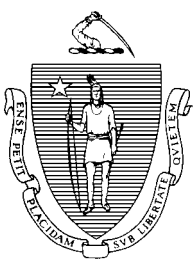
The State Auditor's Report on the Massachusetts Municipal Medicaid Program

June 2004



The Commonwealth of Massachusetts

AUDITOR OF THE COMMONWEALTH

Division of Local Mandates

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June 7, 2004

His Excellency Mitt Romney
Honorable Robert E. Travaglini, President of the Senate
Honorable Thomas M. Finneran, Speaker of the House of Representatives
Honorable Richard T. Moore, Senate Chair, Committee on Health Care
Honorable Peter J. Koutoujian, House Chair, Committee on Health Care
Honorable Robert A. Antonioni, Senate Chair, Committee on Education, Arts and Humanities
Honorable Marie P. St. Fleur, House Chair, Committee on Education, Arts and Humanities
Honorable Daniel F. Keenan, Chair, House Committee on Medicaid
Honorable Members of the General Court

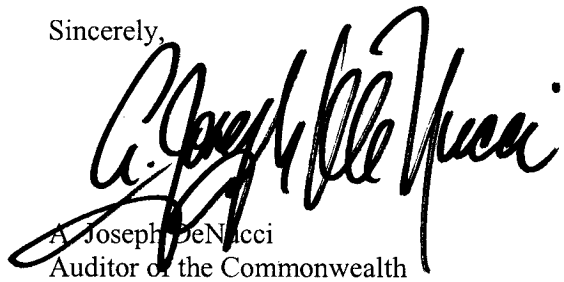
I am pleased to submit this review of the Massachusetts Municipal Medicaid Program, our state's system of accessing federal Medicaid money to help support the cost of services for special needs children. This work was undertaken in accordance with Chapter 126 of the Acts of 1984, which authorizes the State Auditor's Division of Local Mandates (DLM) to review state laws and regulations that have a significant financial impact on cities and towns.

Under this authority, I issued a report in 1991 recommending, among other things, that Massachusetts take steps to capitalize upon this source of federal assistance as one means of easing the cost of special education for local governments. These efforts have brought over $560 million in federal aid to our cities, towns, and regional school districts through 2003. The purpose of this report is to follow-up on those recommendations, to assess the effectiveness of the state program, and to learn whether there may be means to further maximize this source of federal money.

This report offers recommendations that could increase these receipts by as much as $50 million per year. This money could be realized through changes in billing methodology, as well as improved billing for all eligible students and types of reimbursement.

I hope the information in this report is helpful to your efforts to support essential public services, especially in this time of fiscal constraints. Please contact DLM Director, Attorney Emily Cousens, with questions or comments you may have on this work. I look forward to continuing to work with you on this and other matters affecting the quality of state government and the services that the Commonwealth provides to its citizens.

Sincerely,



A. Joseph DeNucci
Auditor of the Commonwealth

THE STATE AUDITOR'S REPORT ON THE MASSACHUSETTS MUNICIPAL MEDICAID PROGRAM

EXECUTIVE SUMMARY

Background and Purpose

Through the Municipal Medicaid Program, Massachusetts accesses a significant source of federal money to help support the cost of special education. The federal program is known as the School Based Health Services Program, and has provided nearly $460 million in federal financial assistance to cities, towns, and regional school districts from its inception in fiscal 1994 through fiscal 2002. Fiscal 2003 receipts exceed $100 million in reimbursements for certain administrative activities, and for qualified services delivered to Medicaid eligible children enrolled in special education programs. Qualified services may include medical evaluations, services of physicians and dentists, physical, speech and occupational therapies, eyeglasses, and prescriptions, among others.

The federal financial participation (FFP) rate for Massachusetts is 50%, so as a general rule, about half of the expense rate allowed for these services provided to special needs students is reimbursable. State law provides that local expenditures serve as the required state match for federal aid, so there is no demand on state revenues or state Medicaid expenditures. Responsibility for state-level program development and administration lies with the Executive Office of Health and Human Services, Division of Medical Assistance (DMA).

There are several objectives of this report. One is to follow-up on the State Auditor's prior recommendations to pursue this source of federal aid as one means to ease the cost of special education for local governments. Another is to evaluate the financial benefit to cities, towns, and regional school districts since program inception. The final objective is to learn whether there may be means to enhance this benefit, and to make recommendations to that effect.

Findings and Recommendations

The overall finding of this report is that a combination of legislative and agency actions could increase federal assistance under this program by as much as $50 million annually. Specifically, we recommend:

- The General Court should enact legislation to earmark Municipal Medicaid receipts for school purposes — at a minimum assuring that at least new federal money realized as a result of new effort is returned directly to school departments. Our survey of special education administrators indicates that lack of earmarking is a significant obstacle to

maximizing this source of federal aid. See Survey Results, page 10, and recommendation 1, page13.

- DMA should develop a fee-for-service rate structure/billing methodology for the program. DMA has failed to pursue earlier UMass work indicating that such a restructuring of the billing method could yield an annual increase in federal aid approaching $50 million. See recommendation 2, page 14.

- DMA and DOE should undertake specified administrative, regulatory, and technical assistance actions to increase the number of claims filed by participating districts. Data indicates that a significant number of districts are entitled to submit claims on account of many more pupils than they actually do. This amounts to a potential loss of federal aid of nearly $10 million per year. Since districts have up to two years from the date of service to submit claims, they may seek reimbursement for pupils served up to two years earlier. In theory, the sum of these retroactive entitlements could approach $20 million. See recommendation 3, page 15.

- DMA should implement oversight procedures to minimize incidences of improper payments. The U. S. Department of Health and Human Services Office of Inspector General found that about 6% of the federal reimbursements claimed by eight districts in fiscal 2000 were inappropriate. DMA has not complied with its duty to ensure that district claims are submitted in compliance with federal requirements. See recommendation 4, page 17.

- DMA should review federal program parameters to ensure that the state program captures all reimbursement opportunities. For example, while other New England states collect federal aid for special education evaluations, the Massachusetts program excludes this service. Additionally, the Massachusetts allowance for Team meeting participants appears to be unduly limited. The fact that these two gaps exist in the state program leads to the concern that there may be other missed opportunities, as well. See recommendation 5, page 18.

- DMA should provide updated program manuals, include a Municipal Medicaid section on its website, and improve overall communications with school districts. See recommendation 6, page 19.

- DMA should implement data management procedures to facilitate program monitoring, oversight, and review. See recommendation 7, page 20.

INTRODUCTION

BACKGROUND

In an effort to assist states with the costs of medically related services provided to special education students, Congress, in 1988, amended Title XIX of the Social Security Act[1], the federal law providing support for medical services for certain low income individuals and families. This amendment makes the resources of the Medicaid program available to school districts that become Medicaid providers and deliver qualified services to Medicaid-eligible children enrolled in special education programs. Qualified services may include medical evaluations, services of physicians and dentists, physical, speech and occupational therapies, eyeglasses, and prescriptions, among others.

Accordingly, in the early 1990's the Massachusetts Legislature took steps to remove impediments in state law, and to provide the framework for state participation in the federal School Based Health Services Program.[2] The state Department of Public Welfare (now known, in part, as the Division of Medical Assistance, DMA) obtained federal approval for an amendment to the state Medicaid Plan. This amendment allows DMA to recognize school districts as Medicaid providers, defines the scope of reimbursable services, and sets the methodology to determine the rates of reimbursement. Importantly, state law provides that school district expenditures serve as the required state match for federal aid, so there is no financial impact on the state Medicaid program.

The federal financial participation (FFP) rate[3] for Massachusetts is 50%, so, as a general rule, about one-half of the expense rate allowed for qualified services provided to special needs students who are Medicaid recipients is reimbursable. In addition to this direct student service component, many Massachusetts school districts also receive FFP for performing administrative activities that support the state Medicaid program.[4] Through fiscal 2002, these two program components have yielded nearly $460 million in federal aid for Massachusetts cities, towns, and regional school districts. Fiscal 2003 receipts exceed $100 million.

The Centers for Medicare & Medicaid Services (CMS) manage the program at the federal level, and a number of documents define the details of program administration.[5] As shown by the variations in state programs, CMS allows each state a measure of latitude in designing their own programs. One noteworthy variation is in the method for determining the rate of reimbursement for direct services to pupils. The majority of states use a fee-for-service method.[6] Although the

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[1] Section 411 (k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P. L. 100-360).

[2] M. G. L. c. 71B, s. 5, and c. 44, s. 72, as amended by St. 1991, c. 138 and St. 1993, c. 50, et al.

[3] The federal government matches most state Medicaid expenditures at rates ranging from 50% to 83%, depending upon the relative per capita income of the state. The higher the state per capita income, the lower the federal matching percentage.

[4] The Massachusetts Medicaid program is known as MassHealth.

[5] These include CMS's *Medicaid and School Health: A Technical Assistance Guide*, August 1997; Office of Management and Budget *Circular A-87*; and CMS's *Medicaid School-Based Administrative Claiming Guide*, May 2003.

[6] *Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight* (General Accounting Office/HEHS/OSI-00-69, April 2000) p. 22.

details of this method may differ from state to state, it generally prescribes maximum reimbursement rates for specific services, and requires documentation of a specific claim for each time a service is delivered. Fee-for-service is the standard remittance method many of us see at work in our own health insurance policies. CMS has also allowed states the option of using a bundled rate methodology (see description below), and encourages the development of innovative systems.[7] During its work on the topic, the United States General Accounting Office (GAO) identified 7 states using bundled rates, Massachusetts among them.[8] However, in 1999, citing accountability and efficiency reasons, the Health Care Financing Administration (HCFA, now known as CMS) announced that it would not entertain future applications for bundled rate approaches from additional states.[9] At the same time, HCFA directed states that were already using bundled rates to develop alternative claiming methods, but has taken no apparent action to enforce this directive.

Responsibility for state-level program development and administration lies with DMA. Through an interagency service agreement, DMA delegates much of this responsibility to the Center for Health Care Financing at the University of Massachusetts Medical School (UMass).[10] Within the parameters allowed by CMS, several documents provide the details for participating in the state program. Among others, these include the State Medicaid Plan, the UNISYS *Municipal Medicaid Billing Guide* (undated), the *Operational Guide for School Districts* (May, 1995), the *Claiming Manual for School-Based Administrative Activities* (January 2001), the *Time-Study Manual for School-Based Administrative Activities* (January, 2001), and Provider Agreements executed between DMA and individual school districts. DMA informs school providers of program and rate changes through periodic bulletins as deemed necessary.

