as medical providers under Medicaid standards. Services delivered by para-professionals in educational settings are generally not reimbursable by Medicaid.

Basic Medicaid rule: Medicaid reimburses only the provider of services.

In exploring which school districts provide their own special education health-related services and which contract with others outside their district, it became known that 35 of 54 school districts contract with South East Regional Resource Center (SERRC). SERRC is a non-profit service organization which employs medically-credentialled staff who provide evaluations and treatment

of referred children, and who provide education and monitoring of paraprofessionals who actually deliver most of the health-related services.

SERRC is the provider but SERRC is not a school district. Therefore, for Alaska DMA to define the school district as the provider of services would eliminate the services provided by SERRC. While other states have defined school districts as the provider of services, it may be possible to otherwise define the education-based health-related provider to include SERRC, but this situation would depend heavily on HCFA approval. Without including this health-care provider, the majority of these small districts would be ineligible to receive Medicaid reimbursement on any level.

Medicaid task: Sorting out which service activity is "medical" in nature and which service activity is "educational" in nature.

HCFA's explanation was that the intent of the amendment under section 411 (k) (13) of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) was "to ensure that services that would ordinarily be provided or paid for by other agencies for handicapped children would be continued." Covered services would include those, "that are medical or remedial in nature."

HCFA specified that formal educational services were those relating to training in traditional aacademic subjects. Subject matter rather than setting, time of day or class size determined whether or not a service was education. Within this context, there are overlapping objectives of services delivered in the educational setting which must be clearly identified so the school service providers understand what is educational and what is medical. Even though the service provider is medically credentialled to perform the task, this identification process is no simple task. Every state must undertake the identification of services task--recognizing the historical nature of each unique environment--the one for educational purposes and the other for medical purposes.

Why Medicaid reimbursement is a funding source: The changing nature of services delivered in the educational setting.

The full impact of IDEA had not begun to be felt until recent years. All children, regardless of their disability, have had a right to a free and appropriate public education since the inception of Public Law 94-142 in 1975. This federal requirement opened the door, in some cases, for the public schools to provide extensive evaluation and treatment services that could only legally and ethically be provided by medically-qualified staff. It was for this reason that the need to explore and support health-related services in the educational setting has become a necessity.

The impact of IDEA will continue to expand and will need to be re-evaluated as the nature of the services delivered in the educational setting continues to cross into the medical environment. Attempts to change the IDEA process through federal reauthorization of the Act have been unsuccessful.

States which attempt to control budgets find themselves in competitive environments where one state agency cost shifts to another to rid themselves of costly programs. When the federal government mandates responsibility to one area, in this case to Education, that agency is left somewhat defenseless and often underfunded. The federal government promised to fund health-related services by up to 40%. To date, federal funding has not exceeded 12%. Other states' experience shows that those states which have not mandated collaboration nor participation among all responsible agencies have been left with little or no support for the task of funding medical services delivered in the educational setting, particularly through special education.

As resources become even tighter, educational agencies will experience attempts by other agencies to shift more and more costs by referring to school districts in order to deliver services to children in the educational setting. In some states where Medicaid managed care has become commonplace, the services ordinarily provided in a fee-for-service environment have been delayed or not provided at all through the managed care providers. The result: children with developmental disabilities have been referred to the education system for evaluation and treatment--the assumption being that the service is a "free" service to all children through Special Education--an assumption which may or may not be based on reality.

Considering the many changes occuring all at once in the health-care community and the lack of understanding of how services are provided in the education community, some communication errors are unavoidable. States that strategically plan for such changes by including all agencies who serve children, however, can avoid most of these unintended results.

An Example of Unintended Results that may Result from Schools Billing:

Alaska's Department of Health and Social Services, Division of Medical Assistance 1995 Annual Report shows there were 35 children with complex medical conditions who received services under the Medicaid Home and Community-Based Care Program and 172 children who received Medicaid through the TEFRA (Tax Equity and Fiscal Reconciliation Act of 1982) Option. One of the primary considerations under these Medicaid-covered reimbursement options is that the cost to provide services outside the institutional setting would be equal or less than that which would be required to maintain the child in an institution.

Since the costs to provide health-related services in the education system has not previously been measurable through the MMIS claims processing system, it is conceivable that this additional cost would cause some children's expenses to increase to the point that they no longer qualified to receive Medicaid coverage through these programs and options.

Case in point: Some of these children would be receiving the following services in the school-setting that would be reimbursable under a School-Based Program:

Occupational Therapy	Speech Therapy
Physical Therapy	Daily Skills Training
Personal Care Attendant	Hearing and Audiologal Services
Low Vision Services	Orientation and Mobility Services
Nursing Services	Delegated Nursing Services
Evaluation services in all categories above	Transportation to and from school-based providers of these services

Depending on the level of services and reimbursement costs, this "package" of services based on individual need could add up to several thousand dollars in monthly reimbursement to school-based providers.

