



MemorandumMarch 13, 2008

TO: Senate Committee on Finance
Attention: Rodney L. Whitlock, Ph.D., Health Policy Advisor

FROM: Elicia Herz, Specialist in Health Insurance Financing
Cliff Binder, Analyst in Health Care Financing
Jean Hearne, Specialist in Health Insurance Financing
Rick Apling, Specialist in Education Policy

SUBJECT: Responses to Medicaid Regulation Questions Governing: Graduate Medical Education, Intergovernmental Transfers, School-based Services, Rehabilitation, and Targeted Case Management

Per your request, we are responding to your specific questions on Medicaid regulations recently issued by the Centers for Medicare and Medicaid Services (CMS).¹ Also as you instructed, we have framed our responses to your request in the context you described as if the proposed regulations did not exist:

“The questions below assume that none of the regulations are allowed to go into effect. Therefore, current statute and any regulations or guidance in place prior to the issuance of these regulations remain in effect.”

Your questions focus on specific aspects of selected issues addressed in the new Medicaid regulations regarding intergovernmental transfers (IGTs), graduate medical education

¹ The recently issued rules include:

- “Medicaid Program; Coverage for Rehabilitative Services,” *72 Federal Register* 45201, August 13, 2007 [P.L. 110-173 included a moratorium to delay the effective date of this rule until June 30, 2008];
- “Medicaid Program Optional State Plan Case Management Services,” *72 Federal Register* 68077, December 4, 2007 [this rule became effective March 3, 2008];
- “Medicaid Program; Graduate Medical Education,” *72 Federal Register* 28930, May 23, 2007 [P.L. 110-28 included a moratorium to delay the effective date of this rule until May 25, 2008];
- “Medicaid Program; Elimination of Reimbursement Under Medicaid for School Administration Expenditures and Cost Related to Transportation of School-Age Children Between Home and School,” *72 Federal Register*, 73635, December 28, 2007 [P.L. 110-173 included a moratorium to delay the effective date of this rule until June 30, 2008]; and
- “Medicaid Program; Cost Limit for Public Providers Operated by Units of Government and Provisions to Ensure the Integrity of the Federal-State Financial Partnership,” *72 Federal Register* 29748, May 29, 2007 [P.L. 110-28 included a moratorium to delay the effective date of this rule until May 25, 2008].

(GME), school-based services, rehabilitation services, and targeted case management (TCM). Therefore, the responses provided in this confidential memorandum are neither intended to be a full discussion of CMS' justifications for each new regulation, nor the counterpoints raised by opponents of the regulations. The Congressional Research Service (CRS) is preparing several reports on these new regulations that will encompass fuller discussions of these issues.

In the meantime if you have addition questions or need clarification, please contact staff as follows:

- IGTs, Jean Hearne (7-7362) or Elicia Herz (7-1377),
- GME and school-based services, Elicia Herz (7-1377),
- the Individuals with Disabilities Education Act (IDEA), Rick Apling (7-7352), and
- rehabilitation services and TCM, Cliff Binder (7-7965).

1.0 Intergovernmental Transfers (IGTs)

1.1 Can a state pay a hospital and require the hospital to return a portion of the payment to the state?

Under certain circumstances, a state can require providers to transfer funds to the state and because a provider's Medicaid receipts are indistinguishable from other receipts, effectively a portion of Medicaid payments may be included in those transfers. There are two allowable methods states can use to require hospitals to transfer funds to states: intergovernmental transfers and taxes. Each method has its own set of requirements. Congress specifically protects the ability of states to collect funds from governmental providers through intergovernmental transfers as long as those transfers are certified public expenditures (Section 1903(w)(6)(A)). States are limited, however, in their ability to collect funds from non-governmental providers. States are able to collect funds from all types of providers through taxes as long as the taxes comport with federal Medicaid law.

