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Executive Summary

Safe Passages Through Adolescence

Communities Protecting the Health and Hopes of Youth

Lessons Learned from W.K. Kellogg Foundation Programming

W.K. KELLOGG FOUNDATION

TO: Elizabeth

From: Eric

Re: Health Care

Achievements Memo

to HRC From

Chris Jennings

11 pages follow

June 8, 2000

MEMORANDUM TO THE FIRST LADY

FROM: Chris Jennings

RE: Health Security Act Links to Administration Health Care Achievements

cc: Melanne Verveer, Jennifer Klein

In 1994, the President wrote the attached letter to Speaker Gingrich and Senator Dole reaffirming his commitment assuring "insurance coverage for every American". He urged the Congress to take the first steps towards addressing the public's insecurity about the health care system by: (1) prohibiting unfair insurance practices and reforming the market; (2) expanding affordable coverage for children and working families; (3)assuring quality and efficiency in the Medicare and Medicaid programs; and (4) containing health care costs to help reduce the Federal deficit.

Since writing this letter, the Administration has compiled an extraordinarily impressive record of health care achievements, arguably reaching every one of the goals he set out in the 1994 letter. These and numerous other legislative and administrative health care accomplishments can be traced back to many provisions of the Health Security Act. Highlights include:

Enacting legislation, including the Kennedy-Kassenbaum insurance reform legislation; the Children's Health Insurance Program; and comprehensive Medicare reform that extended the solvency of the Medicare program by 26 years, instituted anti-fraud, waste, and abuse measures, and added a range of new preventive benefits.

Taking executive action, including providing the 85 million Americans in Federal health plans receive critical patient protections; and developing privacy protections for electronic medical records.

Proposing major new health reforms, including the investment of $110 billion over 5 years in a comprehensive coverage proposal that includes parents, individuals aged 55-65, and 19 to 20 year olds; financing a new voluntary prescription drug benefit for Medicare; and investing over $28 billion over 10 years in a new long term care initiative to support individuals with long term care needs family caregivers.

Attached is the first draft of a summary documenting those health care achievements with a clear link to the Health Security Act. Jennifer Klein has reviewed this document and is now in the process of adding specific cites of relevant Health Security Act provisions. We both feel confident, however, that each listing has a legitimate Health Security Act lineage.

We wanted to forward you this document to make certain that it reflects the type of presentation that is of interest to you. We will forward you the updated version of this document, along with the specific cites, as soon as it is completed. Please don't hesitate to call if you have any questions or suggestions about this document.

THE IMPACT OF THE HEALTH SECURITY ACT ON SUBSEQUENT HEALTH CARE ACHIEVEMENTS

I. REFORMING THE INSURANCE MARKET / ASSURING PATIENT PROTECTIONS

The Health Security Act had numerous provisions to reform the insurance market and assure consumer protections. These included protections against discriminatory underwriting practices, patient and medical records privacy protections, steps towards mental health parity, and provisions to streamline the duplicative and burdensome red tape associated with insurance and provider claim forms.

Enacted the landmark Kennedy-Kassenbaum legislation that ensures individuals continued access to health insurance (Public Law 104-191). The Kennedy- Kassenbaum (Health Insurance Portability and Accountability Act) legislation prevents individuals from being denied coverage because they have a preexisting medical condition. It requires insurance companies to sell coverage to small employer groups and to individuals who lose group coverage without regard to their health risk status. It also prohibits discrimination in enrollment and premiums against employees and their dependents based on health status. Finally, it requires insurers to renew the policies they sell to groups and individuals.

Enacted legislation requiring mental health parity for annual and lifetime insurance limits (Public Law 104-204). To help eliminate discrimination against individuals with mental illnesses, the President enacted legislation containing provisions prohibiting health plans from establishing separate lifetime and annual limits for mental health coverage.

Enacted legislation to eliminate duplicative and wasteful administrative requirements of the health care system (Public Law 104-191). The Health Insurance Portability and Accountability Act (HIPAA) provided the Administration with the authority to develop a single set of national standards for all health care providers and health plans that engage in electronic administrative and financial transactions to promote more cost-effective electronic claims processing and coordination of benefits. This implementation of this law will eliminate administratively burdensome, duplicative, and wasteful billing requirements for health care providers and insurers.

Issued landmark Federal regulations protecting the privacy of electronic medical records. In the absence of Congressional action, under authority provided by HIPAA, the Administration released a new regulation protecting the privacy of electronic medical records held by health plans, health care clearinghouses, and health care providers. This rule limits the use and release of private health information without consent; restricts the disclosure of protected health information to the minimum amount of information necessary; established new requirements for disclosure of information to researchers and others seeking access to health records; informs consumers about their right to access their health records and to know who else has accessed them; and establishes new administrative and criminal sanctions for the improper use or disclosure of private information.

Enacted legislation prohibiting discriminatory underwriting practices by insurers through the use of genetic information (Public Law 104-191). This legislation, which applies to the insured and self insured markets but not to the individual market, prevents group health insurers from using genetic information to deny individuals health insurance benefits.

Established and endorsed the recommendations of the historic Quality Commission. In 1996, the President created a non-partisan, broad-based Commission on quality and charged them with developing a patients' bill of rights as their first order of business. In October of 1997, the President accepted the Commission's recommendation that all health plans should provide strong patient protections, including guaranteed access to needed health care specialists; access to emergency room services when and where the need arises; continuity of care protections; and access to a fair, unbiased and timely internal and independent external appeals process. The work of the Commission lay the foundation for subsequent administrative and legislative initiatives to improve patient protections and quality improvement.

Issued executive memorandum requiring that the 85 million Americans in Federal health plans receive critical patient protections. In the absence of Congressional action, President Clinton directed HHS, OPM, DOL, DOD, and DVA to ensure that their employees and beneficiaries had the important new benefits and rights that are guaranteed to health care consumers in the Administration's proposed Patients Bill of Rights, including choice of providers and plans, access to emergency services, participation in treatment decisions, confidentiality of health information and a fair complaint and appeals process. Medicare, Medicaid, S-CHIP, the Indian Health Service, FEHBP plans, the Veterans Administration facilities, and the Military Health System are responding by ensuring that all protections that can be extended under current law be provided.