DMA is responsible for fiscal oversight and monitoring of program costs and would be required to add the costs of delivering services in the school setting to the overall costs of Medicaid expenditures. This unintended outcome impacting one or more children currently receiving Medicaid through these programs/options would clearly be counter-productive. An initial comparison between those children receiving services at school and those children in the TEFRA Option program shows little risk that these children would exceed their allowed threshhold amounts. Expenditures should be tracked closely, however, if a school billing program were implemented.

Note: Other states may not have encountered this because they do not participate in the TEFRA Option or they have minimal school reimbursement programs.

SPECIAL EDUCATION: UNDERSTANDING THE AUTHORIZATION FOR MEDICAID REIMBURSEMENT

The first consideration for the Council is to understand the limit of the school district population under consideration. Only students receiving a health-related evaluation or treatment under the "IDEA" legislation qualify for Medicaid reimbursement under the P. L. 94-142 and Title 4, Chapter 52 Alaska Administrative Code.

School districts must have a process in place to take referrals of educators, parents, the medical community, specialists, the courts, to adequately assess a referred child's condition to determine whether or not either special instruction or treatment is necessary for a child/student to benefit from his education. Special Education law covers children from school age (6) through their 21st birthday.

This "process" is defined by federal law complete with timelines which are a critical part of the process. School districts risk financial penalties if they are found to be in violation of the special education requirements. The categories of disabling conditions defined by federal law and are explicitly defined and described in the Alaska Administrative Code: Title 4, Chapter 52 Special Education Regulations (January 1995) produced by the Alaska Department of Education. Categories qualifying for special education are these:

Mental Retardation
Hearing Impairments
Speech or Language Impairments
Visual Impairments
Serious Emotional Disturbance
Orthopedic Impairments
Other Health Impairments
Specific Learning Disabilities
Deaf-Blindness
Multiple Disabilities
Autism
Traumatic Brain Injury

It is imperative to acknowledge that the only services qualifying for Medicaid reimbursement are those evaluation, treatment or related services provided through the above categories. As identified above, these categories are specifically defined in federal legislation. The scope of any proposed Medicaid reimbursement is not intended to cover any evaluation, treatment or related services outside those categories as there is no authorization to do so.

For example, a child may have been injured in a car accident which significantly impairs this student to participate in his educational program. While the school district may accommodate that student under separate federal legislation so he can continue his educational program on schedule, this "injurious condition" would not likely qualify for "special education." One reason is that the federal definition requiries that the disabling condition be a disability of nine months or longer in duration. In other words, the criteria for special education qualification is specific and unless the process is

followed according to the federal law, one could not and should not assume that a child qualifies.

Reimbursement for Health-Related Service Delivery in the Alaska Educational System: One Way it Could Work

One way to reimburse for health-related special education services in order to meet federal requirements to make payment to the provider of services is to develop and to then contract with regional educational entities. There may currently be regional organizations which could assume the role and responsibility of a "billing center." An example could be

1. The "Southeast Regional School-Based Provider System of Juneau,"
2. The "Southwest Regional School-Based Service Center"or
3. The "South Central Regional School-Based Provider System of Anchorage" etc.
4. The "North Central Regional School-Based Provider System of Fairbanks"

These "four" designated School-Based Provider Systems would function as the "billing provider (in MMIS terminology) or billing center or health-services administrator" and could be a consortium of local education agencies (school districts) responsible for health-related services under special education law. Conceptually, these organizations could also serve as Intermediate Service Agencies with multiple functions.

These Provider Systems could receive payment based on electronic reporting on claim format to the Division of Medical Assistance with the following information:

•Name, and Medicaid number of the child.

•Condition of the child reported according to the ICD-9 diagnosis coding system. (Cross-coding of child's primary disabling condition according to special education category would allow sophisticated analysis for tracking services.)

•Description of services delivered reported according to procedure codes developed specifically for this purpose. This information would include date of service, units of service, place of service and amounts charged. Amounts charged would be based on the cost of delivering and supporting the service.

•Provider identification number: Juneau School District, Fairbanks School District etc. would be considered the provider of services.

These "providers" would be responsible for assuring that the service was delivered by an appropriately credentialled service provider.

When a service could not be delivered directly by a school provider, the S-BP System could "contract" for services to be delivered by other community providers such as Southeast Regional Resource Center or the local mental health contracted provider. These services could also be billed through a School-Based Provider Billing Program. This "contract" billing would not necessarily add new services, but could provide revenue for more adequate service levels that should be given, but cannot be provided due to limited funding. "Contract" billing would also allow existing relationships which are currently providing efficient health service delivery to continue. Contract services could be billed at the same or different rates under a separate procedure code from those services provided by staff.

This billing center would keep service records identifying the plan of treatment (the Individual Education Plan which identifies all health-related services to be delivered) as well as all service logs which furnish the documentation of service delivery.