OVERVIEW OF THE MASSACHUSETTS MUNICIPAL MEDICAID PROGRAM

As indicated above, the Massachusetts program allows school districts to receive federal reimbursement for two distinct categories of service: direct services to pupils and administrative activities. For simplicity, we refer to districts as receiving the reimbursement, although in fact, only regional school districts receive the money directly. Reimbursements for pupils served and administrative activities performed by local school districts are deposited with the city or town treasurer; any pass-through to the school department is at the discretion of the local appropriating authority.[11]

Direct Service Reimbursement. Since 1994, school districts that became Medicaid providers have been eligible to receive 50% federal reimbursement for the rate value of services provided

[7] See pp. 36-38 of CMS's *Medicaid and School Health*…cited at footnote 5.
[8] The others are Connecticut, Kansas, Maine, New Jersey, Utah and Vermont.
[9] May 21, 1999 letter from HCFA Director to state Medicaid Directors.
[10] As DMA is the responsible agency, in most cases our writing will refer to DMA, even though UMass may be the underlying actor.
[11] See G. L. c. 44, s. 72.

to MassHealth members enrolled in special education programs, as prescribed by an Individualized Education Plan (IEP). Note that this is not 50% reimbursement for the actual cost of services provided. It is 50% of the rate determined by DMA, with the approval of CMS. As noted above, Massachusetts adopted a bundled rate methodology, with the aim of easing the administrative burden of Medicaid billing on school districts. These bundled rates reflect the average incidences of qualified medical services provided to special needs pupils in various school placement settings. With this system, schools may receive a rate of FFP related to the child's program placement, and need not keep track of the specific medical services actually provided to each individual. Rather, for most categories of service, Medicaid billing is based upon student days in attendance. With proper parental authorization,[12] this system allows school districts to claim FFP for every special needs pupil who is enrolled in MassHealth, including those individuals that receive no medical services. Because children that receive no medical services are factored into the incidence rate for each program placement, some rates may appear to be artificially low. The current rates and the FFP value for various special education placements and other items are shown in Table 1.

Table 1.

Municipal Medicaid Program
Current Rates and FFP Value[a]

Service	Rate	FFP Value
Home Assessment	$76.75/Unit[b]	$38.38/Unit
Team Meeting	$30.70/Unit[c]	$15.35/Unit
Public Day Program	$12.41/Day	$6.21/Unit
Separate Placement	$26.95/Day	$13.48/Day
Private Day School	$50.62/Day	$25.31/Day
Private Residential	$52.67/Day	$13.17/Day[d]
Early Childhood	$120.79/Week	$60.40/Week

[a] This presentation omits rates for private duty nursing services, as these are rarely utilized. These four rates range from $29.50/hour to $14.40/hour, reimbursable at 50%.

[b] One unit = one professional (social worker, nurse, or qualified counselor), capped at one assessment/year with a maximum of three professionals.

[c] One unit = one professional (RN, social worker, certified guidance counselor, or psychologist), capped at three meetings/year/child, with a maximum of three professionals/meeting.

[d] Because the state pays one-half of the cost of these placements, it retains one-half of the FFP.

With the exception of FFP earned for pupils served in private residential settings, 100% of the reimbursement for each placement is deposited in the city, town or regional school district

[12] The federal Family Educational Rights and Privacy Act (FERPA) requires parental authorization (by signature) for schools to share student record information with "third parties," including state Medicaid agencies. 20 U. S. C. s. 1232g; 34 CFR Part 99.

treasury. Due to the fact that the state has paid 50% of the cost of residential placements, it has retained 50% of the FFP earned on account of pupils in private residential settings.[13]

Administrative Reimbursement. Since 1998, districts have been allowed to submit claims for FFP for administrative activities that support the MassHealth program. Among other things, these activities include outreach efforts to identify and enroll eligible pupils in the MassHealth program, efforts to arrange for or provide medical services for pupils, and related transportation. Most documented, administrative costs are reimbursed at 50%. Administrative reimbursements do not necessarily relate to services provided to special needs students, and school districts do not need to become Medicaid providers to access this benefit. Because administrative activities may relate to the entire student body, some districts receive greater FFP for this category than for direct services provided to special needs pupils.

Claims for administrative activities[14] are determined by a time study process to isolate the amount of time certain school personnel devote to MassHealth support activities. These personnel range from school physicians, psychiatrists, and nurses, to speech and physical therapists to social workers. They may also include directors of special education and pupil support services, along with their related staffs. Time study results are used to allocate portions of the costs of relevant personnel to Medicaid related activities. The program also provides methods to allocate portions of general administration, overhead, capital, and other expenses to Medicaid.

OBJECTIVES AND METHODOLOGY

There are several objectives of this review of the Massachusetts Municipal Medicaid Program. One is to follow-up on the State Auditor's earlier recommendations[15] to pursue this source of federal aid as one means to ease the cost of special education for local governments. Another is to evaluate the financial benefit to cities, towns, and regional school districts since program inception. We also sought to learn whether there may be means to further enhance this benefit, and to make recommendations to that effect. Our methods included: compilation and analysis of relevant data from the Commonwealth Information Warehouse, CMS, DMA, and the state Department of Education (DOE); review of relevant federal and state laws, regulations, guidelines, bulletins, and studies; review of periodical writing on the topic; personal and telephone interviews with selected federal and state personnel, and the Massachusetts Administrators for Special Education Association; a telephone survey of selected school districts; and a telephone survey of state Medicaid Directors from the other New England states.

[13] G. L. c. 44, s. 72. Note: In fiscal 2004, the state share of residential placements is governed by the "Circuit Breaker" Law, G. L. c. 71B, s. 5A, as amended in the fiscal 2004 state budget, St. 2003, c. 26. Subject to appropriation, the state will pay 75% of the amount by which any private residential tuition exceeds $29,320.

[14] See *Claiming Manual for Administrative Activities* and the companion *Time-Study Manual*, UMass, January 2000.

[15] See *The State Auditor's Report on Special Education in Massachusetts*, March 1991.

Subsequent Event: *St. 2003, c. 26, s.15 substantially reorganized the Executive Office of Health and Human Services, so that the Division of Medical Assistance is now known as the Office of Medicaid.*

Agency Comments: We provided a draft of this report to the Director of the Office of Medicaid at the conclusion of our work. On April 20, 2004, the Director expressed general agreement with most of our recommendations, and stated that they are working toward implementation of a number of them. The Director specifically noted that the agency is in the process of reviewing rate methodology alternatives, and is hopeful that changes might generate additional revenue for cities and towns. She also provided supplemental information regarding the audit by the Health and Human Services Office of the Inspector General that is reflected in this final report. The Director disagreed with our finding that the Agency needs to implement data management procedures to facilitate program monitoring and oversight. This matter is fully discussed in part 7 of the Findings and Recommendations section of this report.

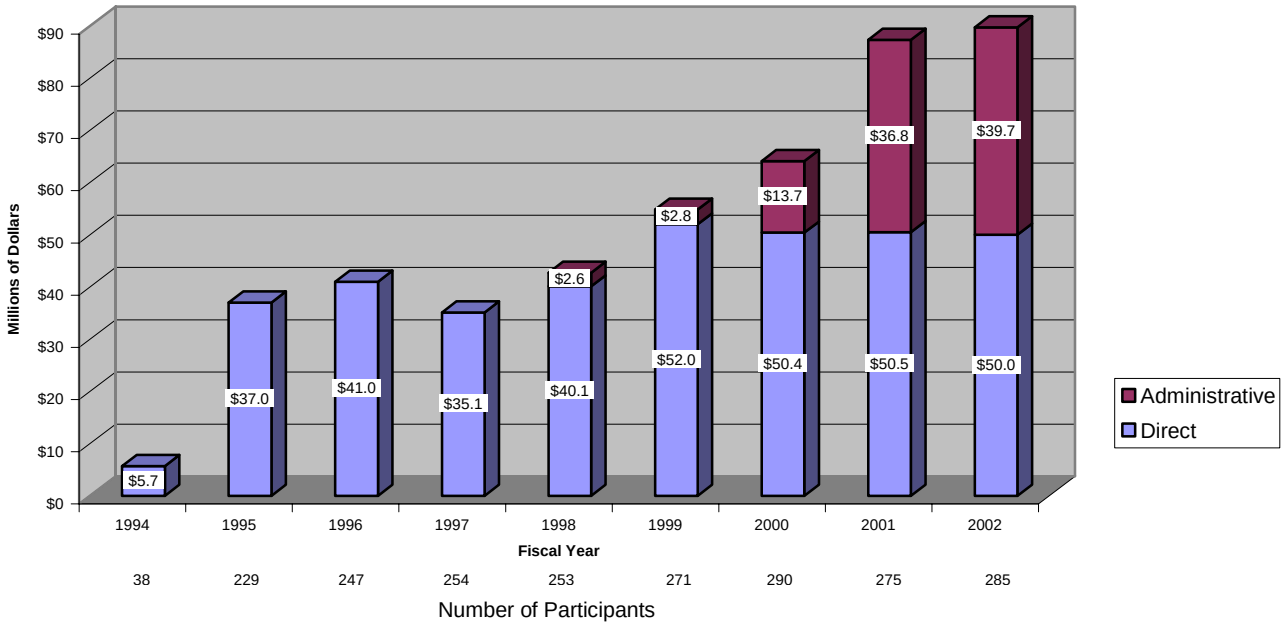
PRESENTATION OF THE DATA

FEDERAL FINANCIAL PARTICIPATION (FFP) THROUGH 2002

As noted earlier, Massachusetts first received reimbursement for direct services to pupils in 1994, and for administrative activities in 1998. Commonwealth Information Warehouse (CIW) data indicates that through 2002, the full benefit of program participation for school districts exceeded $457 million, an average annual benefit of about $51 million since program inception. A majority of the total, approximately $362 million, was for direct services, and the remaining $95 million was for administrative activities. Figure 1 shows the annual FFP for both categories, with 2002 amounts at about $50 million for direct services, and $40 million for administrative activities, a total of about $90 million. This amounts to roughly 4.5% of the $2 billion[16] in local, state, and federal resources spent for special education services in Massachusetts in 2002. Figure 1 also shows the number of participating districts each year, growing from 38 in the first year to 285 in 2002.

Figure 1.

Total FFP and Number of Participants FY 1994 to FY 2002



[16] *Massachusetts Students With Disabilities Annual Report: 2002 – 2003*, Massachusetts Department of Education, November 2003.

Appendix 1 shows CIW data detailing the total FFP over this period for each participating school district. Boston received the greatest amount, exceeding $96 million, while the average program benefit over the period was just under $1.4 million. Appendix 1 also shows specific payments to each district in 2002.

2002 DATA

Direct Services

The data indicates that in 2002, 282 school districts received $49,942,498 in reimbursements for the cost of providing direct services to Medicaid eligible, special education students. Accordingly, about 86% of the 329 operating school districts received direct services FFP ranging from $74 for Topsfield to $10,553,439 for Boston. The average amount was approximately $177,000.

Administrative Activities

For administrative activities, 2002 data shows that 62% (205) of the school districts received $39,724,730. These payments ranged from a minimum of $112 for Freetown to $6,598,336 for Boston. The average FFP for these activities was approximately $194,000.