Endorsed the bipartisan Norwood-Dingell Patients' Bill of Rights and worked for its passage. This legislation, endorsed by over 200 health care advocacy groups, is the only proposal that meets the Administration's fundamental criteria: that patient protections be real and that court enforced remedies be accessible and meaningful. The legislation includes: guaranteed access to needed health care specialists; access to emergency room services when and where the need arises; continuity of care protections; access to a fair, unbiased and timely internal and independent external appeals process; and an enforcement mechanism that ensures recourse for patients who have been harmed as a result of health plan's actions.

Issued executive order preventing genetic discrimination in Federal hiring and promotion actions. In February of 2000, President Clinton signed an executive order prohibiting every civilian Federal Department and agency from using genetic information in any hiring or promotion action. This historic action prevents critical information from genetic tests used to help predict, prevent, and treat diseases being used against them by their employer. Since 1997, the Administration has called for legislation that will guarantee that Americans who are self-employed or otherwise buy health insurance themselves will not lose or be denied that health insurance because of genetic information.

Endorsed legislation to prohibit unauthorized use of genetic information by health insurers and employers. President Clinton has endorsed the Genetic Nondiscrimination in Health Insurance & Employment Act of 1999. This bill would extend the protections for genetic information included in the President's executive order preventing discrimination on the basis of genetic information by Federal employers to the private sector. HIPAA prevents group health insurers from using genetic information to deny individuals health insurance benefits. The Daschle-Slaughter legislation finishes the job begun by HIPAA and ensures that genetic information used to help predict, prevent, and treat diseases will not also be used to discriminate against Americans seeking employment, promotion, or health insurance.

II. EXPANDING COVERAGE

The Health Security Act was designed to ensure that every American had affordable, quality, health insurance. Subsequent achievements and proposals by the Clinton Administration provide targeted coverage expansions. Since 1995, the President has enacted the Children's Health Insurance Program, the Work Incentives Improvement Act, and the Foster Care Independence Act. In addition, he has proposed several major health care expansions that would represent the largest investment in health insurance coverage since the enactment of Medicare.

Enacted single largest investment in children's health care since 1965 (Public Law 105-33). The Balanced Budget Act included $48 billion for the State Children's Health Insurance Program – the single largest investment in health care for children since the enactment of Medicaid in 1965. This new program, together with Medicaid, will provide meaningful health care coverage for up to five million previously uninsured children – including prescription drugs, vision, hearing, and mental health services. Within three years of enactment, all 50 states have implemented S-CHIP programs, and over 2 million children have been covered. In addition, the number of states covering children up to 200 percent of poverty increased by more than 7 fold – to 30 states – during that time.

Enacted landmark legislation providing new health insurance opportunities for working people with disabilities (Public Law 106-70). The Jeffords-Kennedy Work Incentives Improvement Act creates important new health insurance options provided to people with disabilities. This landmark new legislation creates two new options for states to offer the Medicaid buy-in for workers with disabilities and provides $150 million in grants to encourage states to take this option; establishes a new Medicaid buy-in demonstration to help people with whose disability is not yet so severe that they cannot work; extends Medicare coverage for an additional 4 and a half years for people in the disability insurance system who return to work; and enhances employment-related services for individuals with disabilities.

Enacted new legislation to help young people leaving foster care (Public Law 106-169). Today, when young people emancipate from foster care, they face numerous health risks, but too often lose their health insurance. The new law grants states the option for these young people to remain eligible for Medicaid up to age 21. HHS issued guidance to all State Medicaid Directors encouraging them to take up this option.

Approved waivers expanding health insurance coverage for Americans. The Clinton Administration has approved 17 state-wide Medicaid waivers linking public health financing with private health plans, providing an estimated 1.4 million low income Americans with critical health insurance coverage for the first time.

Issued Executive Directives to target and enroll uninsured children and launched the national Insure Kids Now Campaign. The President issued two executive directives to enhance current efforts to identify and enroll uninsured children in Medicaid and S-CHIP; one requiring Federal agencies to implement over 150 new actions to enroll eligible but uninsured children, and one directing Cabinet Secretaries to develop strategies to integrate children's health insurance outreach into schools. These Executive Memoranda cut across jurisdiction and traditional agency inflexibility by directing Federal agencies to work together to design collaborative initiatives that build on state innovations. The Insure Kids Now Campaign was designed to build on Administration actions to further promote outreach and enrollment. This bipartisan, public-private education and information campaign includes: the "1-877-KIDS NOW" Hotline, a toll free number to provide information about Medicaid and CHIP to families in all 50 states; running PSAs on national television and radio about Insure Kids Now; printing the toll free number on common products; and reaching out to enlist every school in the country in a children's health outreach campaign.

Proposed $110 billion in FY 2001 budget to extend coverage to over 5 million currently uninsured Americans and provide more affordable coverage to millions more. This initiative would help cover parents of S-CHIP children, 19 and 20 year olds, 55 to 65 year olds, workers in between jobs, and small businesses and their employees. It addresses the nation's multi-faceted coverage challenges by building on and complementing current private and public programs. Specifically, the initiative would:

- **Provide a new, affordable health insurance option for families.** This proposal invests $76 billion over 10 years to provide health insurance to the uninsured families. S-CHIP would be expanded to provide higher Federal matching payments for expanding health insurance to parents of children eligible for or enrolled in Medicaid and S-CHIP. FamilyCare: provides higher Federal matching payments for expanding coverage to parents; increases S-CHIP allotments and makes them permanent to ensure adequate funding for parents and their children; enrolls parents in the same program as their children; covers lower income parents first; and requires all states to cover at least all poor parents by 2006, providing the same coverage their children have today.