One of the primary functions of this "administrator" would be to identify students who are Medicaid eligible and forward pre-headed service logs to the treatment provider on a routine basis ie. monthly.

Services could be expanded beyond special education in the future as DMA determined other services that could be reimbursed through these Provider Systems i.e. EPSDT screenings or mental health.

This service delivery model focuses on the school setting as a natural and efficient way to deliver services to children, including children with special needs. The alternative model focuses on the medical setting as the primary method of delivering services. The medical setting is the method of choice for those states where managed health care plans are the primary delivery methods for the Medicaid population.

As all states, the Alaska Division of Medical Assistance has been investigating ways to control costs while assuring quality care. One option could be managed care. This consideration may be a factor in the direction the state chooses: coordination through the educational setting or the medical setting.

It is recommended that any exploration of an integrated service delivery model include the process of identification and service delivery through federal and state special education and early childhood special education and be expanded to include early intervention (Infant Learning Program) in the future.

Several other states, including Oregon, have designated the Department of Education as the lead agency for the Early Intervention program. This increases the federal participation to the School-Based School Billing to include the birth-3 age range. The percent of infants in the Early Intervention program is much higher than pre-school and school-age only. Alaska would not have benefit of receiving reimbursement through a school-based billing program for like services provided to the Early Intervention infants who qualify for Medicaid unless and until this population was included.

Many health-care services are delivered in the school-setting outside of special education, including routine public health services (communicable disease control, head lice etc.) and alcohol, drug and tobacco, teen pregnancy, as well as other health impairments (allergies, medication administration and monitoring).

Efficient and effective health-care service delivery integration to children doesn't happen easily for two reasons:

1. As one perceptive speaker succinctly described the problem: Within both the education and medical environments there is a pervasive and traditional disease known as "TURF-DUMB."

2. Even when this "disease" is in check and the motivation "to do the right thing at the right time" is great, the health-care needs, delivery and funding of services to children with disabilities is incredibly complex.

With this basis, the following characteristics of an efficient program that meet Medicaid and Special Education criteria are identified:

Characteristics of an efficient program that meet Medicaid and Special Education Criteria.

1. DMA will establish billing relationships with a few billing centers such as "four" rather than each school district. This will:

a. Provide an efficient and simplified structure since DMA would be communicating with four entities instead of 55.

b. Allow a train-the-trainer structure for ongoing communication, education and information-sharing. The "four" entities could develop site coordinators at each reporting district and provide the staff training, monitor the billing activity and documentation. Staff turnover could best be handled

by cultivating resources who know both Medicaid requirements and special education requirements.

c. Keep costs low for hardware, software and eligibility verification. DMA would only need to establish electronic connections with these four entities. Interaction with DMA staff would be more manageable with four points of contact than with 55.

d. Provide flexibility in district needs vs. state needs. Reporting could be uniform to the state yet be flexible enough to meet local district needs and differences. Billing centers would be responsible for all reports to DOE and DMA.

2. The school billing program will include all services that can be covered under a Medicaid rehabilitation program that are also required through health-related special-education and prescribed in the plan of treatment known as the Individual Education Plan, such as:

Occupational Therapy	Speech Therapy
Physical Therapy	Daily Skills Training
Personal Care Attendant	Hearing and Audiological Services
Low Vision Services	Orientation and Mobility Services
Nursing	Delegated Nursing Tasks
Evaluation services in all the above categories	Transportation to and from school-based providers of these services
Counseling and mental health	

3. Health-care providers who are qualified to deliver services under the rehabilitation model but who may not be reimburseable under a medical model will qualify based upon careful examination of medical credentials or academic standards recognized within the state of Alaska. Providers of services for which there is no medical standard may qualify through other examination standards.

4. The federally-defined process of identification and eligibility for special education services would be the reimbursement model on which to base program coverage decisions and policy. Through the Medicaid EPSDT program, identification, screening, evaluational, referral and treatment through the IEP process can all be reported under EPSDT services so DMA can continue to meet its federal standards.

By designing the Medicaid program around the IEP program there will be the least disruption (1) to the child who has been referred and identified as needing a related-health service under federal special education rules and regulations and (2) to the service provider who is legally required to follow the IEP process. School districts with the responsibility to follow special

education law will continue to identify, refer and evaluate Medicaid-eligible children as with all children and to begin treatment according to the specific timelines required by law--without delay caused by physician referral, DMA authorization or managed care plan referral or authorization requirements. Such delays cannot be tolerated for children with developmental disabilities.

To design a program to meet the traditional Medicaid model would unnecessarily delay or withhold services to children with developmental disabilities and could also create a system which provides negative incentives for schools to postpone or withhold services pending Medicaid authorization procedures. This program design would defeat the purpose for which the special education process was developed.