Combined FFP

Both types of reimbursements yielded $89,667,228 in 2002. The average combined FFP was $426,279, ranging from $1,219 for Berlin to $17,151,775 for Boston. As further shown in Table 2, FFP is not even across communities. By its nature, the Municipal Medicaid Program offers the greatest aid opportunities to areas with larger low-income populations. For example, Boston received over 19% of the 2002 FFP. The other urbanized centers shared about 51%, while the remaining 238 participants shared varying portions of 30% of the total. Presented on page 7, Table 2 shows districts participating in 2002 grouped by various levels of FFP.

SELECTED DATA ON DIRECT SERVICES CLAIMING

Although it is necessary to use CIW data to examine amounts of FFP paid to districts,[17] DMA data showing program variables within a given date-of-service period appears to be maintained in a reliable manner. This data indicates that in 2001, reimbursable direct services were provided to 40,154 pupils, approximately 25% of the special education enrollment. The average claim per pupil was about $1,275. As Massachusetts uses the bundled rate methodology, data is not available to determine the number of claims made for specific types of services, for example, speech therapy or psychiatric treatments. Rather, data is maintained by the bundled rate categories that generally relate to the several types of special education placements.

[17] See commentary at recommendation number 7, page 20.

Table 2

Stratification of FY 2002 FFP Across Districts (000's Omitted)

>$17,000 n=1	>$100<$250 n=75	>$50<$100 n=49	<$50 n=104	<$50 Continued
BOSTON	ABINGTON	ACUSHNET	ACTON	PROVINCETOWN
>$3,000<$6,000 n=2	ADAMS-CHESHIRE R.S.D.	AVON	ACTON-BOXBOROUGH R.S.D	READING
	AMESBURY	BELMONT	ANDOVER	ROCKPORT
SPRINGFIELD	AMHERST	BLACKSTONE- MILLVILLE R.S.D.	ASSABET VALLEY R.V.T.	ROWE
WORCESTER	AMHERST-PELHAM R.S.D	BLUE HILLS REGIONAL R.V.T.	BEDFORD	SAVOY
>$2,000<$3,000 n=6	ARLINGTON	BREWSTER	BELLINGHAM	SHARON
	ASHBURNHAM-WESTMINSTER R.S.D.	CARVER	BERKLEY	SHERBORN
CHICOPEE	ASHLAND	DUDLEY-CHARLTON R.S.D.	BERLIN	SILVER LAKE R.S.D.
FALL RIVER	ATHOL-ROYALSTON R.S.D.	EAST BRIDGEWATER	BERLIN- BOYLSTON R.S.D.	SOUTH SHORE R.V.T.
LAWRENCE	AUBURN	EAST LONGMEADOW	BLACKSTON VALLEY R.V.T.	SOUTHBOROUGH
LOWELL	BELCHERTOWN	EASTHAM	BOXFORD	SOUTHEASTERN R.S.D.
LYNN	BERSHIRE HILLS R.S.D.	EASTON	BOYLSTON	SOUTHERN WORCESTER R.V.T.
NEW BEDFORD	BOURNE	FAIRHAVEN	BRIMFIELD	STURBRIDGE
>$1,000<$2,000 n=8	BROOKLINE	FOXBOROUGH	BROOKFIELD	SUDBURY
	BURLINGTON	FRANKLIN COUNTY R.V.T.	CAPE COD R.V.T.	SUNDERLAND
BROCKTON	CENTRAL BERKSHIRE R.S.D.	FRONTIER	CARLISLE	TANTASQUA R.S.D.
CAMBRIDGE	CHELMSFORD	HAMILTON-WENHAM R.S.D.	CLARKSBURG	TISBURY
CHELSEA	CLINTON	HANOVER	CONCORD	TOPSFIELD
FRAMINGHAM	DANVERS	HOLBROOK	CONWAY	TRI-COUNTY R.V.T.
HOLYOKE	DARTMOUTH	IPSWICH	DEERFIELD	TRURO
MALDEN	DEDHAM	LYNNFIELD	DIGHTON-REHOBOTH R.S.D.	TYNGSBOROUGH
PITTSFIELD	DRACUT	MANSFIELD	DOUGLAS	UP ISLAND R.S.D.
SOMERVILLE	EASTHAMPTON	MEDWAY	DOVER	WALES
>$500<$1,000 n=15	GARDNER	METHUEN	DOVER-SHERBORN R.S.D.	WELLFLEET
	GATEWAY	MILLBURY	DUXBURY	WEST BRIDGEWATER
BARNSTABLE	GILL- MONTAGUE R.S.D.	MILLIS	EDGARTOWN	WESTWOOD
BILLERICA	HAMPDEN-WILBRAHAM R.S.D.	MINUTEMAN R.V.T.	ERVING	WHATELY
DENNIS-YARMOUTH R.S.D.	HARWICH	NAUSET	ESSEX	WILLIAMSTOWN
EVERETT	HOLLISTON	NORTH BROOKFIELD	FARMINGTON RIVER R.S.D.	WRENTHAM
FALMOUTH	HUDSON	NORTH MIDDLESEX	FLORIDA	
FITCHBURG	HULL	NORTH SHORE R.V.T.	FRANKLIN	
GREATER LOWELL R.V.T.	LEXINGTON	NORTHEAST METROPOLITAN R.V.T.	FREETOWN	
HAVERHILL	LONGMEADOW	NORWELL	FREETOWN-LAKEVILLE R S D	
MEDFORD	LUDLOW	PATHFINDER R.V.T.	GEORGETOWN	
NORTH ADAMS	MARBLEHEAD	PEMBROKE	GRAFTON	
QUINCY	MARSHFIELD	SHAWSHEEN R.V.T.	GRANBY	
REVERE	MELROSE	SHIRLEY	GRANVILLE	
SALEM	MIDDLEBOROUGH	SOMERSET	GREATER NEW BEDFORD R.S.D	
WEST SPRINGFIELD	MONSON	SOUTH HADLEY	GROTON- DUNSTABLE R.S.D.	
WESTFIELD	NARRAGANSETT R.S.D.	SOUTH MIDDLESEX R.V.T.	HALIFAX	
>$250<$500 n=25	NASHOBA	SOUTHBRIDGE	HAMPSHIRE R S D	
	NEEDHAM	SOUTHERN BERSHIRE R.S.D.	HATFIELD	
AGAWAM	NEWBURYPORT	SOUTHWICK-TOLLAND R.S.D.	HAWLEMONT R.S.D.	
ATTLEBORO	NEWTON	SWANSEA	HINGHAM	
BEVERLY	NORTH ATTLEBOROUGH	UPPER CAPE COD R.V.T.	HOLLAND	
BRAINTREE	NORTH READING	WEST BOYLSTON	HOPEDALE	
BRIDGEWATER-RAYNHAM R.S.D.	NORTHAMPTON	WESTFORD	HOPKINTON	
GLOUCESTER	NORTHBRIDGE	WHITTIER R.V.T.	KING PHILIP R.S.D	
GREENFIELD	NORTON	WINCHESTER	KINGSTON	
LEOMINSTER	ORANGE		LAKEVILLE	
MARLBOROUGH	PALMER		LEE	
MASHPEE	PIONEER VALLEY R.S.D.		LEICESTER	
MILFORD	QUABBIN R.S.D.		LENOX	
MOHAWK TRAIL R.S.D.	QUABOAG R.S.D.		LEVERETT	
NATICK	RALPH C MAHAR R.S.D.		LINCOLN-SUDBURY R.S.D.	
NORWOOD	ROCKLAND		LITTLETON	
PEABODY	SANDWICH		LUNENBURG	
PLYMOUTH	SAUGUS		MANCHESTER	
RANDOLPH	SEEKONK		MANCHESTER ESSEX R.S.D.	
STOUGHTON	SHREWSBURY		MARTHAS VINEYARD R.S.D.	
TAUNTON	SPENCER-EAST BROOKFIELD R.S.D.	.	MASCONOMET R.S.D	
WALTHAM	STONEHAM		MAYNARD	
WAREHAM	SWAMPSCOTT		MEDFIELD	
WEBSTER	TEWKSBURY		MIDDLETON	
WEYMOUTH	TRITON R.S.D.		MONTACHUSETTE R.V.T.	
WINTHROP	WACHUSETTS R.S.D.		NASHOBA VALLEY R.V.T.	
WOBURN	WAKEFIELD		NEW SALEM-WENDELL R.S.D.	
	WALPOLE		NORTH ANDOVER	
	WARE		NORTHBOROUGH	
	WATERTOWN		NORTHERN BERKSHIRE R.V.T.	
	WESTBOROUGH		OAK BLUFFS	
	WESTPORT		OLD COLONY R.V.T.	
	WHITMAN- HANSON R.S.D.		ORLEANS	
	WILMINGTON		PENTUCKET R.S.T.	
	WINCHENDON		PLAINVILLE	

Table 3 provides selected DMA data for each category of reimbursable service.[18]

Table 3.

Selected Data
Direct Service Claiming
Fiscal 2001

Service	Number of Providers	Percent of Providers	Number of Pupils	Percent of All Pupils Served in Category	Average FFP Per Pupil
Home Assessment	5	2%	557	Data not available	$ 38
Team Meeting	78	27%	4,731	Data not available	$ 31
Public Day Program	278	98%	24,850	21%	$ 843
Separate Placement	234	82%	12,130	46%	$ 1,766
Private Day	179	63%	1,760	35%	$ 3,262
Private Residential	161	57%	589	46%	$ 2,724
Early Childhood	183	64%	2,223	25%	$ 1,736

Note: To show the sum of the number of providers or the sum of the number of pupils presented in this table would result in inflated values because the numbers in this table are discreet only to the type of service. One district may be counted 7 times in such a sum, as it might make claims for all 7 service categories. A single pupil may be counted a number of times, if that pupil received more than one type of service in the period.

This table shows, for example, that in 2001, 98% of participating school districts provided FFP-eligible services in public day programs. Providers claimed an average of $843 for each of these 24,850 pupils, so that FFP was claimed on about 21% of all pupils in special needs public day programs that year. Over half of school providers served Medicaid-eligible pupils at private residential facilities, claiming an average of $2,742 for each of these 589 students. Nearly half of all private residential placements generated FFP under the program. In contrast, only 2% of participating districts made claims for home assessments. Although not shown here in detail, the underlying data indicates that only four of the participating districts submitted claims in all seven available reimbursement categories: Beverly; Holyoke; Lawrence; and Worcester.

[18] Data related to private duty nursing services is omitted due to little utilization.

SURVEY RESULTS

Initial review of the data indicated that districts took advantage of the two major components of the Municipal Medicaid Program to varying degrees in fiscal 2001, the most current year of complete data at the time of our survey. Participation rates fell into four groups:

Group 1: Those that fully participated, and received reimbursement for both direct services and administrative activities, 186 districts (57%).
Group 2: Those that received reimbursement for direct services, but not for administrative activities, 97 districts (29%).
Group 3: Those that received reimbursement for administrative activities, but not for direct services, 3 districts (1%).
Group 4: Those that did not participate, and received no reimbursement, 43 districts (13%).