- **Accelerate enrollment of uninsured children eligible for Medicaid and S-CHIP.** The President's budget, which will invest $5.5 billion over the next five years in this initiative, will: (1) promote school-based outreach by allowing states to use information on school lunch applications to find uninsured children and to automatically enroll children in the school lunch program in Medicaid and SCHIP while their applications are formally processed; (2) allow additional sites such as child care referral centers to enroll children while their applications are formally processed; (3) require states to synchronize Medicaid and SCHIP eligibility processes.

- **Expand health insurance options for Americans facing unique barriers to coverage.** Some vulnerable groups of Americans often lack access to employer-sponsored insurance and insurance programs like Medicare or Medicaid. This proposal: expands state options to insure children aged 19 and 20 through Medicaid and FamilyCare; establishing a Medicare buy-in option and making it more affordable through a tax credit equal to 25 percent of their insurance premiums; providing a 25 percent tax credit to make COBRA continuation coverage more affordable for workers in between jobs; improving access to affordable insurance by providing tax incentives and technical assistance to establish voluntary purchasing coalitions for workers in small businesses; and extending transitional Medicaid for people leaving welfare for work as well as restoring state options to insure legal immigrants.

- **Strengthen programs that provide health care directly to the uninsured.** This historic new grant program invests $1 billion over 5 years to support community providers of services to the uninsured. These grants will allow providers to deliver the full range of primary care services to the uninsured, rather than treating only the most emergent problems. Currently, many uninsured individuals do not have access to primary care, mental health, and substance abuse services. Funds will be used to preserve access to critical tertiary care services while holding providers accountable for health outcomes.

Invested $220 million in the FY 2001 budget for Medicaid coverage of certain uninsured women with breast and cervical cancer. President Clinton included $220 million in his FY 2001 budget for a new Medicaid option to provide needed insurance coverage to the thousands of uninsured women with breast and cervical cancer detected by Federally supported screening programs. This new proposal will help eliminate the current and frequently overwhelming financial barriers to treatment for these women. The Vice President and the First Lady, national advocates for the prevention, diagnosis, and treatment of breast cancer, strongly advocated for this initiative, which has been endorsed by the National Breast Cancer Coalition and other cancer groups.

III. ELIMINATING TAX INEQUITIES IN HEALTH CARE

The Health Security Act included a number of provisions to eliminate tax inequities in health care, including limiting the exclusion for employer provided health benefits, increasing the deduction for self-employed workers, and providing tax breaks on long-term care insurance premiums.

Enacted legislation to eliminate the discriminatory tax treatment of the self- employed (Public Laws 104-191 and 105-33). HIPAA law increased the tax deduction from 30 percent to 80 percent for the approximately 10 million Americans who are self-employed. The President also signed into law a provision to phase it in to 100 percent in the BBA.

Enacted legislation to provide consumer protections and tax incentives for private long-term care insurance (Public Law 104-191). The HIPAA legislation took steps to make long-term care more affordable by guaranteeing that employer sponsored long-term care insurance receives the same tax treatment as health insurance; implemented new consumer protections to assure that any tax favored product meets basic consumer and quality standards.

Proposed a new 25 percent tax credit for COBRA premiums. COBRA allows workers in firms with greater than 20 employees to pay a full premium (102 percent of the average cost of group health insurance) to buy into their employers' health plan for up to 18 months after leaving their job. This proposal would provide a 25 percent tax credit to make COBRA continuation coverage more affordable for workers in between jobs.

IV. STRENGTHENING AND MODERNIZING MEDICARE

The Health Security Act would have made a significant contribution to extending the life of the Medicare Trust Fund through a series of improvements and program efficiencies, as well as added a new Medicare prescription drug benefit.

Enacted Medicare reforms that extended solvency, provided new preventive benefits, and added new plan choices (Public Laws 105-33 and PL 103-66). The Balanced Budget Act of 1997 contained major new Medicare reforms including:

- **Payment and structural reforms that extend the life of the Medicare Trust Fund until 2025.** When the President came into office, Medicare was projected to become insolvent in 1999. The President's 1993 economic package included policy and structural changes that extended the life of the Medicare Trust Fund by at least three years, and the Balanced Budget Act extended the life of the Trust Fund by an additional 10 years. The Administration's stewardship of Medicare and efforts to combat fraud, waste, and abuse in the program has resulted in the longest Medicare Trust Fund solvency in a quarter century, extending the life of the Medicare Trust Fund by a total of 26 years and offering premiums that are nearly 20 percent lower today than projected in 1993.

- **New structural reforms to modernize the program.** The BBA included a series of structural reforms which modernize the program, bringing it in line with the private sector and preparing it for the baby boom generation. These reforms: increased the number of health plan options; improved Medicare managed care payment methodology and informed beneficiary choice; implemented a prospective payment systems for skilled nursing home facilities, home health, and hospital outpatient departments; and adopted private-sector oriented purchasing.

- **New preventive benefits.** The BBA also: waived cost-sharing for mammography services and provided annual screening mammograms for beneficiaries age 40 and older to help detect breast cancer; established a diabetes self-management benefit; ensured Medicare coverage of colorectal screening and cervical cancer screening (early detection of cancer can result in less costly treatment, enhanced quality of life, and, in some cases, greater likelihood of cure); ensured coverage of bone mass measurement tests to help women detect osteoporosis, and increased reimbursement rates for certain immunizations to protect seniors from pneumonia, influenza, and hepatitis.

Enacted legislation and took administrative action to fight fraud and waste in Medicare (Public Law 104-191). Since 1993, the Clinton Administration has assigned more federal prosecutors and FBI agents to fight health care fraud than ever before. As a result, convictions have gone up a full 410% saving more than $50 billion in health care claims. In addition, HIPAA law created a new stable source of funding to fight fraud and abuse that is coordinated by the HHS Office of the Inspector General and the Department of Justice. Since its passage, nearly $1.6 billion in fraud and abuse savings has been returned to the Medicare Trust Fund.