5. Reimbursement rates to school districts would be based on the cost of delivering the service in the school setting and not according to private provider reimbursement which may include profit. Each district may report a separate fee schedule for the services provided, however, DMA may reimburse at one or more levels. Costs and reimbursement rates should be revised annually.

6. Out-of-pocket medical services should be reimbursable to districts for medical evaluations provided for a specific child when those services cannot be obtained by a district provider.

7. Services which are contracted by districts because it is the most efficient way to obtain needed qualify services should be reimbursable to districts, based on cost to purchase the service and for which the provider qualifies under federal Medicaid enrollment requirements. Until and unless federal laws are changed, some small districts may not qualify to be an enrolled Medicaid provider because they do not "employ" any staff person for whom services may be billable.

8. School districts should provide their own state matching funds for special education so that the Medicaid program budget remains neutral. Medicaid or other state funds would be used for non-special education services. The differences could be tracked precisely based on procedure codes billed.

9. While the Division of Medical Assistance has the legal obligation, the leadership would be shared with the Education providers through the four billing centers. These responsibilities would include reporting expenditures to districts and provide oversite activities to monitor service levels and provide ongoing technical support and training to district staff. Requesting federal waivers and state plan amendments, developing program policies and establishing eligibility verification methods, producing provider manuals, revising the MMIS system to recognize school districts as providers,

calculating reimbursement rates, developing procedures and paying claims, however, would be the ongoing responsibility of DMA. Program maintenance and liaison between DMA and the billing centers would also be required.

VI. IMPLEMENTATION ACTIVITIES

This section includes implementation activities of enrolling school districts as Medicaid providers using information provided by the Division of Medical Assistance and two sample school districts. It also includes the implementation activities of the Department of Education and the Division of Medical Assistance as well as describes other implementation activities of the Alaska State Legislature and DMA State Plan Amendments and Federal Waiver requests that may become necessary if the program is implemented.

A. COSTS AND BENEFITS OF ENROLLING SCHOOL DISTRICTS AS MEDICAID PROVIDERS

SUMMARY of COST PROJECTIONS

	Implementation	Ongoing
DMA costs		
Capital	$35,000	
Training (guide)	$10,000	
Operations	000	
Staff	$68,400	$98,800
Travel		$15,000
SubTotal	$113,400	$113,800
Billing Centers		
Capital	$16,000	
Training	000	
Operations		$72,000
Staff		$316,800
Travel		$60,000
SubTotal	$16,000	$448,800
Districts		
Capital	000	
Training	$276,500	
Credentialing	$ 80,250	
Operations		
Staff (Not out of pocket)		$300,000
Travel		
SubTotal	$356,750	$300,000
TOTALS	$471,750	$862,600

($300,000 of this is not out of pocket)

SUMMARY OF REVENUE PROJECTIONS

YEAR 1:	$5,300,000	or	50% = $2,650,000 (new) federal revenue
YEAR 2:	$5,500,000	or	50% = $2,750,000
YEAR 3:	$5,600,000	or	50% = $2,800,000

When the costs are subtracted from the net revenue, Alaska will benefit by approximately $1.8 million the first year--most likely increasing the benefit as the program matures.

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Billing Center Costs (Proposed 4 sites)

The following expenses would likely be borne by the aggregate school districts. Figures are rounded for ease of comparison. Costs and expenses are used interchangeably.

Expense:	Rate/cost	Duration
Staff costs		Implementation/ongoing

The following staff will be employees and subject to 50% admin overhead added to salaries (admin included):

Coordinator (Supv) (.75 FTE)	$45,000	Each year; ongoing
Clerical Expenses (.75 FTE)	$27,000	Each year; ongoing

Three sites will cost out at the above rates; one remote site costs out at 40% differential. Calculations include four sites with one reflecting the differential.

TOTAL Estimated Staff costs (Including one site at 40% differential)	$316,800	all sites
Operating Expenses Office supplies and forms	$1,500/mo	Each year; ongoing
TOTAL Estimated operating expenses	$72,000	all sites
Equipment costs		
486 computer, printer, terminal, modem, etc.		$2,000 hardware
Communications software and tracking		$2,000 software
TOTAL Estimated equipment costs	$16,000	all sites
Travel expenses For training, meetings and oversite activities.		
TOTAL Estimated travel expenses	$60,000	all sites

DISCUSSION OF DISTRICT IMPLEMENTATION costs (55 districts):

1. Training costs: There are approximately 428 professional staff and 55 clerical staff statewide who would need training to participate in the billing program. Due to the few hours of time, the costs for this would most likely not be actual dollars expended. In keeping with the conservative approach to this project, however, these costs are treated as actual dollars.