For those that did not fully participate, Groups 2, 3 and 4, we reviewed DOE data showing special education enrollments and numbers of low-income pupils to learn whether local demographics might not warrant full participation. In some cases, the reasons for less than full participation were apparent. For example, relatively small districts with low numbers of special needs and/or low-income pupils might have little, if anything, to gain from the program. In other cases, the reasons were less clear, because the demographic data suggested that some of these districts would benefit from enrolling in the program or expanding to full participation.

Methodology

To learn why some districts declined full participation (Groups 2 and 3), or did not participate at all (Group 4), DLM conducted a telephone survey over the course of two weeks. Group 2 local school districts (as distinguished from regional school districts) were also questioned as to whether the local appropriating authority allocated any of the direct services reimbursement to the school department, or directed that money to other municipal purposes. In the first instance, callers contacted special education administrators, although in a number of cases they were referred to school superintendents, school business managers, or educational collaborative personnel. Callers attempted contact with every district in the three groups, including those for which demographics suggested that participation would yield little, if any, financial benefit; this was done to verify their reasons without making assumptions. To enhance the response rate, callers assured respondents anonymity as to their individual and district identities. Of the 143 calls, 90% responded, with 15 districts declining to respond.

Group 2 results, 97 districts that received reimbursement for direct services, but not for administrative activities in fiscal 2001.

Eight of the Group 2 districts declined to respond. Of the 89 respondents, 20 indicated that they began administrative claiming in fiscal 2002. Among the remaining 69, the most frequently cited reason for declining reimbursement for administrative activities was that the process was too cumbersome (35 districts, 51%). Respondents specifically cited the volume of paperwork, difficulty with compiling the necessary data, staff turnover, and problems with billing agents. Eleven districts (16%) stated that they were unaware of the opportunity for administrative reimbursement, and about half of these asked our callers for material on the program, which we

provided. Eleven (16%) noted that they have few low-income pupils, and consequently do not participate in the types of activities that would generate this reimbursement. Seven (10%) stated that it would not be worth their effort to seek the administrative reimbursement, because the city or town allocates the direct services reimbursement to municipal purposes. Five others (7%) indicated that they did not know why their districts did not participate, or that they are considering future participation.

As noted above, callers also asked Group 2 respondents that are local (v. regional) school districts whether the local appropriating authority allocated any of the direct services reimbursement to school purposes, or to general municipal services. Among the 89 respondents, 70 were local school districts, and 14 of these (20%) stated that they did not know. Of the 56 that stated that they knew, 22 (39%) reported that some or all of the reimbursement was appropriated to school purposes. Almost half of these 22 knew what portion of the reimbursement was returned to schools, with 10 stating that the school department received 100%, and 3 stating about 50%. Thirty-four (61%) of the local district respondents reported that none of the direct services reimbursement was allocated to school purposes.

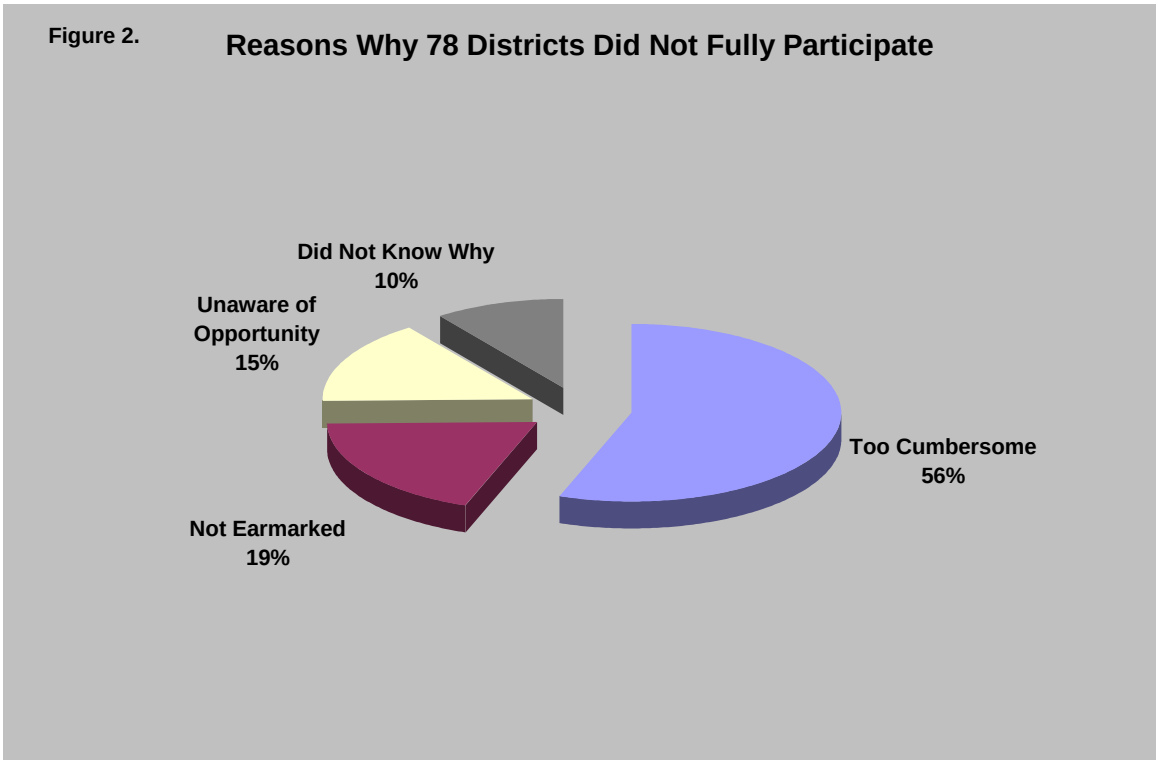
Group 3, 3 districts that received reimbursement for administrative activities, but not for direct services in fiscal 2001.
For this small group, responses cannot be reported without compromising the assurance of anonymity.

Group 4 results, 43 districts that did not participate at either level, and received no reimbursement in fiscal 2001.
Among the 36 that responded, 2 indicated that they enrolled in the program in fiscal 2002. For the remaining 34, 14 (41%) reported that they had too few special needs or low-income pupils to warrant participation. For these districts, even full dedication to the program would yield few, if any, federal dollars. Eight (24%) stated that the claiming process was too cumbersome, while 5 (15%) felt that the process was not worthwhile, because the money is not earmarked for schools. One was unaware of the program. Others (6, or 17%) indicated that they do not know why their districts do not participate, or that they are considering future participation.

Observations
The combined results of the responses of Groups 2 and 4 show that 103 districts did not fully participate in fiscal 2001, and did not indicate new enrollment for 2002. Twenty-five of these stated that the reason for this is the demographic nature of their student populations, a factor that would lead to little, if any, benefit from the program. *Accordingly, 78 districts may be missing this opportunity for federal dollars.*

Forty-three of these 78 (56%) indicated that they did not fully participate because the nature of the claiming process is too cumbersome. Fifteen (19%) of these 78 stated that they did not participate, or did not fully participate because state law does not target the federal reimbursement for schools. The remainder stated that they were either unaware of this opportunity, or did not know why their district did not participate. Figure 2 illustrates these results.

Figure 2.



For administrative claiming, our assessment is that there is little room for streamlining this process, because the DMA guidelines are no more stringent than federal requirements. Yet, 186 districts managed within the current process to collect nearly $51.2 million in federal reimbursements for direct services, and $34.6 million for administrative activities in fiscal 2001. Admittedly, the return for some was relatively low; the minimum reimbursement for direct services was $336. The minimum for administrative activities was $515. Nonetheless, the median for each type of reimbursement was about $51,000.

The following section of this report offers recommendations to enhance participation in the Municipal Medicaid Program and to address these and the additional findings presented below.

FINDINGS AND RECOMMENDATIONS

1. The General Court should enact legislation to earmark Municipal Medicaid reimbursements for schools—at a minimum assuring that at least new FFP realized as a result of new effort is returned to school departments. As explained earlier, state law[19] provides that Municipal Medicaid reimbursements be deposited with the municipal treasurer, to be used at the discretion of the local appropriating authority. In the case of regional school districts, this FFP is directed to the regional district treasury, and allocated at the discretion of the regional school district committee. In 1991, this office recommended that this federal aid should be earmarked for school departments, as an incentive and reward for the extra labor required to capture this resource. Over the years, the General Court has shown some interest in this issue, but has yet to take definitive action.[20]

While we commend the development and implementation of this program at both the state and local levels, the findings detailed below demonstrate that there are means to further maximize this source of federal money. Our telephone survey of special education administrators in selected districts indicates that lack of earmarking is an ongoing obstacle to this goal. As reported earlier, of the districts that did not participate yet stood to gain from the program, nearly 20% stated that they did not participate because the money was not earmarked for schools. Of those that participated but received direct services reimbursement only, 60% reported that none of the money was returned to the school department. Many of these stated that this was the reason they did not go the extra step to claim reimbursement for administrative activities. One respondent summarized this sentiment: "It simply is not worth the extra effort."

The following findings and recommendations present the potential to increase federal revenues for medically related special education services by approximately $50 million annually, but not without extra effort on the part of school personnel. Accordingly, we renew our recommendation for legislation to earmark at least a portion of Municipal Medicaid reimbursements for school departments. At a minimum, new FFP generated as a result of reforms described below should be guaranteed as incentive and reward to the local department that does the work to earn it.

[19] G. L. c. 44, s. 72.

[20] Most recently, a provision of the Municipal Relief Act purports to earmark 50% of Municipal Medicaid receipts for schools in cities and towns that meet defined conditions. However, this provision has no apparent effect because one of the conditions does not occur in any city or town. St. 2003, c. 46, s. 118.

2. DMA should instruct UMass to develop a fee-for-service rate structure/billing methodology. Pursuant to an interdepartmental service agreement (ISA),[21] UMass conducts a number of revenue maximization studies and activities for DMA. Relevant to the Municipal Medicaid Program, one ISA amendment provides that UMass develop and implement a fee-for-service rate structure, if required to do so by HCFA (now, CMS). The amendment stated the anticipated benefit of this change: "On an annualized basis, it is estimated that the Commonwealth may receive $50,000,000 of new federal revenue…."[22] Notwithstanding the May 1999 HCFA instruction that states utilizing bundled rates develop alternatives, based upon an apparent, unwritten understanding that this directive will not be enforced, neither DMA nor UMass could demonstrate steps taken in this direction.[23]

Nonetheless, we questioned DMA as to why they would wait for a further instruction from CMS, if a change in rate structure could almost double the direct services FFP for Massachusetts communities. We also questioned the basis for the $50 million projection. By joint memorandum, DMA and UMass explained their concern that the comparatively burdensome documentation requirements of a fee-for-service system might cause a drop in the school district participation rate. This memorandum also provided a cursory explanation of the basis of the $50 million projection. In response to our request for details, they arranged for an interview with senior UMass staff.