Enacted legislation to help remedy the reimbursement concerns of health care providers (Public Law 106-113). The Administration advocated strongly for the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, which addresses flawed policy and excessive payment reductions resulting from the Balanced Budget Act of 1997. This legislation invests $16 billion over 5 years to moderate the impact of the BBA by placing a moratorium on therapy caps; increasing payments for very sick patients in nursing homes; restoring funding to teaching hospitals; and easing the transition to the new prospective payment system for hospital outpatients.

Issued an Executive Memorandum directing Medicare to reimburse providers for the cost of routine patient care associated with participation in clinical trials. The President issued an Executive Memorandum directing the Medicare program to revise its payment policy and immediately begin to explicitly reimburse providers for the cost of routine patient care associated with participation in clinical trials. HHS was directed to take additional action to promote the participation of Medicare beneficiaries in clinical trials for all diseases, including: activities to increase beneficiary awareness of the new coverage option; actions to ensure that the information gained from important clinical trials is used to inform coverage decisions by properly structuring the trial; and reviewing the feasibility and advisability of other actions to promote research on issues of importance to Medicare beneficiaries.

Proposed new, comprehensive plan to strengthen and modernize Medicare for the 21st century. This historic initiative would:

- **Make Medicare more competitive and efficient.** The President's plan adds price competition and successful private-sector management tools to Medicare. These policies manage cost growth and allow flexibility to adopt innovative private practices to improve quality and efficiency.

- **Modernize Medicare's benefits, including a long overdue prescription drug benefit.** The current Medicare benefit package does not include all the services needed to treat health problems facing the elderly and people with disabilities. The President's plan would take strong new steps to ensure that Medicare beneficiaries have access to affordable prescription drugs and preventive services that have become essential elements of high-quality medicine by establishing a new voluntary Medicare "Part D" prescription drug benefit that is affordable and available to all beneficiaries and proposal eliminates all cost sharing for all preventive benefits in Medicare. The benefit also provides financial incentives for employers to develop and retain their retiree health coverage if it provides a prescription drug benefit to retirees that was at least equivalent to the new Medicare outpatient drug benefit. In addition, the President's FY 2001 budget also includes financing for protections against the cost of catastrophic drug expenses.

- **Strengthening Medicare's financing for the 21st century.** The President's Medicare plan would strengthen the program and make it more competitive and efficient. However, no amount of policy-sound savings would be sufficient to address the fact that the elderly population will double from almost 40 million today to 80 million over the next three decades. Without new financing, excessive and unsupportable provider payment cuts or beneficiary cost sharing increases would be needed. The President proposes to dedicate $299 billion over 10 years from the non-Social Security surplus to the Medicare Trust Fund, improving its financing and reducing debt.

V. PROTECTING MEDICAID AND IMPROVING LONG-TERM CARE

The Health Security Act ensured that Medicaid beneficiaries received the same stable, high quality health care coverage as other Americans. It also assured that former Medicaid beneficiaries continued to receive all additional specialized services that they received under Medicaid. The Act provided for a new program to deliver home and community based care, as well as tax incentives for quality long-term care insurance.

Vetoed Republican proposals to block grant Medicaid, which threatened insurance coverage for millions of low income people and nursing home residents. The President protected the Medicaid guarantee for children, elderly, pregnant women, and people with disabilities. The President vetoed the Republican proposal to block grant the Medicaid program, and protected the guarantee of meaningful health care coverage or benefits to 37 million beneficiaries.

Enacted new actions to modernize the Medicaid program (Public Law 105-33). The Balanced Budget Act of 1997 (BBA) included several provisions to modernize the Medicaid program and increase state flexibility, including:

- **New steps to increase provider payment flexibility.** The BBA repealed the Boren Amendment and the cost-based reimbursement requirement for Federally qualified health centers and rural health clinics, providing states with greater discretion in establishing their provider payment rates. It also eliminated the burdensome administrative standards for payment to obstetricians and pediatricians, freeing providers from completing up to 300 pages of paperwork before being able to be reimbursed for their services.

- **New flexibility for Medicaid managed care programs.** The BBA allowed states to implement managed care programs without Federal waivers if beneficiaries have a choice of plans. States are permitted to enroll Medicaid beneficiaries in a health plan for up to six months and to guarantee Medicaid eligibility during this enrollment period. It also established Federal guidelines for new state-based quality improvement programs to ensure that managed care providers maintain reasonable access to quality health care.

- **Simplifies state options to expand eligibility and design community based long-term care programs.** States able to manage costs below their per capita limits can expand coverage to any group of people with incomes below 150 percent of the Federal poverty level without a waiver. States can also scale back their coverage expansions to the minimum required by law if they wish. In addition, states can now provide home and community based services to elderly and disabled Medicaid enrollees below 150 percent of the poverty level without a Federal waiver.

Launching a comprehensive nursing home quality initiative. The Clinton Administration has made ensuring the health and safety of nursing home residents a top priority and has issued the toughest nursing home regulations in the history of the Medicare and Medicaid programs, including increased monitoring of nursing homes to ensure that they are in compliance; requiring states to crack down on nursing homes that repeatedly violate health and safety requirements; and changing the inspection process to increase the focus on preventing bedsores, malnutrition and resident abuse. The Administration also established the Nursing Home Compare website, which provides prospective consumers facility specific information on nursing homes. Finally, the Administration recently instructed states to impose immediate sanctions, such as fines, against nursing homes any time that a nursing home is found to have caused harm to a resident on consecutive surveys, in order to put additional pressure on nursing homes to meet all health and safety standards. In addition, the implementation of provisions in the BBRA will invest over $2.7 billion over 5 years in these critical providers, a $500 million increase in reimbursement in 2000 alone.

Approved state waivers to help seniors and individuals with disabilities to stay in their communities. The Clinton Administration has approved over 200 home and community based waivers nationwide, helping hundreds of thousands of people receive the critical health care services they need to function at home rather than requiring them to enter nursing homes in order to receive care.