Professional Staff Training Costs: For cost projections, contractor assumed average staff salaries of $70,000 (FTE) plus 50% admin overhead. Training time assumed to be 8 hours/school year for each professional staff person (includes meeting time to discuss Medicaid billing) X 428 staff. ($617 each professional)

SUBTOTAL estimated professional training time costs: $264,000

Clerical Training Costs For cost projections, contractor assumed average clerical (Billing) staff salaries of $30,000 plus 50% admin overhead. Training time assumed to be 16 hours for each district coordinator --$226 x 55 (includes meeting time to discuss Medicaid billing) staff statewide.

SUBTOTAL Estimated clerical training cost $ 12,500

TOTAL Estimated (Indirect) Training Costs $276,500 Implementation

2. Indirect Staffing costs Each of the 55 district would need to designate a facilitator and administrator to be responsible for reporting and administrative oversite. Variables: Not all districts will participate; however, the assumption for estimates include participation at 100%.

Position and estimated % FTE		Cost	Duration
District Billing Facilitator	.10 FTE	$1,500	Annual
Administrative (supv)	.05 FTE	$4,000	Annual

TOTAL Estimated Indirect staffing costs for district coordination = $300,000

TOTALS (1) and (2) = $558,000 Estimated Statewide Cost to Districts

3. Credentialing costs At start up, $750 continuing education for each uncredentialed staff person may be needed; all other educational costs would be borne by individual staff as in the past.

From data supplied by Anchorage, Juneau and SERRC, 75% of all service providers (including speech) are currently professionally licensed or would be reimbursable under a rehabilitation model. An actual comparison of staff credentials would take approximately three months to assess.

TOTAL Estimated Statewide Direct cost for credentialing $80,250 statewide

TOTAL PROJECTED ANNUAL REVENUES	$5,300,000 (Rounding up)
TOTAL PROJECT IMPLEMENTATION COSTS	$ 471,750
TOTAL PROJECTED ANNUAL EXPENSES TO COLLECT REVENUE	$ 862,600

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DISCUSSION OF REVENUE PROJECTIONS The estimated revenues are conservative and the variables include:

1. Age range covered. The estimates include only those students receiving services under special education. If the Early Childhood population (3 - 5 year olds) were included, this would expand the reimbursement base. Likewise, if the Infant Learning Program (Birth - 3 year olds) were included, this would also expand the reimbursement base.

2. The availability of qualified staff. Estimates include assumptions on a somewhat equal basis statewide. This is particularly variable in the state of Alaska. Some districts would be unable to receive any reimbursement due to lack of service providers.

3. Number of Medicaid-eligible children receiving billable services by qualified providers on any given date. Estimates will vary district by district and from month to month and year to year in response to the varying economic conditions in Alaska. Based on the Division of Medical Assistance estimates of eligible children in each school district, the percent of children who are Medicaid eligible varies from 1% in Chugach to 71% in Kashunamiut with the average being 24%.

4. Frequency of service by qualified providers. Some larger districts such as Anchorage, Juneau, Kenai have on-staff professional service providers directly delivering the service. Other districts depend on contract service providers who may only deliver a direct service once a month. This unpredictable frequency of billable services will also cause fluctuations in revenue.

5. IEP services identified and appropriately indicated. District practices also vary in identifying and detailing the IEP plan of treatment. This

variable will also result in unpredictable revenue projections from district to district.

6. Efficient communication systems/coordinating technologies. Unless a statewide communication system can be implemented with efficiency, eligibility verification and reporting of services for billing to DMA will result in inconsistent and unpredictable revenues.

7. Transportation services that may be billable. There is currently no way to assess the potential revenue from transporting the child to a Medicaid-billable service. The variety of conditions by which districts identify transportation on a child's IEP and the actual provision of services cannot be calculated with any predictability. Therefore, these costs are not included in the revenue projections except for the Juneau School District. Potentially, small districts could benefit the most from transportation reimbursement; however, they are also least likely to have standing as a Medicaid provider due to federal requirements that they "employ" their staff.

BENEFITS TO CHILDREN AND FAMILIES, SCHOOL DISTRICTS AND THE STATE OF ALASKA:

1. Improved quality of service to children by promoting higher standards of therapy staff. Focus on professional medical licensure reinforces current direction of education to have the highest professional standards wherever possible.

2. Increased revenue to districts to fund improved overall services to all children, particularly children with special needs.

3. Increased internal and external awareness of special education process, including timelines and legal requirements.

4. Increased cooperative agreements between medical community, managed care organizations that surface, and school medical providers.

5. Provides opportunity for professional growth and awareness of medical model blending with educational model of delivering services. Many education therapy staff have not worked outside the school setting.

6. Improved special education recordkeeping and staff communication which should result in better coordination of services to children with disabilities.

7. More frequent inclusion of nursing staff in MDT and IEP meetings. Increased awareness that nursing assessments can prevent unnecessary therapy because student had medical condition undetectable by therapy staff.

8. Reduces potential for duplicate evaluations thereby reducing unnecessary stress on children and unnecessary time and effort of families with children with disabilities.