2.0 Graduate Medical Education (GME)

2.1 Is there any guidance in statute for how states should bill CMS for IME and GME?

Most states make Medicaid payments to help cover the costs of training new doctors in teaching hospitals and other teaching programs. Historically, both Medicare and Medicaid have recognized two components of GME: (1) direct graduate medical education (DGME) (e.g., resident salaries, payments to supervising physicians), and (2) indirect graduate medical education (IME) (e.g., higher patient costs in teaching hospitals due to treating sicker patients, residents ordering more diagnostic tests than experienced physicians).

There is one explicit reference to GME in the federal Medicaid statute. Section 1932(b)(2)(D)² of the Social Security Act stipulates that non-managed care organization providers (non-MCO providers) that deliver emergency care to an MCO

² Added by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171)

beneficiary must accept as payment in full (up to) the maximum amount applicable in the fee-for-service (FFS) setting, minus any GME payments.

There also is one explicit reference to GME in federal regulations at 42 CFR 438.6(c)(5)(v). This regulation stipulates that if a state makes payments to providers for GME costs under an approved state plan, the state must adjust capitation rates for managed care to account for those GME payments made on behalf of MCO beneficiaries, not to exceed the aggregate amount that would have been paid under the fee-for-service (FFS) delivery system. States must first establish actuarially sound capitation rates prior to making adjustments for GME.

These provisions are intended to prevent duplicate GME payments under Medicaid managed care since states may make supplemental GME payments directly to teaching hospitals outside of provider payments assumed in capitation rates to MCOs.

2.2 Do states bill for IME and GME using a consistent methodology?

There appear to be no data that directly address how states claim federal Medicaid matching dollars for payments related to IME and DGME. These payments may be included in claims for inpatient and outpatient hospital services when made on a FFS or direct payment basis, and also may be represented in claims for capitation rates paid to managed-care organizations.

Survey data³ show that 48 states provided payment for DGME and/or IME costs under their Medicaid programs. States use a variety of methods to calculate IME and DGME payment amounts under both FFS and managed care. Some states use more than one method. For example, under FFS in 2005, 20 states reported following Medicare's methodology; 12 used a per-resident amount based on a teaching hospital's share of total Medicaid revenues, costs or patient volume; 5 used a lump sum amount; 4 used a per-Medicaid discharge amount; and 19 states used other methods. Also, under FFS, states typically use two methods to distribute GME payments to hospitals. Thirty-one states included GME payments as part of the hospital's per-case or per-diem rates, 20 states made a separate direct payment to teaching hospitals, and 2 states used other methods.

Under managed care, ten states recognized and included GME payments in capitation rates for MCOs, but only two of those 10 required MCOs to distribute DGME/IME payments to teaching hospitals; the other 8 states assumed MCOs provided these payments to their participating hospitals.

2.3 Do all states separate out IME and GME in billing CMS?

Data do not appear to be available with which to directly answer this question. However, according to the AAMC survey, in 2005, 11 states reported that their GME payments to providers did not distinguish between IME and DGME under at least one delivery system (FFS, managed care, or both).

³ Tim M. Henderson, *Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey*, Association of American Medical Colleges, November, 2006.

2.4 Does CMS know how much they are being billed for IME and GME?

States are not required to report GME payments separately from other payments made for inpatient and outpatient hospital services when claiming federal matching payments under Medicaid. For the Medicaid GME proposed rule published in the May 23, 2007 *Federal Register*, CMS used an earlier version of the AAMC survey data as a base for its savings estimate and made adjustments for inflation and expected state behavioral changes, for example.

3.0 School-based Services

3.1 Based on the original intention of the program, are states under-funded by the federal government for the provision of IDEA services?

States, school districts, interest groups, and parents of children with disabilities often argue that the federal government is not living up to its obligation to ‘fully fund’ Part B of the Individuals with Disabilities Education Act (IDEA, P.L. 108-446) (the grants-to-states program). This argument can be made on one of two grounds.