Proposed new assistance for individuals with long-term care needs and their caregivers. In 1999 and 2000, President Clinton's budgets included an historic long-term care initiative. The President's 2001 budget included a $3,000 tax credit for people with long-term care needs or their caregivers – tripling the credit over last year's proposal and increasing the total investment in long-term care to $28 billion over 10 years. This credit is the centerpiece of the President's historic long-term care initiative. The initiative tackles the complex problem of long-term care that affects millions of elderly, people with disabilities and families who care people in need. In addition, the initiative will:

- **Establish a commitment to provide services to assist family caregivers of older persons.** Recent studies have found that services like respite care can relieve caregiver stress and delay nursing home entry, and that support for families of Alzheimer's patients can delay institutionalization for up to a year. This nationwide program would support families who care for elderly relatives with chronic illnesses or disabilities by enabling states to utilize a visible, reliable network to provide: quality respite care and other support services; critical information about community-based long-term services that best meet a families' needs; and counseling and support.

- **Improve equity in Medicaid eligibility for people in home- and community-based care settings.** This proposal would enable states to provide services to nursing-home qualified beneficiaries at 300 percent of the Supplemental Security Income (SSI) limit (about $15,000) without requiring a complicated and frequently time-consuming Federal waiver. This proposal contributes towards this goal of giving people with long-term care needs the choice of remaining in their homes and communities.

Proposed that the Federal government serve as a model employer by offering quality private long-term care insurance to Federal employees. The Office of Personnel Management (OPM) to use its market leverage and set a national example by offering non-subsidized, quality private long-term care insurance to all federal employees, retirees, and their families at group rates. This proposal will provide employers a nationwide model for offering quality long-term care insurance. OPM anticipates that approximately 300,000 Federal employees would participate in this program.

VI. PUBLIC HEALTH

The Health Security Act included major developments in public health, including significant new investments in biomedical and behavioral research related to health promotion and prevention of disease and health services research. In addition, the Act provided grants to states for core public health functions, a focus on health care for the traditionally underserved, and support for health care professionals and institutions that work in this area.

Enacted unprecedented investments in biomedical research. Funding for NIH has increased by $7.3 billion since 1993 – an increase of 73 percent. In 1997, the President made a commitment to increase the NIH budget 50 percent over the next 5 years. Since that time, the NIH budget has increased by over $4.3 billion, for an all-time high of $18 billion. Last year, NIH received $2.3 billion, a 15 percent increase over FY 1999 funding levels, to build on the President's commitment to biomedical research. With the $1 billion increase proposed by the President in the FY 2001 budget, the Administration will be one year ahead of schedule in reaching the 50 percent goal. As a result, NIH now supports the highest levels of research ever on nearly all types of disease and health conditions, making new breakthroughs possible in vaccine development and use and the treatment of chronic and acute disease.

Enacted historic investments in reproductive health. Since the Clinton-Gore Administration took office, funding for domestic family planning services has increased by 58 percent. During his Administration, President Clinton has taken a number of steps to provide safe and effective family planning services to women, including launching a National Task Force on Violence Against Health Care Providers to coordinate the investigation of violence against women's health care clinics nationwide. In addition, President Clinton has: reversed the ban on the importation of RU-486 and threatened to veto a provision that would have prevented the FDA from using government funds to test, develop or approve drugs that may induce medical abortion; defeated Republican proposals to require minors to obtain parental consent prior to receiving any Title X family planning services and make it illegal to transport a minor across State lines for the purpose of avoiding parental consent or notification laws; and upheld his veto of a bill banning certain late-term abortions without an appropriate exception to protect the life and health of women.

Enacted new investments in mental health prevention and treatment. Since the beginning of the Clinton Administration, funding for mental health services has increased by 65 percent for a total of $631 million in FY 2000. In addition, the President's FY 2001 budget includes a new investment of $100 million for mental health services, an increase of 16 percent over last year's funding level and a 90 percent increase since 1993. This includes a $60 million increase for the Mental Health Block Grant, which provides integral support to States for services for people with severe mental illnesses and $30 million for new Targeted Capacity Expansion grants to assist those with mental illnesses that the Mental Health Block Grant is not authorized to serve.

MEDICAID ADMINISTRATIVE CLAIMING GUIDE -- UNRESOLVED ISSUES

Issue: **Should the free care rule apply to school-based health services?**

HCFA has interpreted their legislation to preclude Medicaid reimbursement for health services normally covered by Medicaid (and the administrative costs associated with those services) provided to Medicaid children by a Medicaid provider if those services are provided free to non-Medicaid eligible children and those services are not required by a child's IEP. For example, no Medicaid reimbursement would be available for non-IEP services provided by the school nurse to Medicaid eligible children if those services are provided free-of-charge to all children in the school—even if most of the children in the school are Medicaid eligible.

Comments: The purpose of the rule is to ensure that Medicaid funds are not used to supplant funding that would otherwise be available for services to Medicaid enrollees. The rule appears to be based on third party liability provisions that were intended to prevent private insurers from escaping from their financial responsibilities. The problem with the free care rule is that in a school-based setting it can operate to undermine the purpose of the Medicaid program—to help ensure that low-income children receive adequate health care. For example, schools can be instrumental in ensuring that poor children receive badly needed services in a school setting. However, schools with significant populations of poor children do not necessarily have the resources to hire professionals to perform these functions. Medicaid funding for an appropriate portion of a school nurse or a school psychologist's time could determine whether this professional is available to meet the needs of Medicaid children in a particular school.

Issue: **Should Medicaid cover services to children protected by section 504?**

Because schools are required to provide services to both Medicaid-eligible and non-Medicaid-eligible children with disabilities who are entitled to services under section 504 of the Rehabilitation Act, HCFA has interpreted third party liability requirements to preclude Medicaid reimbursement for services required by section 504—unless these children are also identified as eligible for services under IDEA. These would include school-based medical services to medically-fragile children with significant physical disabilities who are not covered by IDEA because they do not require special education.

