

November 5, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2287-P
Mail Stop S3-14-22
7500 Security Boulevard
Baltimore, MD 21244



*Excellence and Equity
in Public Education
through School Board
Leadership*

Re: *Comments on Proposed Rule CMS-2287-P*

On behalf of the nation's 95,000 local school board members, the National School Boards Association asks that the Centers for Medicare and Medicaid Services (CMS) rescind its proposed rule [CMS-2287-P] to eliminate reimbursement under Medicaid for school administration expenditures and certain transportation costs published in the *Federal Register* on September 7, 2007.¹

NSBA strongly opposes this proposal, which would deny schools reimbursement for legitimate and necessary administration services undertaken by school employees or contractors and curtail the range of transportation costs that are considered eligible for federal financial participation (FFP), on the grounds that it: 1) contradicts the terms of the statute to allow states flexibility in administering their state Medicaid plan; 2) exceeds Secretarial authority; and 3) discriminates against schools. These points are explained in more detail below.

In addition, cutting funding for Medicaid outreach and services in a school setting is neither sound fiscal or social policy. In proposing this rule, CMS will impose a significant financial burden on local school districts, estimated to cost more than \$3.6 billion over the first five years. Conversely, the proposed federal savings of this rule represents less than 0.2% of 2006 federal Medicaid expenditures—a minimal impact on the federal budget.

More importantly, this rule would create a lost opportunity to reach our most vulnerable children. Every school day, close to fifty million students attend more than 97,000 public schools, uniquely situating schools to efficiently reach the majority of disadvantaged youth and their families.² If finalized, this rule will impede us from serving these populations.

Statutory Authority

Under the federal-state Medicaid program, collaboration with other public agencies is a consistent statutory theme. Collaboration is perhaps most obvious in the case of children, because of the unique requirements of the early and periodic screening, diagnostic and treatment (EPSDT) benefit, which requires states to perform EPSDT outreach and informing, as well as help Medicaid-eligible children and their families access services.³

¹ 72 Fed. Reg. 51397-51403 (September 7, 2007).

² NCES, 2005-2006, 2007-2008.

³ 42 U.S.C. §1396a(a)(43).

Office of Advocacy

- *Norman D. Wooten*
President
- *Anne L. Bryant*
Executive Director
- *Michael A. Resnick*
Associate
Executive Director

Schools are and have been a strategic partner in this process. They are ideal places to identify Medicaid-eligible children and connect them to needed services in schools and their communities, since children must attend school and they have access to professional specialists on site. As CMS itself indicated, in its Medicaid *School-Based Administrative Claiming Guide*, “the school setting provides a unique opportunity to enroll eligible children in the Medicaid program, and to assist children who are already enrolled in Medicaid to access the benefits available to them.”⁴

Because schools are such an effective location for outreach, many state Medicaid programs have entered into interagency agreements with local school systems. These agreements cover a range of activities including outreach, helping families through the Medicaid application process, and providing assistance to arrange necessary health care services for children.

School involvement in the Medicaid program is not only common among states; it is also expressly contemplated in statute. The statute’s eligibility determination provisions expressly designate elementary and secondary schools as “qualified entities” for purposes of making presumptive and permanent eligibility determinations in order to afford eligible children and adults the ability to promptly apply for medical assistance and be enrolled.⁵ In addition, CMS’ own *State Medicaid Manual* encourages state Medicaid agencies to coordinate EPSDT administrative activities with schools.

Furthermore, with respect to students with disabilities, Congress clearly intended to preclude the Secretary of Health and Human Services (HHS) from denying payment for Medicaid-covered services provided pursuant to a child’s Individualized Education Program (IEP). Under the *Medicare Catastrophic Coverage Act of 1988* (P.L. 100-360), school districts are allowed to receive payment from Medicaid as the primary payer for Medicaid services provided to Medicaid-eligible students under the Individuals with Disabilities Education Act (IDEA). Such services may include diagnostic, preventive, and rehabilitative services; speech, physical and occupational therapies; and transportation for such services. This proposed rule would expressly contradict the intent of this statute by reversing current policy that allows federal matching funds for transportation provided to children with special health care needs who receive health care services while they are at school.