First, when IDEA was enacted in 1975, the Congress set a goal (or made a promise—depending on one’s interpretation of the legislative history) to fund up to 40% of the excess cost of providing special education and related services to children with disabilities.⁴ The metric used to measure excess cost is the national average per pupil expenditure (APPE). Appropriations for Part B have never reached the 40% level. Current appropriations represent about 17%. Based on this goal, promise, or intent, one can argue that IDEA has been under-funded.

Another argument for under-funding can be based on authorization levels contained in the Act. The 2004 reauthorization of IDEA added specific authorization levels for FY2005 to FY2011. The authorization levels were intended to provide a path to “full funding” by FY2011.⁵ The FY2008 authorization is \$19.2 billion while the FY2008 appropriation is \$10.9 billion. So the current appropriation is below the “full funding” level, which would be about \$25 billion for FY2008, and it is significantly below the FY2008 authorization level, which was meant to be a target on the path to eventual “full funding.”

3.2 Are school-based transportation services focused largely on children who are receiving IDEA services?

When certain conditions are met, the costs of transportation from home to school and back home again may receive federal matching funds as a Medicaid benefit.⁶ These conditions are: (1) the child receiving the transportation must be enrolled in

⁴ “In 1975, when the Act was originally enacted, Congress established the goal of providing up to 40 percent of the national average per pupil expenditure to assist States and local educational agencies with the excess costs of educating students with disabilities.” H. Rept 108-77, p. 93.

⁵ The House Report noted that the House bill (H.R. 1350) “has established a clear and genuine pattern to reach the 40 percent goal within the next seven years.” (H. Rept. 108-77, p. 93). The Senate bill (S. 1248) contained a similar authorization pattern.

⁶ School-based transportation services can also be claimed as an administrative expense, for which additional requirements apply.

Medicaid and receiving services pursuant to an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) under IDEA, (2) the need for specialized transportation must be listed in the child's IEP or IFSP, (3) the transportation is billed on a day when the child receives a medically necessary Medicaid covered service in school pursuant to the IEP or IFSP, and (4) the school or school district that is billing for the transportation must be a certified Medicaid provider.⁷ In this context, "specialized transportation" means the child requires transportation in a vehicle adapted to serve the needs of individuals with disabilities, including a specially adapted school bus. In addition, if a child resides in an area that does not have school bus transportation (e.g., areas in close proximity to school), but has a medical need for transportation that is noted in the IEP, that transportation may also be billed to Medicaid. Transportation from school to a provider in the community may also be billed to Medicaid for both Medicaid/IDEA children and Medicaid/non-IDEA children. These policies apply whether the state is claiming FFP for transportation as medical assistance or administration.

There does not appear to be data that show the proportion of school-based transportation services that are provided to Medicaid/IDEA versus Medicaid/non-IDEA children. It is generally assumed that such transportation is predominantly provided to Medicaid/IDEA children.⁸

4.0 Rehabilitation Services

4.1 Do states bill CMS for rehabilitation services and how much has it increased recently?

There are two reporting mechanisms that states may use to report expenditures for optional rehabilitation services: the Form HCFA-64 and MSIS. States report expenditures on the Form HCFA-64, a quarterly financial accounting reporting form. There is a separate category on the HCFA-64 form where states may report optional rehabilitation services. States report rehabilitation expenditures through Medicaid Statistical Information System (MSIS). MSIS data are derived from individual paid Medicaid claims. Even though there is a category for reporting rehabilitative service expenditures, states have discretion in deciding which paid claims will be classified as rehabilitative services.

States report rehabilitation expenditures to CMS when claiming FFP. States or fiscal agents⁹ receive bills or Medicaid claims for payment from providers (e.g., hospitals, physicians, physical therapists, psychologists, social workers, nurses, and other providers). Claims submitted to Medicaid are verified that they meet certain requirements and electronically checked before being paid.

⁷ Letter to State Medicaid Directors, May 21, 1999, and conversation with CMS staff on March 6, 2008.

⁸ Conversation with CMS staff, March 6, 2008.