Intangible Costs that may become Management Issues:

1. Resistance of staff to the review of job and treatment activities.

2. Resistance of staff to improve service delivery documentation. Some districts currently require no progress reporting other than that which is officially required on the IEP and re-evaluation schedule.

3. Revision of job descriptions to include Medicaid reporting, tracking and documentation activities.

4. Perception that districts will change IEP procedures or policy to "chase" Medicaid dollars.

5. Perception that districts will be induced to divert qualified staff to Medicaid-eligible children while non-Medicaid-qualified staff will be assigned to other students. May result in parent complaints or ethical issues within some districts.

6. Belief that increased workload for reporting, tracking and documenting services for Medicaid-eligible children is unreasonable and unnecessary. May result in union issues in some districts.

B. IMPLEMENTATION ACTIVITIES AND PROGRAM COSTS NECESSARY FOR STATE AGENCIES:

COST TO DEPARTMENT OF EDUCATION

Other than participating in planning meetings of key DOE staff, there should be few costs to the Alaska Department of Education. Support would be policy analysis and program development versus technical, administrative or oversite. DOE should assure that special education procedures are understood and followed during development of a Medicaid reimbursement program. This report assumes Special Education monitoring occurs statewide on a required three-year cycle.

COST TO DIVISION OF MEDICAL ASSISTANCE (DMA)

Costs to DMA could be substantial since it requires developing a new provider type, system changes and federal waiver and state plan amendment approval. The major tasks necessary for program implementation are outlined with estimates of staff cost required to complete the tasks follow:

1. Establish new provider type for schools billing Medicaid for Special Educationclaims processing modification. This requires legislative authority as well as significant system modification.

2. Provide streamlined eligibility verification method

3. Request Third Party Waiver and State Plan Amendment from HCFA The waiver process and SOA could include travel to HCFA Region X in Seattle and the process can be labor intensive due to a written response process to explain program to approving authority.

4. Gain State Legislative Approval for School-based Reimbursement Program. This process could be procedurally cumbersome but may not be politically difficult if the legislature acknowledges revenue benefits the state would receive.

5. Develop policy and provider manual including forms and process This task can be tedious and timecomsuming and will likely include annual revisions. Contractors can assist with the task.

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Project Leadership costs may be borne by districts but included in DMA costs. Funds for this leadership would likely need to be forward funded as DMA would not have this in their budget.

Implementation Project leader(.50 FTE)		
Contract Costs	$46,000	Each year; first three years
Travel Expenses	$15,000	Each year; first three years
SUBTOTAL Project Leadership:	$61,000	Annual for three years

DMA staff time equal to the following FTE to complete implemention and administrative tasks by current staff. Salaries used were provided by State Personnel salary levels. Implementation period is considered to be the first 6 months prior to program: Fall 1997.

Position	Ongoing	Implement
$46,000 for Policy Analyst	.20 FTE	.50 FTE Imp
$24,000 Clerical	.10 FTE	.25 FTE Imp
$40,000 Systems Analyst	.05 FTE	.50 FTE Imp

Assume addition to salary of 50% of salary for benefits, supervision and office set-up (Admin overhead)

SUBTOTAL Estimated Current Staff Costs to implement program:
$68,400 First six months

SUBTOTAL Estimated Current Staff Costs for ongoing program:
$37,800 Each Year; ongoing

Can be agency or contract staff. HCFA will match 50% for development and operations coverage. This match rate will not be included in cost projections.

DMA system changes	$30,000
Eligibility verification system	$ 5,000
Production of Provider Guide	$ 10,000
Staff travel expenses:	$ 15,000

TOTAL Estimated Implementation Costs	$ 113,400	Six months Prior
TOTAL Estimated Ongoing Costs	$ 98,800	Annual (3 Years)

VII. THE KNOWLEDGE BASE: ANALYSIS

This section includes a summary of key data which has been gathered by the contractor regarding numbers of children who are receiving services in the school environment under special education. This summary includes an analysis of the scope, frequency and level of services which may result in reimbursement for the school districts. It includes data from other states' experience as well as from the Alaska DOE special education census reports required by federal law. It also includes MMIS reports from the Alaska Division of Medical Assistance as well as selected school district statistics.

Estimating the potential for reimbursement through a School-Based Billing Program for health-related services was based on data provided by the following agencies:

- The Division of Medical Assistance who generated a report identifying the number of Medicaid eligible children in each of Alaska's 55 school districts.

  This report for Fiscal Year 1995-96 school revealed the total Medicaid-eligible student population to be 27,275 out of District Attendance figures of 122,770 or 22.2% of the population. For purposes of estimating numbers being served through special education, a conservative estimate based on actual figures in Oregon, is that 24% of the special education population receiving billable services are also Medicaid eligible.

- Juneau School District provided actual counts of providers according to a table of billable service providers used in Oregon. The district also provided a count of students receiving services that qualify for reimbursement under the rehabilitation service delivery model. These numbers were used to calculate potential revenue for that district as well as provide the basis for projecting numbers for other districts and the state.