Secretarial Powers

In its proposed rule, CMS relies on its authority under §1903(a)(7) of the Act⁶ to limit federal payments for administrative services to payments “found necessary by the Secretary for the proper and efficient administration of the state plan.”⁷ In making this assertion, the Secretary of HHS finds that these activities performed specifically *by school employees* are not “necessary...for the proper and efficient administration of the State [Medicaid] plan.”

⁴ CMS

⁵ 42 U.S.C. §1396r-1a(b)(3)(A).

⁶ 42 U.S.C. §1396b(a)(7).

⁷ 72 Fed. Reg. 51397.

NSBA believes that Secretarial authority in this regard cannot be construed to limit the power of states to administer their plans, or to act in the best interest of beneficiaries, or to involve other agencies in plan administration—which is exactly what this rule would do. Such action constitutes an overstep of Secretarial powers and a willful disregard for Congressional intent. As noted above, Congress itself has involved schools in the administration of plans, therefore, as a matter of law the Secretary cannot find that school administration is improper or inefficient.

In addition, this rationale makes little sense. State Medicaid programs enter into interagency agreements with local school systems precisely *because* they are effective and efficient locations through which to reach families and provide services. School-based outreach and enrollment activities are successful because they use school staff that are trusted by families and are already in the schools and in contact with children and families.⁸ It is inconceivable to think that state agencies would be able to effectively manage a program of this size without relying on local agency personnel to help administer and communicate information about the program.

Secondly, the Secretary's power to deny federal financial participation is tied to the duty of making findings. In this case, CMS points to several audits and the failure of its 2003 Administrative Claiming Guide to halt errors related to school administration claiming. However, the reports of abusive billing that CMS cites took place well *before* states were required to implement the 2003 guidance. Furthermore, the fact that audits are happening is not a valid basis for halting federal administrative payments. Were audits the basis for such a disallowance, there would be no payment under federal law for any medical assistance costs or state administrative service undertaken by either the state agency or any other agency.

In the world of accounting, audits are a commonplace way of improving the fiscal management of a program, not dismantling it. Negative audit findings should not reverse worthwhile public policies, but rather should inform the process of improving their fiscal integrity. In issuing this rule, CMS would rather eliminate an entire program than accept responsibility for improving its accountability.

Discriminates Against Schools

NSBA believes that the proposed rule overtly discriminates against schools since it attempts to disqualify local school districts from receiving Medicaid reimbursement for performing the same activities that other local agencies do in administering the state Medicaid plan. Despite statutory authority, case law, and precedent that establish an irrefutable basis for schools to receive Medicaid reimbursement, CMS seems set on prohibiting schools from receiving federal Medicaid dollars.

⁸ Center for Budget and Policy Priorities, *Administration Moves to Eviscerate Efforts to Enroll Un-Insured Low-Income Children in Health Coverage through Schools*, Washington: September 2007.

NSBA questions whether CMS is proposing that Medicaid agency staff should be stationed in schools to carry out administrative functions essential to securing health care services to Medicaid eligible children who need them. If this is the case, it should be noted that many state Medicaid agencies do not employ outreach and enrollment workers, service coordination personnel, or other personnel essential to the enrollment of children and carrying out EPSDT health care access obligations. As the statute illustrates, state agencies are expected to rely on other public agency staff to carry out their obligations. For those states that might have the resources available to commit their own employees into the schools, *this* certainly would be an inefficient approach.

In addition, the fact that other federal and local sources of funding exist to help provide health services to students with disabilities does not absolve the federal Medicaid program of its responsibility to provide payment for Medicaid services to Medicaid-eligible students. This issue was clearly decided by Congress with passage of the *Medicare Catastrophic Coverage Act of 1988*, which allows Medicaid to be the primary payer for Medicaid services for Medicaid-eligible students with disabilities. Schools should not be penalized financially, just because other departments of the federal government also have a responsibility to provide for these children. To propose so, is especially troublesome given that the federal government is woefully behind in its commitment to fund special education. In fact, current funding for IDEA is less than half of what Congress promised three decades ago to states and local school districts to implement this federal mandate.