⁹ In June 2007, 15 states operated their own Medicaid Management Information Systems (MMIS) while the remainder of the states and the District of Columbia contracted with private companies for their MMIS support. MMIS systems process Medicaid claims and serve other administrative and data processing functions. There were eight companies contracting as Medicaid fiscal agents in 2007.

As shown in Table 1, in FY2005 total federal and state Medicaid expenditures reported via MSIS as rehabilitation services were approximately \$6.4 billion. In FY 1999, states reported MSIS rehabilitation expenditures of approximately \$3.6 billion. Between FY1999 and FY2005, federal and state Medicaid rehabilitation expenditures increased by 77.7%. In FY1999, 1.2 million beneficiaries received rehabilitation services; but by FY2005, the number of beneficiaries receiving rehabilitation had increased by 36.2% to more than 1.6 million. Further, average per beneficiary rehabilitation expenditures increased by approximately 30% between FY1999 and FY2005. In FY2005 six states reported no rehabilitation services expenditures and another state reported only 2 beneficiaries received rehabilitation services.¹⁰

Table 1: Medicaid Rehabilitation Services Expenditures and Beneficiaries FY 2005 and FY 1999

Item	FY1999	FY2005	% Change FY1999-FY2005
Beneficiaries	1,207,543	1,645,095	36.2%
Expenditures, Federal and State (in billions)	\$3.6	\$6.4	77.7%
Aver \$/Beneficiary	\$3,020	\$3,916	29.7%

Source: Medicaid Statistical Information System (MSIS), FY1999 and FY2005, downloaded March 6, 2008. FY2004 MSIS data for Maine were used as an estimate of state expenditures for Rehabilitation in FY2005.

4.2 Is there clear guidance to states for appropriate billing for rehabilitation services so that states bill on a consistent basis?

Guidance for claiming rehabilitation service expenditures and receiving FFP can be found in Section 1901¹¹ [42 U.S.C. 1396] of the Social Security Act (SSA) which gives states the option to cover rehabilitation services. Section 1905(a)(13) of SSA, and Medicaid regulations [42 CFR 440.130(d)] define rehabilitation services broadly as “any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.”

States may receive more explicit guidance on what specific services may be included as rehabilitation when preparing and submitting state plan amendments to CMS’ Regional Central Offices. CMS’ Regional and Central Office staff must review and approve all SPAs before a state may add or change a service.

In addition, a state Medicaid director letter (SMDL) was issued by CMS in June 1992 (#FME-42) that provided states some guidance on using the rehabilitation option as a vehicle for providing services to mentally ill beneficiaries. This letter reiterated regulatory guidance that rehabilitation services were intended to be “medical and remedial in nature for the maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.” The letter offered

¹⁰ Colorado, Florida, Georgia, Hawaii, North Carolina, and Oklahoma reported no expenditures to MSIS for rehabilitation; Vermont had only 2 beneficiaries who received rehabilitation services.

¹¹ Appropriation, Sec. 1901. . . . “and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title.” . . .

some examples of services that states could cover under the rehabilitation option including: basic living skills, social skills, and counseling and therapy. The SMDL also described examples of services CMS believed to fall outside of the definition of rehabilitation including: vocational training, direct personal care services, case management (case management is covered under a separate benefit option).

There have been several attempts to clarify in statute and regulation what activities states may cover as rehabilitation services. These administrative and legislative activities strived to define how rehabilitation service benefits should be used as well as to control or reduce states' rehabilitation service expenditures. For example, the Secretary approved a few states to cover *habilitative* services in the 1970s and 1980s under the rehabilitation option for individuals with mental retardation. Habilitative, in contrast to rehabilitative services, are intended to help individuals acquire, retain, and improve self-help and adaptive skills, but are not intended to remove or reduce individuals' disabilities. The Secretary later withdrew approval for habilitative services, because the services were determined to not meet conditions to qualify for the rehabilitation benefit.