At that time we were offered what we consider to be a reasonable basis of support for the proposition that changing to a fee-for-service method would bring significant and worthwhile new federal dollars into the state. First, the projection assumes the capture of federal dollars for expenses of Medicaid eligible, special needs pupils that schools are not presently claiming. Second, it assumes that presently participating school districts stay with the program, and applies current fee-for-service rates used for non-school providers to historical utilization rates of various services delivered in the school setting. When making this projection, UMass used the service utilization rates developed for the purpose of establishing the bundled rates back at program inception in the early 1990's. According to UMass staff, this projection "is not solid," due to the age of the underlying data.

In our opinion, it is reasonable to assume that the frequency of the need for various types of medical services across the special education population would remain relatively constant, if not grow, over time. If variant, it would tend to grow in frequency rather than reduce, due to the development of new treatment methods and the growth in the numbers of children born with moderate and serious medical needs.[24] For these reasons, we consider $50 million to be a

[21]See Interdepartmental Service Agreement between the Division of Medical Assistance and the UMass Medical School, July 1, 1999 through June 30, 2004 and Amendment governing fiscal 2002 activities, p. 5.

[22]A June 28, 2002 amendment retained the contingent directive, but eliminated the statement of benefit to the Commonwealth.

[23] An April 25, 2003 letter from DMA Acting Commissioner to Dept. of Health & Human Services Regional Inspector General for Audit Services (federal) states that DMA "…is actively exploring alternative rate methodologies." DMA offered no evidence of such work to this office.

[24] See Massachusetts Association of School Superintendents, *The Impact of Special Education Reform: A Case Study of Massachusetts* (2001), and DOE data showing that the number of 3 and 4 year olds in special education increased over 50% in the last decade.

reasonable, if not conservative, estimate of the potential benefit of adopting a fee-for-service rate structure and billing methodology.

We are also confident that with the incentive and reward of additional FFP, the number of school districts that might withdraw from the program because of the difficulties inherent in such a change would not have a significant impact on overall receipts. By way of illustration, if all districts currently receiving less than $50,000 annually for direct student services withdrew, the estimated loss of FFP would be under $2.8 million, based upon current methods. We would expect the growth in receipts for districts staying with the program to more than offset this loss. However, this expectation loses ground, unless the change to a fee-for-service system is accompanied by legislation to earmark at least new dollars for school programs. *Without an earmarking guarantee, schools would have little or no incentive to continue participating in a system that would require more work, with no direct reward.*

3. DOE and DMA should develop and implement a more effective process for obtaining parental authorization, and DOE should amend its special education regulations to require that participating districts take steps to maximize the opportunities of the Municipal Medicaid Program. In addition, DMA should provide targeted technical assistance to districts underutilizing the program. As explained earlier, under the bundled rate system, schools are entitled to claim FFP for each day each Medicaid eligible, special needs child attends school, whether or not the child receives Medical service. *Although we would not expect schools to file claims on 100% of eligible students,* we sought to learn how close schools are to maximizing this opportunity. To establish a benchmark for each district, we assume that the percentage of special needs pupils generating FFP should approximate the percentage of special needs pupils that are considered to be low income, extrapolating from DOE data.[25] To estimate the number of special needs pupils that are low income, we assume that the incidence of low-income factors across the special needs population is proximate to the incidence across the total school enrollment in each community. Impressively, the aggregate, statewide result of these comparisons shows that about 25% of the special needs student population is low income, and about 25% of special needs pupils generate FFP. Yet, a closer look at the data shows a wide variation in community experience that – in theory-- could generate up to an additional $10 million in FFP annually. The consensus among staff at CMS, DMA, UMass and DOE is that a primary reason many participating districts are not closer to full utilization is due to lack of parental authorization.

As explained earlier, among other things, the federal Family Educational Rights and Privacy Act[26] (FERPA) requires informed consent of a child's parent or guardian to share certain student education records with non-school personnel. This requirement applies to the process of providing necessary student information to DMA for claiming FFP. When we asked UMass

[25]Source: Oct. 2000 (fiscal 2001) Individual School Reports. Note: DMA offered a Medicaid eligibility factor (the % of total enrollment that is actually Medicaid eligible) for the subset of districts that claim administrative FFP, but the dates of the source data were inconsistent. Where comparable, DOE's low income percents tended to be smaller than the Medicaid eligibility factors. Accordingly, our benchmarks tend to be conservative.

[26] 20 U. S. C. s. 1232g; 34 CFR Part 99.

staff for an opinion on means to alleviate this obstacle, we were told that this is not a Medicaid requirement, and were referred to DOE. DOE staff had little to offer, except that this is a current topic for a discussion group on Municipal Medicaid issues. DOE did provide districts with model notice to parents and authorization forms back in the early 1990's[27], but we were not apprised of any further state-level guidance on the matter. Although this issue potentially involves up to 25% of the special needs population, state special education regulations do not mention the Municipal Medicaid Program, or related FERPA requirements.[28]

Nonetheless, the data show that some districts are very close to their theoretical benchmarks, while others are far off. For example, we estimate that about 1,120, or 72%, of Holyoke's special needs pupils are low income, and therefore could generate FFP for the City under the bundled rate system. In fact, DMA data indicates that Holyoke made claims on account of 1,110 pupils in fiscal 2001. Even closer to its benchmark of 424 pupils (28% of its special education enrollment in 2001), Quincy billed for 422 pupils. In contrast, the data suggests that Somerville could make claims on as many as 830, or 64% of its special needs students, yet this district billed for 440 in 2001. Again, although we would not expect that the district could bill for 100% of eligible pupils, the potential loss in FFP for the other 390 pupils exceeds $500,000.[29] Similarly, the gap between benchmark and actual billing in Haverhill (465 v. 243 pupils) represents a loss of up to of $286,000. Springfield could be missing up to $2.7 million annually on 2,000 students. This type of data should raise a red flag in a call for state-level assistance. Appendix 2 shows selected data and potential additional FFP for those districts that are below benchmark by 20 or more students, so that they are missing the opportunity for at least $25,000 in additional FFP. In sum, Appendix 2 illustrates the potential for additional annual FFP up to $9.7 million. The incentive to find the means to capture this revenue grows in light of the fact that *schools have two years from the date of service to submit claims to DMA, so they may seek reimbursement for pupils served up to two years earlier.* The statewide sum of these retroactive entitlements could result in a one-time infusion of federal revenue approaching $19 million.

This potential additional FFP is closely tied to the fact that Massachusetts uses a bundled rate methodology, so that schools are entitled to submit claims for all Medicaid eligible special needs pupils whether or not they receive medical services. Even if Massachusetts were to develop an alternative system as recommended above, the process of claiming FFP and obtaining the related FERPA parental consent should be standardized in state special education regulations. Some sources suggest that opportunities exist for near-automatic authorization, if it is sought during the IEP approval process or at the time of Medicaid initial enrollment or eligibility review for school aged children. The existing discussion group on Municipal Medicaid issues could offer advice to DOE and DMA on the specific details. Importantly, there is no risk that school access to a student's Medicaid benefits will compromise benefits otherwise available in non-school

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[27] July 23, 1993 Memorandum from Commissioner of Education to Superintendents of Schools and Administrators of Special Education re: Update on the Implementation of the Municipal Medicaid Project.

[28] The U. S. Department of Health and Human Services, Office of the Inspector General recently observed that some Massachusetts school districts submitted claims and received reimbursement without the required FERPA authorizations. *Medicaid Payments for School-Based Health Services—Massachusetts Division of Medical Assistance—July 1999 Through June 2000* (A-01-02-00009, July 2003).

[29] Estimated loss in FFP is calculated by multiplying the number of potential additional pupils by the weighted average amount of FFP per pupil across the various school settings in 2001: $1,289. (The weighted average at $1,289 contrasts to the simple average of $1,275 used earlier in this report.

settings,[30] so parents and families have nothing to lose. Further, UMass staff indicate that it would take a number of years to develop and implement an alternative rate system. In the meantime, DOE, DMA and participating school districts should take action to assure that claims are filed for every eligible special needs student, and filed to recoup retroactive reimbursements where proper. DMA, perhaps through UMass, should analyze program utilization data and provide targeted technical assistance where warranted. The agency should also explore the utility of including a "best practices" section in its guidance documents to capitalize upon the successful procedures of districts that do maximize this source of federal revenue.

4. DMA should implement oversight procedures to minimize incidences of improper payments. In the course of a review of FFP for direct student services in 8 Massachusetts school districts[31], the U. S. Department of Health and Human Services Office of Inspector General (OIG) found that about 6% of fiscal 2000 payments were made on inappropriate grounds. As a result, CMS is requiring these districts to repay approximately $1.2 million. Table 4 shows the specific amounts for each of these urban districts that, as a group, received almost half of the state total direct services FFP that year.

Table 4.

OIG Findings of Inappropriate FFP for Eight School Districts

Provider School District	Total FFP	Inappropriate FFP	Inappropriate FFP Percent Of Total
Boston	$ 9,759,660	$ 244,402	3%
Fall River	$ 1,095,125	$ 11,642	1%
Haverhill	$ 253,287	$ 56,676	22%
Holyoke	$ 1,065,413	$ 161,669	15%
Lynn	$ 1,094,239	$ 93,325	9%
New Bedford	$ 2,340,129	$ 475,166	20%
Springfield	$ 2,187,563	$ 162,848	7%
Worcester	$ 2,032,952	$ 33,075	2%
Total	$19,828,368	$ 1,238,803	6%

[30] Letter from Deputy Commissioner Bullen, State Department of Public Welfare (now DMA) to Associate Commissioner Fafard, State Department of Education, September 30, 1992.

[31] See report citation at footnote 28, and Memorandum from CMS, Division of Medicaid and Children's Health to the State Office of Medicaid regarding final determination of overpayments, March 5, 2004.

The OIG cited 5 reasons for inappropriate payments:[32] 1) Services were delivered by unqualified personnel; 2) Claims were paid for days students were absent from school; 3) School billed for students that had no IEP on record; 4) Claims were made for days school was not in session, e.g. holidays and weekends; and 5) School claimed payment based on the wrong service code.