Comments: HCFA argues that Congress did not intend to permit Medicaid reimbursement for services provided to section 504 children because the language it enacted as part of the Medicare Catastrophic Coverage Act allowing Medicaid to pay before education only referred to children identified under IDEA. However, a question can be raised regarding whether Congress ever intended that either IDEA or section 504 be read to create a third party liability that would preclude Medicaid reimbursement for Medicaid-eligible services required by those authorities. Notably, HCFA staff do not believe, as a matter of policy, that Medicaid should cover services to children with disabilities that schools are required to provide as part of their obligation to provide a free appropriate public education.

Issue: **Should Medicaid cover any activities that are part of the IEP process?**

HCFA believes that with the sole exception of medical evaluations, IEP-related activities required by the IDEA should not be covered by Medicaid because these are "education"

activities. These would include activities surrounding the development of the IEP, IEP meetings, and IEP review meetings. Although HCFA staff acknowledge that these activities might involve discussions among medical professionals regarding the need for medical services, determinations regarding the intensity and frequency of service, and arranging for such services, they are opposed to permitting coverage for activities that require "hair-splitting" determinations. They also argue that the State-determined rates for the medical services themselves may already provide or could appropriately provide for some built-in coverage for these kinds of administrative activities.

Comments: Because some school districts appear to be billing for IEP activities that are not related to Medicaid, some clarification in this area is arguably needed. For example, schools should not bill Medicaid for the costs of an entire IEP meeting if part of the time is spent discussing needs of the child that do not involve Medicaid-covered services. Schools should not bill Medicaid for preparing the IEP since that document is not needed for medical purposes. A key question is whether schools can distinguish between activities that support the Medicaid program and those that do not if HCFA allows billing for activities that require such fine distinctions to be made.

Issue: **Should Medicaid cover any activities that are part of "child find"?**

IDEA requires school districts to engage in activities aimed at identifying children with disabilities who are eligible for services under the IDEA. In the course of identifying children with disabilities, school districts identify Medicaid-eligible children who are not enrolled in Medicaid and enrolled children who are not connected to services that meet their needs. Nevertheless, HCFA does not believe that any child find activities should be covered since these are education activities carried out for the purpose of identifying children who are eligible for a free appropriate public education, not Medicaid.

Comments: There would appear to be considerable overlap, particularly in high-poverty districts, in child find activities aimed at identifying IDEA-eligible children and Medicaid outreach activities aimed at enrolling Medicaid eligible children. In addition, activities designed to help connect Medicaid-eligible children disabled children with therapies and other medical services they need arguably should not be treated differently than arranging for Medical services for a sick Medicaid-eligible child.

Issue: **What changes are needed to facilitate the appropriate sharing of personal information on children between schools and Medicaid agencies?**

Information on individual children is needed both to target outreach efforts aimed at enrolling more children in Medicaid and to obtain Medicaid reimbursements for a variety of school-based services. For example, Medicaid agencies can use data on school lunch eligibility to identify poor children who have not enrolled in Medicaid. Schools need data on Medicaid-enrolled children in order to bill for direct services and to calculate the discount rate for administrative services that benefit both Medicaid-eligible and non-Medicaid-eligible children. The problem is that legislation designed to protect the privacy rights of families can create barriers to the sharing of information that is needed for these purposes. For example, Medicaid agencies cannot share information about individual children with schools that are not Medicaid providers and schools can not provide information from children's education records to Medicaid agencies without parental consent.

DRAFT Summary of List of Issues/Comments on the Medicaid School-Based Administrative Claiming Guide

	Issue	Commentor	Description of issue	Resolution?
Issues We Have Agreement On and Can Resolve Now				
Technical Assistance				
1	School Overregulation/ Lack of Tech. Assistance	CGCS, NASDSE, **TX Education Agency**	HCFA has singled out only the school-based sector of the Medicaid program for overregulation. In addition, neither HCFA nor ED have helped schools participate in the Medicaid program.	Special guidance is needed for schools because schools are not typically Medicaid providers. After Guide is finalized, both HCFA/ED will provide TA. In this TA, we may explain the rate setting process in States.
Tone and Clarification				
2	Guide is hard to understand and has a negative tone.	CGCS, CEC, AASA, Sara Rosenbaum, AMCHP, AOTA, MDLC, NASP, TX Education Agency, Dallas Ind. School District, Chicago Public Schools, IA Dept. of Ed., TX IHSM, NASN, MI Dept. of Community Health, MeccaTech, NJ Dept. of Human Services, CCSSO, NSBA	Most of the commentors noted that the Guide was not user-friendly, and emphasizes what schools cannot get reimbursed for rather than what they can. **It was also noted that the Guide does not provide any examples of existing systems as good models of what administrative reimbursement is allowable.**	Guide will be revised across the board to make it easier for all interested parties to use, and will include more examples of what is allowable.
3	Definitions	APHSA, **CA Local Education Consortium, TX Education Agency, AASA**	Guide needs to define terms. **Newly clarified and existing policies should be identified in an appendix.**	HCFA/ED will add a glossary **to the Guide and will consider adding an appendix**.
4	**Separation of Services from Admin.**	**AASA, APHSA, Sara Rosenbaum, TX Education Agency, Council for Exceptional Children, MI Dept. of**	**The Guide artificially separates administration from services. It should show the connections between the two.**	**The Guide will be clarified with respect to the relationship and distinction between administration and services. However, the Guide is intended to focus on administrative**