In 1989, with passage of the Omnibus Budget Reconciliation Act of 1989 [§6411(g), P.L. 101-239], Congress intervened and specifically allowed states that already had received the Secretary's approval to cover habilitative services for individuals with mental retardation to continue to cover these services. Congress disallowed other states from being approved to cover habilitative services for mental retardation.

4.3 Is there clear guidance to states so that they can tell when they should be billing Medicaid for rehabilitation services or another program?

States need initial CMS' approval for state plan amendments to offer services for rehabilitation. There is limited formal guidance for states in Medicaid statutes and regulations on how to determine when medically necessary services should be billed as rehabilitation services. However, there is some informal guidance that states could utilize from GAO and HHS/OIG reports as well as audits, SPA denials, disallowances, and deferrals (see footnotes in next section).

Guidance also is often provided on a state-by-state basis from CMS' Regional Office staff. CMS' Central Office staff in the Center for Medicaid and State Operations also may provide individual state guidance on what services might be claimed as rehabilitation services.

4.4 Is there a clear definition for states of what constitutes 'rehabilitation'?

Section 1905(a)(13) of SSA, and Medicaid regulations [42 CFR 440.130(d)] define rehabilitation services broadly as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level."

In 2006, 47 states and the District of Columbia covered rehabilitation services.¹² Rehabilitation services can be difficult to describe because the rehabilitation benefit is so broad that it has been described as a catchall.¹³ Services provided under the Medicaid rehabilitation optional benefit span a broad range of treatments from physical rehabilitation to behavioral health and substance abuse treatment, but there may not be consensus on one definition of Medicaid rehabilitation. GAO in particular has attributed confusion about the rehabilitation benefit to the lack of clear guidance and inconsistent enforcement of existing regulations across states and CMS Regions.¹⁴ Some states have been audited and faced subsequent disallowances and claim denials, while other states have been permitted to continue similar rehabilitation claiming practices.

Often Medicaid rehabilitation services assist beneficiaries who have mental-health conditions. In one study,¹⁵ nearly 80% of MSIS claims that states classified as rehabilitation expenditures, contained a diagnosis for mental health. Programs like the New Freedom Initiative that encouraged better integration and acceptance of mental health treatments and settings might have led states to utilize Medicaid rehabilitation benefits to reach mentally-ill beneficiaries. Also, state initiatives to close psychiatric facilities may have contributed to a surge in utilization of the Medicaid rehabilitation benefit for providing treatment to individuals with mental illness. Although mental health services are important, even dominant components of states rehabilitation service benefits, they are not the only services encompassed by the benefit. States also utilize rehabilitation to assist beneficiaries with services such as physical, occupational, and speech therapy, as well as other comprehensive services to treat and help individuals recover from substance abuse disorders.

5.0 Targeted Case Management (TCM)

5.1 How do states bill CMS for case management services and how much has it increased recently?

In 2006, only Delaware did not cover TCM.¹⁶ Most states report TCM expenditures in their Medicaid Statistical Information Systems (MSIS) data. MSIS data are derived from paid Medicaid claims. In FY2005, six states and the District of Columbia did not report any TCM expenditures in the MSIS data. In addition, states report Medicaid expenditures to CMS to claim FFP using a financial accounting form (Form HCFA-64)¹⁷. The HCFA-64 has a reporting line for targeted case

¹² The Kaiser Commission on Medicaid and the Uninsured, Medicaid Benefits: Online Database (October 2006).

¹³ Federal Register, Vol. 72, No. 155, August 13, 2007, Centers for Medicare and Medicaid Services, Medicaid Program; Coverage for Rehabilitative Services.

¹⁴ See page 30, U.S. Government Accountability Office, Report to the Chairman, Committee on Finance, U.S. Senate, Medicaid Financing, States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight, June 2005.

¹⁵ Medicaid's Rehabilitation Services Option: Overview and Current Policy Issues, Kaiser Commission on Medicaid and the Uninsured, August 2007.