The concern with overpayments is the potential need for communities to repay the federal government monies that have long been spent. When questioned about their oversight procedures, DMA and UMass cited text in the standard form provider agreement and state regulations that requires school providers to comply with applicable regulations and allows DMA to recoup overpayments, but they did not describe any procedures.[33] During interview, DMA staff stated that claims are screened for student and provider eligibility, but agreed that additional edits could be added to detect other ineligibility factors, like billing for holidays and weekends. In recent communication, DMA reminded school providers of the need to ensure "appropriate audit mechanisms."[34] However, in light of CMS requirements, this is not a responsibility that can be passed on to school districts without additional state oversight. "State Medicaid agencies are responsible for ensuring that applicable policies are applied uniformly throughout the state, and that claims are submitted to CMS in conformance with such requirements."[35] Although no system can be completely error-free, DMA should implement edits to at least screen out easily detected errors, and amend erroneous claims prior to submission to CMS. For example, had such a system been in place, nearly one half of the amount OIG identified as inappropriate overpayment to one community could have been avoided. Additionally, DMA should initiate more frequent communication with school providers to caution them about error pitfalls and the need for more accurate claiming procedures.[36] Noting that OIG found error rates ranging from 1% to 22% of FFP, this variation warrants investigation for discovery and dissemination of practices that minimize erroneous claiming.

5. DMA should review federal program parameters to ensure that the state program captures all reimbursement opportunities. Although a full comparison of reimbursable services in the federal program v. the state program is beyond the scope of this report, there are two apparent areas for expanding the Massachusetts program. First, special education evaluations are excluded. When asked why, DMA expressed the belief that FFP is not available for this service.[37] The CMS *Medicaid School-Based Administrative Claiming Guide* states that evaluations may not be claimed as administrative expenses.[38] Yet, this same manual explains that it does not set the standard for direct services claims, and for that purpose, refers the reader

[32] CMS staff indicate that Massachusetts is not unique in this situation; audits conducted in other states are finding similar problems.
[33] December 19, 2002 Memorandum from DMA and UMass staff to this office.
[34] MassHealth Municipally Based Health Services Bulletin 8, October 2003.
[35] CMS's *Medicaid School-Based Administrative Claiming Guide*, May 2003, p. 2.
[36] In Bulletin 8, cited above, and Bulletin 9 also issued in October 2003, DMA included reminders on the need for more accurate claims processing and compliance with applicable laws and regulations.
[37] December 19, 2002 Memorandum from DMA and UMass staff to this office.
[38] See p. 18 of CMS Guide.

to CMS's 1997 *Medicaid and School Health: A Technical Assistance Guide*.[39] This guide explains that FFP is not available for evaluations to determine a child's educational needs, but that FFP may be available for evaluations (or portions of evaluations) "to determine a child's health-related needs for purposes of the IEP…."[40] In telephone interviews with Medicaid Directors (or designees) in the other New England states, we learned that Massachusetts is unique among our neighbors in this situation. Other New England states collect FFP for certain evaluations in various ways. These range from Maine, which factors the cost of evaluations into its bundled rates for direct services, to Connecticut which established a separate FFP rate of $1,014 for each qualified evaluation.

Second, we note that the Massachusetts allowance for Team meeting participants is unduly limited. While the federal program does not specifically limit the types of medical personnel, our state program provides that schools may bill for the work of up to three professionals per meeting, including registered nurses, social workers, certified guidance or adjustment counselors, and psychologists. Yet, the Team for a particular individual might include other medical professionals, such as audiologists, and occupational, speech and physical therapists. The fact that the allowed field of professionals is limited may be a reason why schools collectively bill for so few Team meetings. DMA data indicates that in fiscal 2001, about 27% of school district providers made about 5,400 claims for Team meetings. Yet, we estimate that there were over 40,000 special needs pupils who were Medicaid beneficiaries that year.[41] State law calls for at least one Team meeting, an annual review, for each of these 40,000 pupils each year.[42] Granted, many special needs pupils have no medical components to their programs, so the Team meeting process would not involve a medical professional. Nonetheless, it is safe to conclude that more than 14% require the active input of medical personnel that could lead to additional FFP.

Based upon these observations, we recommend that DMA undertake a full, detailed review of elements allowed by the federal program, and take steps to ensure that the state program includes every opportunity for FFP.

6. DMA should provide updated program manuals, and improve overall communication with school district providers. Although supplemented by periodic bulletins, current manuals[43] for direct services claiming have not been revised since 1995. DMA did not offer a single sheet of paper that lists current reimbursable services, codes, and rates, until CMS established National Uniform Service Codes effective October 1, 2003.[44] The full range of claimable services and rates had to be pieced together from a series of bulletins issued from 1995 through 2000. Additionally, DMA is aware of the need to update the state administrative claiming manuals in light of the May 2003 CMS guide on the topic. As well, we recommend that DMA establish on its website a page dedicated to the Municipal Medicaid program. In addition to describing the

[39] See p.2 of CMS Guide.
[40] See p.14 of CMS Guide.
[41] Approximately 25% of the 160,366 special needs pupils.
[42] G. L. c. 71B, s. 3.
[43] The Introduction to this report provides a list of relevant state documents.
[44] DMA informed participants of the uniform national codes, and other matters, in MassHealth Municipally Based Health Services Bulletin 9, October 2003.

overall program, this page could be used to issue periodic updates, and to publicize best practices as suggested in earlier recommendations.

7. DMA should implement data management procedures to facilitate program monitoring, oversight and review. DMA maintains data on the direct services portion of the Municipal Medicaid program, and UMass maintains the administrative activities data. Our efforts to combine these two sources to show the full financial impact for each school district were seriously compromised by several factors. Among these, a number of school districts are identified by different names in the separate databases. Additionally, the UMass administrative activities database does not use provider numbers. This makes the process of aligning the data from the two sources extremely tedious. Moreover, our requests were repeatedly met with data from inconsistent timeframes, so we were led to combine DMA direct services data for a given period with UMass administrative data for a different period. This discrepancy became apparent only because we had monitored program implementation since its inception, and maintained historical data files that differed significantly from what was now being provided. A series of attempts to reconcile these discrepancies was unsatisfactory, so we resorted to the Commonwealth Information Warehouse for data used in this report to show the annual statewide totals and amounts paid to each school district since program inception. DMA needs to coordinate the two separate databases on this program so that it can readily be monitored and reviewed by internal, as well as, external observers.

Appendix 1

Municipal Medicaid FFP
FY 1994 – FY 2002 with 2002 Detail

School District	1994-2002 Total	FY 2002 Direct Service	FY 2002 Administrative	FY 2002 Total
ABINGTON	$ 428,715	$ 68,456	$ 41,819	$ 110,275
ACTON	190,049	11,594	38,364	49,958
ACTON-BOXBOROUGH R.S.D	159,077	19,514	22,130	41,644
ACUSHNET	379,204	8,409	44,051	52,460
ADAMS-CHESHIRE R.S.D.	854,300	111,147	84,552	195,699
AGAWAM	2,033,797	283,242	216,146	499,388
AMESBURY	1,267,535	176,900	69,196	246,096
AMHERST	564,299	89,836	71,852	161,688
AMHERST-PELHAM R.S.D	682,733	129,234	86,727	215,961
ANDOVER	332,059	27,975		27,975
ARLINGTON	769,408	112,558	77,688	190,246
ASHBURNHAM	19,702			
ASHBURNHAM-WESTMINSTER R.S.D	395,243	84,807	65,379	150,186
ASHLAND	744,649	94,537	82,686	177,223
ASSABET VALLEY R.V.T.	56,485	6,122		6,122
ATHOL	8,667			
ATHOL-ROYALSTON R.S.D.	1,599,862	80,861	42,991	123,852
ATTLEBORO	1,630,673	292,954	142,892	435,846
AUBURN	408,507	81,015	68,303	149,318
AVON	220,834	23,820	53,899	77,719
BARNSTABLE	3,792,274	597,708	196,913	794,621
BEDFORD	97,025	11,966	35,306	47,272
BELCHERTOWN	723,571	116,147	53,415	169,562
BELLINGHAM	524,256	15,267		15,267
BELMONT	343,777	25,123	47,520	72,643
BERKLEY	135,722	9,534	26,843	36,377
BERLIN	34,701	614	605	1,219
BERLIN BOYLSTON R.S.D.	47,821	13,314	1,195	14,509
BERSHIRE HILLS R.S.D.	660,169	86,642	77,097	163,739
BEVERLY	2,487,819	348,976	125,719	474,695
BILLERICA	1,155,313	378,827	147,649	526,476
BLACKSTONE MILLVILLE R.S.D.	340,557	14,246	57,999	72,245
BLACKSTON VALLEY R.V.T.	129,196	34,685	10,797	45,482
BLUE HILLS REGIONAL R.V.T.	274,014	18,653	70,951	89,604
BOSTON	96,442,358	10,553,439	6,598,336	17,151,775
BOURNE	462,582	44,427	94,619	139,046
BOXFORD	36,350	5,534		5,534
BOYLSTON	51,280	10,048	624	10,672
BRAINTREE	1,439,083	135,431	249,448	384,879
BREWSTER	220,571	70,183	1,996	72,179
BRIDGEWATER	22,826			
BRIDGEWATER-RAYNHAM R.S.D.	1,245,325	77,452	279,859	357,311
BRIMFIELD	106,966	22,803		22,803
BROCKTON	8,899,808	601,485	931,728	1,533,213
BROOKFIELD	205,099	22,851		22,851

Appendix 1

Municipal Medicaid FFP
FY 1994 – FY 2002 with 2002 Detail

School District	1994-2002 Total	FY 2002 Direct Service	FY 2002 Administrative	FY 2002 Total
BROOKLINE	$ 872,601	$ 107,245	$	$ 107,245
BURLINGTON	534,879	79,222	135,006	214,228
CAMBRIDGE	7,954,186	661,379	896,792	1,558,171
CANTON	145,509			
CAPE COD R.V.T.	223,572	33,012		33,012
CARLISLE	14,314		1,178	1,178
CARVER	512,656	37,459	59,916	97,375
CENTRAL BERKSHIRE R.S.D.	877,489	110,112	47,227	157,339
CHATHAM	33,124			
CHELMSFORD	964,106	123,722	120,943	244,665
CHELSEA	5,347,292	431,949	856,406	1,288,355
CHESTERFIELD-GOSHEN R.S.D.	11,081			
CHICOPEE	6,904,738	878,073	1,158,804	2,036,877
CLARKSBURG	58,447	10,266		10,266
CLINTON	1,100,261	125,206	64,180	189,386
CONCORD	82,667	6,215	936	7,151
CONCORD-CARLISLE R.S.D.	86,545			
CONWAY	15,462	5,151		5,151
DANVERS	753,567	121,624		121,624
DARTMOUTH	599,320	69,788	143,376	213,164
DEDHAM	271,471	89,366	83,522	172,888
DEERFIELD	43,851	10,025		10,025
DENNIS-YARMOUTH R.S.D.	3,017,878	429,545	298,311	727,856
DIGHTON-REHOBOTH R.S.D.	70,114	33,319		33,319
DOUGLAS	96,292	33,986		33,986
DOVER	68,211	7,007		7,007
DOVER-SHERBORN R.S.D.	46,089	7,145	22,761	29,906
DRACUT	1,291,001	95,289	119,264	214,553
DUDLEY-CHARLTON R.S.D.	432,986	86,619		86,619
DUXBURY	259,907	42,423		42,423
EAST BRIDGEWATER	563,788	72,867	2,361	75,228
EAST LONGMEADOW	439,479	66,392	24,194	90,586
EASTHAM	119,139	57,428		57,428
EASTHAMPTON	685,188	139,753	1,039	140,792
EASTON	412,353	81,502		81,502
EDGARTOWN	40,698	10,629		10,629
ERVING	44,074	3,705		3,705
ESSEX	71,948	4,649		4,649
EVERETT	2,679,221	465,660	377,922	843,582
FAIRHAVEN	199,044	18,495	33,493	51,988
FALL RIVER	11,586,317	998,337	1,170,948	2,169,285
FALMOUTH	1,728,116	236,295	279,911	516,206
FARMINGTON RIVER R.S.D.	53,347	6,192		6,192
FITCHBURG	3,369,860	555,655		555,655
FLORIDA	35,298	4,076		4,076