	Issue	Commentor	Description of issue	Resolution?
		Community Health		**claiming and will not be recast as a vehicle for providing guidance on Medicaid services and reimbursement.**
5	Medicaid Service Translation	APHSA, FL AHCA, AASA	Most schools cannot afford separate units to perform translation functions, which the Guide seems to require.	HCFA will revise the Guide to clarify that a separate translation unit is not required.
6	Third party liability	NGA, Hillsborough County School District (FL), MO Dept. of Ed., CEC, TX IHSM, ATAP, MeccaTech, NJ Dept. of Human Services, AASA, **NCSBA, CMSO**	TPL provisions should be clarified.	HCFA will consult with NGA. **The** Guide will be revised to clarify policy on third party liability. **Medicaid pays before ED, but after other third parties. In order for Medicaid to pay for admin associated with services in a child's IEP, the school must first seek reimbursement for the service from third party payers. (See also matrix issue No. 43.)**
7	IDEA Related Services vs/ HCFA IEP/IDEA Related Activities	CGCS, MeccaTech, TX IHSM, **NCSBA**	The Guide includes a confusing mix of terminology in the discussion of "IDEA related services," which has a statutory definition, and "IEP/IDEA related activity." This leads the impression that some activities are not reimbursable.	We will review the Guide and clarify the definitions and terminology related to the IEP.
8	Child Find – Outreach vs. Identification	CGCS, CCSSO, AASA	For reimbursement purposes, the Guide should distinguish between "child find" as identified in the IDEA statute and Medicaid outreach.	We will distinguish between the two activities. HCFA does not believe that IDEA "Child Find" should be billable to Medicaid. **(See also matrix issue No. 40.)**
9	IDEA Part C/IFSP's	NGA	The Guide doesn't say whether it also applies to IDEA Part C, which serves children aged 0-3.	The Guide does apply to Part C children if they are being served in schools. HCFA/ED will work together to

	Issue	Commentor	Description of issue	Resolution?
				develop appropriate language on Part C for the Guide.
10	Documentation	NGA, DMG-Maximus, MO Dept. of Ed., TX Dept. of Health, NJ Dept. of Human Services, **TX Education Agency**	Guide needs to provide details on documentation requirements.	HCFA will specify in the Guide what documentation is necessary.
11	SPMP -- Documentation	APHSA, Sara Rosenbaum, NCSBA, TX Dept. of Health, Dallas Ind. School District, TX IHSM, NJ Dept. of Human Services, AASA, **TX Education Agency**	Need to clarify documentation requirements for enhanced rate. **The Guide**'s current description goes beyond standard practice. **The employer-employee relationship for SPMP activities is not clear.**	Richard will contact APHSA about questions. This issue will be raised with education groups, too. **HCFA will clarify that the criteria for SPMPs not employed directly by the State Agency do not include the requirement that an employer-employee relationship exist between the State Agency and the SPMP.**
12	Claiming for Medicaid outreach	APHSA, TX Dept. of Health, TX Education Agency, MI Dept. of Community Health, AASA	The Guide should not discourage claiming for Medicaid outreach campaigns.	The interagency workgroup agreed that efficiency is an important principle, and this will be noted in the Guide. HCFA will reimburse claims as long as States provide sufficient documentation for allowable activities.
13	Ensuring Services Are Provided	CGCS, MO Dept. of Ed., TX Dept. of Health, TX Education Agency, Chicago Public Schools, TX IHSM, MI Dept. of Community Health, NASDSE	The Guide seems to hold schools responsible for ensuring the provision of services once a referral has been made.	HCFA will pay for the referrals regardless of whether the service was provided. But the Guide may include a statement indicating that States need to have a system in place for ensuring that students are actually receiving services.

	Issue	Commentor	Description of issue	Resolution?
14	Medicaid Matching Exclusions	CGCS	The Guide should require the Federal matching funds be provided to the schools, particularly when the schools put up the State share.	We may add language to the Guide addressing the schools' concerns.
15	SCHIP	APHSA, CSBA, TX IHSM, AASA, NSBA	There should be a discussion on SCHIP and the relationship between Medicaid and SCHIP.	HCFA will add a discussion, including how discounting should be applied to outreach that covers both Medicaid and SCHIP.
16	Provider Participation	Sara Rosenbaum, Hillsborough County School District (FL), IL State Board of Education, CSBA, Chicago Public Schools, CA Local Educational Consortium, NSBA, AASA, **TX Education Agency**	The Guide should clarify whether schools and staff that conduct administrative activities must be certified Medicaid providers.	HCFA will address this concern in the Guide.
17	New Policy in Guide	Austin Ind. School District, Sara Rosenbaum, Hillsborough County School District (FL), Macomb Ind. School District (MI), CSBA, TX Education Agency, Chicago Public Schools, MeccaTech, NJ Dept. of Human Services, NSBA, AASA	The Guide proposes to change existing Medicaid policy on many issues.	HCFA will address this concern in the Guide.
18	Interaction of Medicaid and Education	All commentors	The Guide should acknowledge the unique role of schools in the Medicaid program. (Also note references to case	HCFA will expand this discussion throughout the Guide.

	Issue	Commentor	Description of issue	Resolution?
	Programs		management under **matrix issue No. 20.)**	
19	Role of Managed Care/ Coordination of Activities	Sara Rosenbaum, Hillsborough County School District (FL), CA School Nurses Organization, Macomb Ind. School District (MI), NCSBA, TX Dept. of Health, NASP, TX Education Agency, CA Local Educational Consortium, NASN, AASA	National reviews have found that few MCOs cover services and administrative activities furnished in schools and in IEPs. The Guide's discussion of managed care does not recognize this finding. The Guide also appears to limit case management functions to MCOs.	HCFA agrees that coordination between schools and MCOs must reflect the requirements of the MCO contracts; however, this point serves to reinforce the coordination principle in the Guide. We will review the language in the Guide to clarify this point.
20	Duplicate Payments	Sara Rosenbaum, Hillsborough County School District (FL), Macomb Ind. School District (MI), NCSBA, TX Dept. of Health, Chicago Public Schools, TX IHSM, MeccaTech, CCSSO, AASA	Although the Guide disallows duplicate payments, there is no provision in the statute that permits the Secretary or a State to deny payment for activities that may also be covered in theory under any other federal, State, or local program. The Guide should clarify whether HCFA will allow multiple providers within a State or school district.	HCFA agrees that this requirement is distinct from the issue of coordination of activities and the performance of them in the most effective and efficient manner possible. We will review the language to ensure that this is clarified in the Guide.
21	Interagency Agreements	NJ Dept. of Human Services, TX Dept. of Health, HCFA Region I, NASP, AASA, **TX Education Agency, CA Local Education Consortium**	Requirements for interagency agreements are not made clear in the Guide.	HCFA will address this concern in the Guide.
Time Study Flexibility				