Impact on Services

The loss of federal reimbursement for administrative and transportation services provided by school districts would have a devastating impact on schools' ability to provide needed services to Medicaid-eligible children. If finalized, this rule will risk poor children not being identified for and receiving needed medical services, and poor disabled students not receiving services in a timely manner.

The loss of these funds would force districts to scale back their special education and special services personnel (such as school nurses and social workers), increasing the specialist-per-pupil ratio. As a result, school personnel would not be available to link children with community medical and health clinics in their area through case referrals. In addition, services identified in a child's Individual Education Plan (IEP)—such as occupation and speech therapies, behavioral modification, counseling, dental and mental cares, and clinic or hospital-based services—could be affected.

Medicaid's transportation reimbursement has enabled school districts to continue to enhance their special buses with ramps, lifts, seat belts and personal aids for students with more severe disabilities. Some schools have used Medicaid transportation funds to hire more bus drivers to run additional routes to transport students for medical services. Without these funds, these enhancements and personal care services would have to be eliminated or scaled back.

Additionally, the loss of this funding will have permeating effects on other programs within schools. With Congress failing to fully fund IDEA, Medicaid reimbursement helps districts plug some of these funding holes. In light of this, these cuts will likely impact students in regular education programs since districts are mandated to offer many special education services. This could mean a variety of things—from larger class sizes, to cuts in electives and after school activities, to reductions in teachers and support positions. Otherwise, governments may be forced to replace lost Medicaid dollars by raising state and/or local taxes.

Financial Impact

Despite these very real and substantial costs, CMS indicates that this rule will not have a “significant economic impact” on local school districts. This finding is based on the assertion that the estimated cost (\$635 million in 2009) of the rule is only “about one eighth of one percent of the total annual spending on elementary and secondary schools” and therefore does not meet the 3 to 5 percent threshold of annual revenues or costs in determining whether a rule has a “significant” economic impact.⁹

This rationale is flawed for a couple of reasons. As CMS clearly knows, not all school districts currently claim or receive FFP for administrative and transportation services. Federal funding is spread unevenly between states, among districts, and between elementary and secondary schools. Therefore, to compare the cost of the proposed rule to overall nationwide spending for elementary and secondary education minimizes its financial impact. Additionally, a large percentage of school districts’ budgets are largely fixed due to contractual obligations and operational costs. Therefore, discretionary funds such as Medicaid reimbursement dollars have a much more significant impact on the availability of resources than if all aspects of a district’s budget were flexible.

A more realistic financial analysis would: 1) examine the financial impact of the proposed cuts only on districts that actually claim for reimbursements; 2) take into consideration the unique aspects (such as fixed costs) of school districts budgets; and 3) include the likely loss of state Medicaid funding that would result from schools no longer being able to sustain these programs.

Conclusion

Unfortunately, this rule demonstrates that the Administration has chosen to rely on bureaucratic arguments in order to retreat from supporting the health needs of our most vulnerable children. Local school board members urge CMS to rescind this proposal and to reaffirm its commitment to low-income and disabled children by continuing to invest in school-based administrative and transportation services. In order to ensure that low-income children are enrolled in Medicaid and are able to access the health care services that they need, schools must be a valued partner in the process. Local school board members want to work together to provide for our nation’s children—it is in the best interest of all of us to ensure that they are healthy and able to learn.

⁹ 72 Fed. Reg. 51397-51403 (September 7, 2007).

Centers for Medicare and Medicaid Services

November 5, 2007

Page 6 of 6

Thank you for this opportunity to comment on CMS-2287-P. Please direct any questions or comments to Chrisanne Gayl, Director Federal Programs at (703) 838-6763 or cgayl@nsba.org.

Sincerely,

A handwritten signature in black ink that reads "Michael A. Resnick". The signature is written in a cursive style with a large initial "M".

Michael A. Resnick
Associate Executive Director

MAR: cg/kc

N:Adv/Medicaid/110207CMSComments