Appendix 1

Municipal Medicaid FFP
FY 1994 – FY 2002 with 2002 Detail

School District	1994-2002 Total	FY 2002 Direct Service	FY 2002 Administrative	FY 2002 Total
FOXBOROUGH	$ 237,825	$ 26,975	$ 50,331	$ 77,306
FRAMINGHAM	4,826,707	413,090	986,016	1,399,106
FRANKLIN	170,814	2,743		2,743
FRANKLIN COUNTY R.V.T.	214,711	41,702	23,409	65,111
FREETOWN	141,936	5,268	112	5,380
FREETOWN-LAKEVILLE R.S.D.	160,635	11,248	9,845	21,093
FRONTIER	217,178	51,341	16,515	67,856
GARDNER	669,539	27,017	159,229	186,246
GATEWAY	615,696	91,026	62,925	153,951
GEORGETOWN	182,972	37,559	514	38,073
GILL MONTAGUE R.S.D.	734,263	112,389	70,585	182,974
GLOUCESTER	2,637,777	319,666	112,911	432,577
GRAFTON	93,789	21,322		21,322
GRANBY	259,331	13,293	32,757	46,050
GRANVILLE	28,395	4,836	2,150	6,986
GREATER LOWELL R.V.T.	1,890,633	184,437	364,369	548,806
GREATER NEW BEDFORD R.S.D.	104,720		12,977	12,977
GREENFIELD	1,735,101	298,884	145,366	444,250
GROTON DUNSTABLE R.S.D.	245,353	21,382		21,382
HALIFAX	106,821	26,654	1,085	27,739
HAMILTON-WENHAM R.S.D.	361,031	29,295	26,879	56,174
HAMPDEN	10,312			
HAMPDEN-WILBRAHAM R.S.D.	590,542	91,776	40,774	132,550
HAMPSHIRE R S D	143,234	12,387		12,387
HANCOCK	1,743			
HANOVER	286,365	44,552	20,607	65,159
HARDWICK	14,888			
HARVARD	3,547			
HARWICH	664,265	126,522	76,377	202,899
HATFIELD	53,023	14,454		14,454
HAVERHILL	3,107,227	234,005	583,604	817,609
HAWLEMONT R.S.D.	64,032	14,210	10,944	25,154
HINGHAM	90,442	7,771		7,771
HINSDALE	765,807			
HOLBROOK	245,627	50,368		50,368
HOLDEN	46,145			
HOLLAND	66,835	7,767		7,767
HOLLISTON	487,800	23,927	81,882	105,809
HOLYOKE	11,374,564	1,157,018	685,544	1,842,562
HOPEDALE	68,219	7,293	15,918	23,211
HOPKINTON	150,302	6,069		6,069
HUDSON	223,061	24,114	85,688	109,802
HULL	622,479	74,378	81,784	156,162
IPSWICH	382,796	26,589	64,155	90,744
KING PHILIP R.S.D	231,945	41,385		41,385

Appendix 1

Municipal Medicaid FFP
FY 1994 – FY 2002 with 2002 Detail

School District	1994-2002 Total	FY 2002 Direct Service	FY 2002 Administrative	FY 2002 Total
KINGSTON	$ 50,217	$ 12,798	$ 7,156	$ 19,954
LAKEVILLE	92,785	3,898	229	4,127
LANCASTER	6,078			
LANESBOROUGH	20,198			
LAWRENCE	13,967,798	1,528,668	860,785	2,389,453
LEE	294,414	20,533	17,870	38,403
LEICESTER	190,189	21,632		21,632
LENOX	86,896	7,134		7,134
LEOMINSTER	2,354,635	202,932	69,578	272,510
LEVERETT	16,674	962		962
LEXINGTON	764,218	71,204	97,903	169,107
LINCOLN	10,154			
LINCOLN-SUDBURY R.S.D.	213,215	10,911	6,322	17,233
LITTLETON	281,425	22,750		22,750
LONGMEADOW	322,739	47,511	84,976	132,487
LOWELL	9,027,096	804,669	1,422,868	2,227,537
LUDLOW	1,222,278	182,628	44,989	227,617
LUNENBURG	82,090	30,680	2,311	32,991
LYNN	15,508,647	1,227,832	1,190,806	2,418,638
LYNNFIELD	318,974	55,947	19,296	75,243
MALDEN	5,072,732	503,633	548,979	1,052,612
MANCHESTER	30,385	6,149		6,149
MANCHESTER ESSEX R.S.D.	2,493	2,493		2,493
MANSFIELD	699,304	84,830		84,830
MARBLEHEAD	386,405	56,823	51,947	108,770
MARION	44,272			
MARLBOROUGH	1,556,332	215,203	259,120	474,323
MARSHFIELD	929,073	165,854		165,854
MARTHAS VINEYARD R.S.D.	78,779	21,544		21,544
MASCONOMET R.S.D.	297,230	28,861	7,830	36,691
MASHPEE	924,777	146,669	112,765	259,434
MATTAPOISETT	27,614			
MAYNARD	55,593	10,631	26,595	37,226
MEDFIELD	112,800	3,014	13,045	16,059
MEDFORD	3,234,570	617,060	216,933	833,993
MEDWAY	292,199	25,104	45,518	70,622
MELROSE	702,859	120,857	72,169	193,026
METHUEN	1,022,872	8,458	78,890	87,348
MIDDLEBOROUGH	796,365	68,947	35,218	104,165
MIDDLEFIELD	26,650			
MIDDLETON	133,848	36,327	1,195	37,522
MILFORD	1,178,238	224,426	191,385	415,811
MILLBURY	509,103	39,961	31,186	71,147
MILLIS	154,076	29,581	25,607	55,188
MILTON	10,495			

Appendix 1

Municipal Medicaid FFP
FY 1994 – FY 2002 with 2002 Detail

School District	1994-2002 Total	FY 2002 Direct Service	FY 2002 Administrative	FY 2002 Total
MINUTEMAN R.V.T.	$ 339,727	$ 36,305	$ 33,607	$ 69,912
MOHAWK TRAIL R.S.D.	725,081	126,234	132,561	258,795
MONSON	524,821	98,673	54,252	152,925
MONTACHUSETT R.V.T.	243,910	14,810		14,810
MONTAGUE	3,708			
MOUNT GREYLOCK R.S.D.	24,125			
NAHANT	32,069			
NARRAGANSETT R.S.D.	366,793	86,697	87,262	173,959
NASHOBA	654,243	67,553	70,546	138,099
NASHOBA VALLEY R.V.T.	151,893	8,016	13,944	21,960
NATICK	1,358,531	162,596	145,733	308,329
NAUSET	277,594	22,895	43,812	66,707
NEEDHAM	443,319	22,181	86,171	108,352
NEW ASHFORD	682			
NEW BEDFORD	19,894,585	2,041,120	276,543	2,317,663
NEW SALEM/WENDELL R.S.D.	45,553	13,129		13,129
NEWBURYPORT	329,242	44,215	67,287	111,502
NEWTON	862,824	44,338	122,851	167,189
NORTH ATTLEBOROUGH	1,003,738	111,410	73,316	184,726
NORTH ADAMS	2,399,957	222,905	464,562	687,467
NORTH ANDOVER	341,542	11,383		11,383
NORTH BROOKFIELD	201,641	82,327	16,834	99,161
NORTH MIDDLESEX	808,060	21,934	73,540	95,474
NORTH READING	395,409	58,331	69,644	127,975
NORTH SHORE R.V.T.	291,007	34,301	43,894	78,195
NORTHAMPTON	1,360,801	72,978	107,717	180,695
NORTHBOROUGH	155,634	27,759		27,759
NORTHBOROUGH-SOUTHBOROUGH R.S.D.	21,143			
NORTHBRIDGE	371,565	80,949	43,452	124,401
NORTHEAST METROPOLITAN R.V.T.	405,851	42,429	48,255	90,684
NORTHERN BERKSHIRE R.V.T.	49,240	5,904		5,904
NORTON	1,155,942	168,132		168,132
NORWELL	113,785	57,228		57,228
NORWOOD	379,231	216,458	101,469	317,927
OAK BLUFFS	34,406	9,765		9,765
OLD COLONY R.V.T.	98,983	23,845	7,952	31,797
OLD ROCHESTER R.S.D.	34,402			
ORANGE	626,419	90,625	51,772	142,397
ORLEANS	60,869	15,270	1,302	16,572
OTIS	10,202			
OXFORD	205,349			
PALMER	747,113	172,751		172,751
PAXTON	5,016			
PATHFINDER R.V.T.	148,167	49,846	35,770	85,616
PEABODY	2,622,203	263,352	9,953	273,305

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Municipal Medicaid FFP
FY 1994 – FY 2002 with 2002 Detail