¹⁶ The Kaiser Commission on Medicaid and the Uninsured, Medicaid Benefits: Online Database (October 2006).

¹⁷ Quarterly Medicaid Statement of Expenditures for Medical Assistance Program, HCFA-64, is an accounting statement that state Medicaid agencies must submit to CMS each quarter to receive Medicaid payments.

management. In FY2006, total federal and state expenditures for TCM reported on the HCFA-64, were \$2.8 billion (individual state-by-state expenditures were not available from this data source).¹⁸ Expenditures reported on the HCFA-64 and MSIS data for the same years can vary considerably, since these systems for capturing and reporting Medicaid activity are independent of each other. HCFA-64 data were for FY2006, while the most recently available MSIS data were reported for FY2005.

Medicaid expenditures for TCM have increased rapidly. As shown in Table 2, between FY1999 and FY2005, total federal and state TCM expenditures reported in MSIS more than doubled from \$1.41 billion in FY1999 to \$2.9 billion in FY2005. For the same period, the total number of beneficiaries increased 62.6% from approximately 1.7 million in FY1999 to approximately 2.7 million in FY2005. The average expenditures per beneficiary also increased during the period FY1999-FY2005 rising by nearly 27%, from \$834 in FY1999 to \$1,058 in FY2005.

Table 2: Medicaid Target Case Management Expenditures and Beneficiaries FY1999 and FY2005

Item	FY1999	FY2005	% Change FY1999-FY2005
Beneficiaries	1,687,440	2,744,027	62.6%
Expenditures, Federal & State (in \$ billions)	\$1.41	\$2.90	105.7%
Average \$/Beneficiary	\$834	\$1,058	26.9%

Source: Medicaid Statistical Information System (MSIS), FY1999 and FY2005, downloaded March 6, 2008. FY2004 MSIS data for Maine were used as an estimate of state expenditures for TCM in FY2005.

5.2 Is there clear guidance to states for appropriate billing for case management services so that states bill on a consistent basis?

Guidance for states on appropriate claiming of federal financial participation for TCM can be found in a number of official and unofficial sources including:

- a 2001 letter to state Medicaid and child welfare directors (SMDL 01-013);
- the Medicaid statute, Sections 1905(a)(19) and 1915(g) of the SSA;
- Section 6052 of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171);
- Medicaid regulations at 42 CFR Parts 431, 440, and 441 (§440.169 for TCM definition);
- the state Medicaid manual at Section 4302, Optional Targeted Case Management Services – Basis, Scope, and Purpose;
- CMS' Regional Office staff and CMS' Central Office state representatives;
- unofficial sources, such as reports from Health and Human Services (HHS) Office of Inspector General and the U.S. Government Accountability Office (GAO); and
- denials and approvals of state plan amendments.

In reviewing states use of contingency contractors, GAO found that CMS has allowed some states to continue to claim for TCM services even though other states were denied approval for state plan amendments for similar proposals to provide TCM

¹⁸ See *Federal Register*, Vol. 72, No. 232/December 4, 2007, Medicaid Program; Optional State Plan Case Management Services.

services. In addition, some states received disallowances, deferrals, and denials for TCM services, while other states were not audited for similar practices. States received guidance on TCM claiming for foster care in a January 2001 letter to state Medicaid and child welfare directors (#01-013). This letter reiterated the statutory definition of TCM and described services “commonly understood to be allowable” as case management including: (1) assessment of the eligible individual to determine service needs, (2) development of a specific care plan, (3) referral and related activities to help the individual obtain needed services, and (4) monitoring and follow-up. Moreover, CMS’ added that, “In general, allowable [case management] activities are those that include assistance in accessing a medical or other service, but do not include the direct delivery of the underlying service.” Although there has been guidance for individual states and some indirect guidance and discussion on TCM claiming, states have received limited written national guidance from CMS.