- The Alaska Department of Education provided the Federal Report of Children and Youth with Disabilities receiving Special Education under Part B of the Individuals with Disabilities Education Act for December 1995. This report identifies number of service providers, by category, as well as number of children identified, by category, to qualify for special education. For purposes of calculating potential revenue and based on experience in the State of Oregon, children within the Learning Disabilities category receive few, if any, reimburseable services so that category was excluded in revenue projections.
  This report identifies 15,600 children (rounding) receiving

special education services and 428 professional staff statewide who deliver services. Neither figure represents actual numbers for purposes of calculating revenue.

Each year, the Alaska Department of Education must systematically collect statistics from all school districts for the current school year in compliance with federal law. This requires reporting the number of students qualifying under the above primary disabling condition categories: the "December 1 child count" for school year 1995 (96) for students aged 6 - 21 was 15,598. (This total includes optional reporting categories that may affect those who qualify by some 640 students.)

For purposes of this report, there were 15,600 students who were identified for special eduation in Alaska. The total school population for the same school year was 122,770. This reflects approximately 13% of the total student population identified for special education which is slightly higher than the national average: 11%. For a more comprehensive analysis of the collection and reporting, interested persons should contact the Alaska Department of Education.

- Southeast Regional Resource Center also provided data for districts they serve and for which service categories they provide and estimated the approximate frequency of direct services. SERRC serves 34 of the 55 districts, but provide billable services to only 29 districts.

The most reliable data available was that provided by Juneau School District who also provided names and date of birth to DMA for a future match against Medicaid eligibility files for more accurate numbers of Medicaid-eligibile children in that district. The data provided by Juneau School District was, therefore, used as a basis for revenue projections, as reflected in the tables provided by Health Outcomes Plus.

One notable variable is the service level of speech services at 23% of the total number of billable services provided. In Oregon, actual frequency and services provided equal 68% of the total revenues received. Due to the frequency and numbers of children who actually receive speech therapy across several disability categories, the 23% figure may be very low.

Due to the high cost of implementing a school-based billing program and the considerable level of effort, revenue projections are conservative and, lacking actual data, a consistent methodology was used and errs on the conservative side. The revenue projections follow.

VII. ISSUE DISCUSSIONS: EVALUATING THE POTENTIAL

This section presents a series of issue discussions regarding the key questions that must be addressed before the Governor's Council on Disabilities and Special Education can make a decision. This basic format includes discussion issues which surfaced in other states during the development of their School-Based Health Services program. It also includes discussion of unique issues which surfaced as a result of research and analysis while developing this report. It also includes principles and criteria for an evaluation plan

Principles and Criteria
For evaluating
The administration and infrastructure
of an Alaska Medicaid/Special Education Billing Program

The administration and infrastructure of the system would be:

EFFICIENT, ECONOMICAL AND ACCOUNTABLE TO taxpayers, providers, state agencies, local districts and , most importantly, to the children (students) served.

Providing funding without reporting requirements that allow responsible management of funds cannot be considered by state administrators. Reporting scope, frequency and level of services provided is critical to future allocation of resources.

Utilizing current methods of reporting is an efficient use of the infrastracture in place in the State of Alaska. Modification of existing systems would assure an efficient, economical way to manage taxpayer dollars while capturing important data about services delivered.

Aggressive reporting requirements serves two important purposes:

1. Provides maximum federal participation as well as allows administrators the benefit of making informed decisions about health-related needs, better interagency coordination and delivery of services to children with disabilities.
2. Provides a reliable system that identifies duplication of services, disparities in services provided throughout the state and deficiencies in program policies. Clearly defined reporting requirements are easier for regulatory agencies to monitor.

SEAMLESS IN TRANSITION students should be able to continue to receive special education related services without experiencing delay or disruption in delivery of needed services.

A transition plan should be developed if the Council decides to implement a Medicaid-funded School-Based Health Services Program.

Providers of service should receive adequate training to be certain they understand service delivery, reporting and documentation requirements.

COST EFFECTIVE AND LEAST DISRUPTIVE (in the long run) to providers of therapy services for districts, to district administrative staff and to state agencies.

The program established to reimburse educational-based health-related programs should be designed specifically to accommodate the service delivery setting required by the federal special education legislation.

New federal funding should be measurable and earmarked to meet health-related needs of student that the state could not otherwise afford. Legislature as well as all involved agencies should agree to how any new federal funds would be used.

Districts should be reimbursed directly for all costs related to generating federal funding and receive benefit for health-related services to students.

Based on qualifying criteria and standards, school districts should be required to participate in the Medicaid reimbursement program so consistent and reliable procedures can be developed and maximum reimbursement potential can be realized. Without full participation, resources cannot be adequately managed.