School District	1994-2002 Total	FY 2002 Direct Service	FY 2002 Administrative	FY 2002 Total
PEMBROKE	$ 251,491	$ 53,131	$	$ 53,131
PENTUCKET R.S.T.	308,889	15,766		15,766
PIONEER VALLEY R.S.D.	499,633	53,725	61,086	114,811
PITTSFIELD	5,303,781	296,489	1,564,771	1,861,260
PLAINFIELD	10,635			
PLAINVILLE	65,209	2,747		2,747
PLYMOUTH	1,318,820	475,436		475,436
PLYMPTON	7,563			
PROVINCETOWN	57,566	10,299		10,299
QUABBIN R.S.D.	343,170	79,403	22,484	101,887
QUABOAG R.S.D.	767,629	130,288	78,668	208,956
QUINCY	5,465,755	455,395	410,709	866,104
RALPH C MAHAR R.S.D.	384,223	82,156	35,730	117,886
RANDOLPH	1,726,433	122,369	348,221	470,590
READING	357,298	25,242		25,242
REVERE	4,188,242	546,737	378,087	924,824
RICHMOND	779			
ROCHESTER	28,993			
ROCKLAND	1,304,549	110,364	93,445	203,809
ROCKPORT	150,192	29,118		29,118
ROWE	6,113	1,621	3,039	4,660
RUTLAND	11,418			
SALEM	3,189,161	322,616	630,622	953,238
SANDWICH	248,295	155,334		155,334
SAUGUS	879,072	129,881	69,342	199,223
SAVOY	39,465	2,391		2,391
SEEKONK	686,115	81,742	50,543	132,285
SHARON	232,664	14,917	768	15,685
SHAWSHEEN R.V.T.	302,321	31,869	33,793	65,662
SHERBORN	15,212	2,811		2,811
SHIRLEY	350,701	17,698	38,257	55,955
SHREWSBURY	536,558	125,045	3,987	129,032
SHUTESBURY	6,343			
SILVER LAKE R.S.D.	152,356	34,064	4,304	38,368
SOMERSET	252,035	47,506	15,482	62,988
SOMERVILLE	6,614,987	767,975	382,262	1,150,237
SOUTH HADLEY	503,014	72,353		72,353
SOUTHAMPTON	39,543			
SOUTH MIDDLESEX R.V.T.	286,550	7,382	58,657	66,039
SOUTH SHORE R.V.T.	87,314	10,816	897	11,713
SOUTHBOROUGH	86,478	23,272		23,272
SOUTHBRIDGE	934,836	70,794		70,794
SOUTHEASTERN R.V.T.	195,067	48,614		48,614
SOUTHERN BERSHIRE R.S.D.	387,961	60,088	13,401	73,489
SOUTHERN WORCESTER COUNTY R.V.T.	66,607	17,088		17,088

Appendix 1

Municipal Medicaid FFP
FY 1994 – FY 2002 with 2002 Detail

School District	1994-2002 Total	FY 2002 Direct Service	FY 2002 Administrative	FY 2002 Total
SOUTHWICK-TOLLAND R.S.D.	$ 466,740	$ 56,167	$ 15,903	$ 72,070
SPENCER	24,026			
SPENCER-EAST BROOKFIELD R.S.D.	938,723	48,368	60,759	109,127
SPRINGFIELD	28,471,931	2,480,281	2,540,343	5,020,624
STERLING	15,191			
STONEHAM	528,232	8,655	130,325	138,980
STOUGHTON	1,551,921	228,861	141,433	370,294
STURBRIDGE	244,786	25,053		25,053
SUDBURY	192,431	16,854	13,096	29,950
SUNDERLAND	39,266	7,849		7,849
SUTTON	115,459			
SWAMPSCOTT	640,373	70,338	136,733	207,071
SWANSEA	339,501	63,579	1,047	64,626
TANTASQUA R.S.D.	134,874	24,794		24,794
TAUNTON	2,416,994	251,729	36,759	288,488
TEWKSBURY	1,221,412	130,821	105,701	236,522
TISBURY	16,004	4,881		4,881
TOPSFIELD	3,039	74		74
TRI-COUNTY R.V.T.	71,292	17,835	1,683	19,518
TRITON R.S.D.	999,245	124,210	106,880	231,090
TRURO	47,793	11,670	19,819	31,489
TYNGSBOROUGH	197,818	28,098		28,098
TYRINGHAM	4,282			
UP ISLAND R.S.D.	12,013	2,467		2,467
UPPER CAPE COD R.V.T.	136,929	30,083	33,691	63,774
UXBRIDGE	41,217			
WACHUSETTS R.S.D.	1,128,295	114,451	84,532	198,983
WAKEFIELD	566,268	109,767	64,705	174,472
WALES	139,771	22,424		22,424
WALPOLE	998,142	98,600	132,396	230,996
WALTHAM	3,895,636	344,858	119,687	464,545
WARE	1,677,988	162,226	39,517	201,743
WAREHAM	2,042,715	201,127	196,939	398,066
WATERTOWN	732,877	83,140	84,932	168,072
WAYLAND	35,614			
WEBSTER	1,034,313	152,279	122,517	274,796
WELLFLEET	82,270	24,155		24,155
WELLSLEY	40,329			
WEST BRIDGEWATER	140,706		22,611	22,611
WEST SPRINGFIELD	2,108,087	344,558	205,273	549,831
WEST BOYLSTON	57,703	28,454	29,249	57,703
WESTBOROUGH	232,611	17,946	84,198	102,144
WESTFIELD	4,482,301	717,571	132,724	850,295
WESTFORD	290,122	46,582	32,540	79,122
WESTHAMPTON	2,334			

Appendix 1

Municipal Medicaid FFP
FY 1994 – FY 2002 with 2002 Detail

School District	1994-2002 Total	FY 2002 Direct Service	FY 2002 Administrative	FY 2002 Total
WESTPORT	$ 243,076	$ 109,975	$ 32,917	$ 142,892
WESTWOOD	63,082	43,333		43,333
WEYMOUTH	1,563,675	300,333	172,684	473,017
WHATELY	13,889	3,098		3,098
WHITMAN	125,408			
WHITMAN HANSON R.S.D.	751,883	152,586	43,945	196,531
WHITTIER R.V.T.	381,143	76,843	17,112	93,955
WILBRAHAM	23,308			
WILLIAMSBURG	48,693			
WILLIAMSTOWN	118,430	16,520		16,520
WILMINGTON	400,544	114,523	55,661	170,184
WINCHESTER	341,815	28,721	45,815	74,536
WINCHENDON	212,370	75,906	46,579	122,485
WINTHROP	1,074,482	169,789	92,165	261,954
WOBURN	1,667,940	162,031	303,281	465,312
WORCESTER	26,909,370	1,771,076	2,129,185	3,900,261
WRENTHAM	103,084	4,829	22,331	27,160
Total	**$ 457,361,132**	**$ 49,942,498**	**$ 39,724,730**	**$ 89,667,228**

Statistics:

Count	**332**	**282**	**205**	**285**
Minimum	**$ 682**	**$ 74**	**$ 112**	**$ 74**
Median	**$ 279,509**	**$ 49,230**	**$ 62,925**	**$ 85,616**
Maximum	**$ 96,442,358**	**$ 10,553,439**	**$ 6,598,336**	**$ 17,151,775**
Average	**$ 1,377,594**	**$ 177,101**	**$ 193,779**	**$ 314,622**

Data Source: The Commonwealth Information Warehouse - Division of Medical Assistance Account 44025011.

Appendix 2 Selected Data and Estimated Potential Additional FFP Greater Than $25,000 At 100% Billing

(note a)

School District	Low Income Percent	Special Education Enrollment	Estimated Potential Billable Students	Actual Number of Students Billed (note b)	Estimated Additional Billable Students	Estimated Additional Potential FFP
Additional FFP >= $1,000,000						
Springfield	70.08%	5,655	3,963	1,861	2,102	$2,710,025
Boston	71.96%	12,446	8,957	8,016	941	1,213,194
Sum					**3,043**	**$3,923,218**
Number of Districts						**2**
Additional FFP $500,000 - $999,999						
Lynn	62.52%	2,758	1,724	1,270	454	$ 585,324
Somerville	64.35%	1,293	832	440	392	505,390
Sum					**846**	**$1,090,714**
Number of Districts						**2**
Additional FFP $100,000 - $499,999						
Lowell	61.18%	2,209	1351	967	384	$ 495,076
Methuen	22.12%	1,253	277		277	357,125
Chelsea	81.69%	772	631	372	259	333,918
Haverhill	26.97%	1,724	465	243	222	286,216
Southbridge	36.18%	526	190		190	244,959
Fall River	50.22%	2,060	1035	867	168	216,596
Taunton	27.64%	1,522	421	291	130	167,604
Greater Lawrence R.V.T.	57.26%	207	119		119	153,422
Framingham	28.02%	1,281	359	252	107	137,951
Brockton	36.47%	2,427	885	783	102	131,505
Salem	34.85%	962	335	238	97	125,058
Gardner	20.81%	631	131	42	89	114,744
Lawrence	78.01%	1,694	1322	1,234	88	113,455
South Middlesex R.V.T.	31.11%	291	91	9	82	105,719
Sum					**2,314**	**$2,983,348**
Number of Districts						**14**
Additional FFP $50,000 - $99,999						
Randolph	24.71%	712	176	106	70	$ 90,248
Leominster	24.98%	1,219	305	236	69	88,959
Webster	34.77%	470	163	100	63	81,223

Appendix 2 Selected Data and Estimated Potential Additional FFP Greater Than $25,000 At 100% Billing

(note a)

School District	Low Income Percent	Special Education Enrollment	Estimated Potential Billable Students	Actual Number of Students Billed (note b)	Estimated Additional Billable Students	Estimated Additional Potential FFP
Additional FFP $50,000 - $99,999 Continued						
Newton	5.59%	1,755	98	37	61	$ 78,645
Greater New Bedford R.S.D.	33.76%	173	58		58	74,777
Waltham	25.75%	1,061	273	215	58	74,777
Fairhaven	21.00%	368	77	22	55	70,909
Everett	37.22%	796	296	243	53	68,331
Oxford	16.01%	309	49		49	63,174
Spencer-East Brookfield R.S.D.	19.53%	471	92	50	42	54,149
Assabet Valley R.V.T.	18.60%	268	50	9	41	52,860
Greater Fall River	23.32%	176	41		41	52,860
Uxbridge	10.32%	398	41		41	52,860
Ayer	25.57%	157	40		40	51,570
Athol-Royalston R.S.D.	29.95%	465	139	100	39	50,281
Winchendon	23.69%	408	97	58	39	50,281
Sum					**819**	**$1,055,904**
Number of Districts						**16**
Additional FFP $25,000 - $49,000						
Milton	5.57%	645	36		36	$ 46,413
Leicester	14.09%	319	45	13	32	41,256
Southeastern R.V.T.	23.66%	288	68	37	31	39,967
Canton	5.21%	575	30		30	38,678
Greater Lowell R.V.T.	34.41%	494	170	140	30	38,678
Bristol-Plymouth R.V.T.	15.88%	183	29		29	37,389
Hudson	10.52%	492	52	23	29	37,389
Pathfinder R.V.T.	20.93%	218	46	17	29	37,389
Northbridge	20.49%	334	68	42	26	33,521
Southern Worcester County R.V.T.	17.60%	238	42	16	26	33,521
Whittier Voc	26.94%	367	99	73	26	33,521
Brookline	10.42%	1,127	117	92	25	32,232
Malden	35.29%	934	330	307	23	29,653
Cambridge	36.41%	1,702	620	598	22	28,364
Franklin	2.97%	861	26	4	22	28,364
Maynard	12.48%	249	31	10	21	27,074
Dedham	8.01%	516	41	21	20	25,785
Montachusett R.V.T.	17.41%	302	53	33	20	25,785
Sum					**477**	**$ 614,977**
Number of Districts						**18**

notes:

a. Estimated additional FFP = the estimated additional billable students x $1,289, the weighted average amount of FFP per pupil across the various school settings in 2001.

b. Sum of actual amounts of students billed contains duplicated enrollment due to transient student population; DMA date of service data.