HHS/OIG and GAO have documented what they describe as states’ attempts to maximize FFP by claiming additional TCM.^{19 20} These tactics include the use of contingency contractors who allegedly assisted states in exploiting ambiguity in Medicaid statutes and regulations to claim additional FFP. Another tactic CMS and GAO cite that states use to increase Medicaid matching funds is the practice of paying for direct services delivered by staff of other state social services programs, such as schools, juvenile justice, parole, child welfare, and foster care programs.²¹ Furthermore, CMS and GAO have cited problems with states use of cost allocation plans that duplicate claiming for administrative expenses by several programs. CMS has repeatedly cited these abuses as rationale for explicit and comprehensive TCM regulation.

5.3 Is there clear guidance to states so that they can tell when they should be billing Medicaid for case management services or another program?

States may find guidance on whether services should be billed as Medicaid case management/TCM or as components of other programs:

- the state Medicaid manual at Section 4302, Optional Targeted Case Management Services – Basis, Scope, and Purpose;
- a 2001 letter to state Medicaid and child welfare directors [(SMDL 01-013), see reference in previous section];
- HHS/OIG audits, such as (A-07-06-03078) [see footnote below];
- Sec. 6052 of the Deficit Reduction Act of 2005, (DRA, P.L. 109-171);
- denials and approvals of state plan amendments; and
- CMS’ Regional Office staff and CMS’ Central Office state representatives.

¹⁹ U.S. Government Accountability Office, Report to the Chairman, Committee on Finance, U.S. Senate, Medicaid Financing, States’ Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight, June 2005.

²⁰ Department of Health and Human Services, Office of Inspector General, Review Of Targeted Case Management Services Rendered By The Massachusetts Department Of Social Services During Federal Fiscal Years 2002 and 2003, May 2006, (A-01-04-00006).

²¹ Dennis Smith, Director, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, testimony to Senate Committee on Finance hearing on Medicaid Fraud and Abuse, June 28, 2005, <http://finance.senate.gov/hearings/testimony/2005test/DSstest062805.pdf>.

Although there may be a number of issues related to claiming FFP for Medicaid addressed in these sources, at least two issues have been sources of confusion, misunderstanding, and dispute. One issue where there has been misunderstanding is non-duplication of payments. Guidance for states on non-duplication of payments can be found in the State Medicaid Manual, “Payment for case management services under 1915(g) of the [SSA] Act may not duplicate payments made to public agencies or private entities under the program authorities for this same purpose.” States can not receive Medicaid FFP for services provided to beneficiaries who received these services from other state agencies, such as schools, foster care, child welfare, and juvenile justice. However, there has been misinterpretation and disagreement about claiming of a share of administrative costs attributable to other programs where there is overlap between Medicaid and other state programs (e.g., foster care, special education, and juvenile justice).²² The aforementioned sources advise states to allocate administrative costs between the overlapping programs in accordance with OMB Circular A-87 under an approved cost allocation plan.

Another area where there has been some disagreement is over the direct delivery of services by other programs where Medicaid is then charged for the direct services provided by the other program. A letter to state Medicaid directors (January 19, 2001, SMDL 01-013) indicates that FFP would not be available for the direct delivery of services by another program:

“Unallowable services: Medicaid case management services do not include payment for the provision of direct services (medical, educational, or social) to which the Medicaid-eligible individual has been referred. For example, if a child has been referred to a state foster care program, any activities performed by the foster care case worker that relate directly to the provision of foster care services cannot be covered as [Medicaid] case management.”

Subsequent HHS/OIG audits recommended that CMS establish policies and procedures to ensure state FFP claims do not include direct medical services.²³

²² Department of Health and Human Services, Office of Inspector General, Review of Allegheny County’s Medicaid Administrative Case Management Costs Claimed by Pennsylvania Between January 2002 and June 2003, April 2007.

²³ Department of Health and Human Services, Office of Inspector General, Iowa Medicaid Payments for Targeted Case Management for Fiscal Years 2003 and 2004, November 2007, pages 1, 6, and 7.