AS SIMPLE AS POSSIBLE: the administrative structure should be as simple as possible to keep costs down, and be built to achieve the intent of federal rules and regulations while recognizing the limitations inherent in funding services where the need is always greater than the resources.

Neither the state Medicaid agency, the Division of Medical Assistance, nor the state Department of Education currently has the capacity to administer the program within their existing systems. Only by developing an interim structure could these agencies efficiently operate and administer a School-Based Health-Related Reimbursement program.

Several tasks, such as verifying which special education students are Medicaid eligible, would need to be systematized in order for school districts

to learn on which students to submit claims. The only mechanism now available to learn which students are Medicaid eligible is an automated phone verification system for providers who may inquire about a patient/student's Alaska Medicaid eligibility on a one-at-a-time basis.

RESPECTFUL OF FEDERAL SPECIAL EDUCATION RULES AND REGULATIONS AND FEDERAL MEDICAID RULES AND REGULATIONS AND LIMITS OF LOCAL SERVICE DELIVERY IN THE EDUCATIONAL SETTING:

Both federal programs, Special Education and Medicaid, are based on individual needs. Both federal programs are based on access to service issues.

The system should respect both the Medicaid purpose which is to provide access to needed medical services and the Special Education purpose which is to provide access to needed educational services. Both serve health-related needs of children as defined in federal laws and both are limited by program requirements and by the availability of health care providers who can meet those needs.

Full evaluation of special education requirements and Medicaid requirements should be performed before a Medicaid program is developed. This report is intended to provide information about most of the key requirements that need to be addressed. Many detailed and specific program requirements play a role in the ultimate success or failure of a Medicaid reimbursement program.

For example, a Medicaid reimbursement program should not be considered that encourages violation of the intent of health-related services provided in a special education setting.

Physical and occupational therapy services provided through the educational system are restricted in scope by the requirement that the goals be relevant to educational access. Some children with special health needs (e.g., those with mild physical disabilities) may not be eligible for services in the educational setting. This means that specific diagnosis may not be funded under either the federally mandated special education program or the state's Medicaid program.

Educationally based therapy programs usually do not have the capacity to address medically necessary therapy needs. The capacity and flexibility of service delivery through the educational system also varies greatly from location to location depending on the availability of service providers.

Services delivered through the educational system for children with special health needs are pertinent and beneficial. However, educationally based services may not be adequate in scope, frequency or format to provide the appropriate range of medically necessary therapy services for children with special health needs.

A thorough program evaluation of which services can be provided in the educational setting is possible when the program is underway--if there is a willingness by both parties to do so. What often happened in other states: there was no ongoing evaluation of service delivery. Medicaid program and policy staff are either unaware of service delivery gaps or assume no responsibility to plug the gaps. It would be impractical to be able to identify all the gaps before a program was implemented.

These gaps, once identified, could be met through the EPSDT process. This would : 1) allow the need to surface, 2) allow the diagnosis code (which identifies the condition that is not being treated) to be added to the "covered" benefits for children and 3) allow payment for these services to be authorized according to Medicaid criteria and be paid by the MMIS claims processing system.

Conversely, when a duplication of services is identified through evaluation and analysis of MMIS reports, ongoing program evaluation would surface this redundancy of services. The Medicaid program and policy administrator could then take appropriate action to prevent further duplication of services.

When an MMIS system is used effectively, it provides invaluable management information which controls costs for the entire state, not just the Medicaid agency. First, the information must be provided to that MMIS system. One way to gain control of the information is to report all health-related services paid through Medicaid through that system. This is not always popular or practical or appropriate.

When comprehensive service delivery to children with disabilities is uncoordinated with few measurable tools in place, gaps in needed services continue without systematic ways to remedy the need and duplication of services are allowed to continue. This may not be a problem in the State of Alaska: administrators have other indicators which give information about gaps in coverage or duplication of services. However, an MMIS system that captures precise data is one of the most efficient and effective ways to gather this information. Projections about service needs outside the Medicaid population can be made based on this information as well.

For this reason, if for no other, the Council should seriously consider implementing a Medicaid reimbursement program for School-Based Health Services Program.

Medicaid reimbursement programs cannot simply say to the educational provider "Go ahead and meet those needs and we'll pay for it."

The Medicaid program should be designed around the special education setting to the extent possible to maximize the revenue potential and minimize the program impact.

Each program area--special education and Medicaid--needs to evaluate the reimbursement program potential based on federal regulations which cannot be changed versus state program regulations or system requirements which may be inconvenient, but possible, to change.

In other words, a Medicaid reimbursement program focus should first be developed on what can be accomplished under the above criteria instead of what cannot be accomplished. Secondarily, the program focus should be on the cost to implement these changes--which may override what can be accomplished.

A PARTNERSHIP: an efficient program that meets both Medicaid and Special Education criteria will be a system that involves all agencies to the best advantage in meeting the special health-care needs of the children living in each Alaskan community.