	Issue	Commentor	Description of issue	Resolution?
22	Flexibility in developing time codes	NGA, APHSA, Hillsborough County School District (FL), NCSBA, MO Dept. of Ed., TX Dept. of Health, TX IHSM, NJ Dept. of Human Services, AASA, **TX Education Agency**	Guide should clarify whether or not States can deviate from the codes.	Schools can deviate from codes, however, parallel coding structure needs to remain in place (i.e., must capture 100% of time).
23	Time Studies	CGCS, TX Dept. of Health, TX IHSM, **AASA, CCSSO**	**HCFA should permit alternative methodologies other than random moment sampling.** HCFA should provide some flexibility for time study validation, such as aggregate analysis versus individual level analysis.	Flexibility is possible as long as method used is statistically valid—HCFA will try to develop some examples of acceptable methods.
24	Time Study periods	NGA, APHSA, HCFA Region VII	Time study periods should be modified to exclude first and last few weeks of classes. The Guide should also permit semester sampling.	HCFA will consult statistician—these methods are acceptable as long as they are statistically valid.
25	Sample Universe	HCFA Region VII, TX IHSM, TX Education Agency	The Guide should indicate the appropriate sampling universe and the need for reviewing State school district staff to determine whether a Statewide pool or multiple pools are necessary.	HCFA will address this issue in the Guide.
26	**Data Sharing**	**CGCS, AASA, CCSSO**	**Schools expressed frustration over the limitations on data sharing for purposes of verifying eligibility and developing Medicaid rates. Other problems are related to accessing databases.**	**This issue should be discussed further with the education groups and should be raised with APHSA.**
Areas Where Agreement is Likely, and the School Groups Will Oppose				
27	Time Study	NGA, APHSA, Texas	All time study code should be 100%	The Interagency Workgroup

	Issue	Commentor	Description of issue	Resolution?
	Codes	Dept. of Health, **TX Education Agency**	Medicaid reimbursable.	disagrees—some time study codes do not distinguish between Medicaid and non-Medicaid eligibles.
28	Discounting methods	NGA, APHSA, IL State Board of Education, NCSBA, Des Moines Public Schools, TX IHSM, NJ Dept. of Human Services, NSBA, **TX Education Agency, CA Local Education Consortium**	Medicaid eligibility verification is administratively burdensome—can schools employ an alternative method, (e.g., school lunch elig proxy).	School lunch proxy is not likely to be acceptable due to potential errors. **HCFA will look into ways for identifying and documenting reasonable methodologies for developing the Medicaid rate.**
29	Training time study participants	CGCS	Only staff selected for the time study should have to be trained	The Workgroup is concerned that this approach may produce a sample that is not statistically valid.
30	HCFA approval process	CGCS	HCFA should not get involved in reviewing and approving school-based claiming proposals—it's micro-management	HCFA disagrees.
31	Validation/Documentation of Claims	CGCS	The Guide proposes unnecessary micromanagement of how schools differentiate between admin. activities. More efficient validation, and State/local flexibility, are needed.	HCFA is not going to reduce the scope of required documentation for claims, especially given the increased outside scrutiny of school-based claims.
32	**Enhanced Rates** and Activity Codes	CGCS, IL Dept. of Public Aid, Hillsborough County School District (FL), NCSBA, TX Dept. of Health, TX IHSM, MI Dept. of Community Health, AASA, **TX**	The Guide should include the possibility for enhanced rates in the activity code listings.	We will not list enhanced rates in the activity codes because it could lead to improper use of these rates. We will amend the Guide to better relate enhanced rates to schools, and HCFA will work with States in developing their activity codes.

	Issue	Commentor	Description of issue	Resolution?
		Education Agency		
33	Cost Allocation Plans (CAPs)	IL Dept. of Public Aid, **Hillsborough Co. Public Schools (FL)**	HCFA should not require CAPs to be reviewed and approved by DHHS (DCA) and HCFA as this would be duplicative.	HCFA will clarify that this approval process is not a change in policy.
34	Family Planning	Sara Rosenbaum, IL State Board of Education, Chicago Public Schools, AASA	Because the Guide requires "offering, arranging and furnishing" of family planning services for an enhanced match, the Guide should provide concrete examples of family planning activities that could be claimable.	HCFA will strengthen this discussion but maintain the current statutory interpretation.
			Unresolved Issues	
Issues Likely to Require Policy Guidance				
35	Transition period	NGA, APHSA, TX Dept. of Health, TX Education Agency, IA Dept. of Ed., NJ Dept. of Human Services	Provide a transition period to allow States to come into compliance with HCFA requirements	Administration needs to come up with a position. The IWG thinks this should be addressed in separate memoranda, not the Guide.
36	Medicaid certified providers	NGA, Austin Ind. School District, TX IHSM, NJ Dept. of Human Services, AASA, **CA Local Education Consortium, TX Education Agency**	Provide relief to schools from administrative burden of verifying Medicaid provider status.	HCFA will look into allowing schools to use a "proportional Medicaid provider rate." HCFA will contact APHSA to see if State Medicaid agencies could disseminate lists of Medicaid providers to schools.
37	Transportation	APHSA, CA School Nurses Association, CGCS, Tuolumne County Schools, Kern County Schools (CA), TX Dept. of Health, TX Education Agency, CA Local	Policy needs to be clarified. **Code 5b is inconsistent with Section K**	HCFA plans to issue policy guidance clarifying the 5/21/99 guidance. If this happens prior to finalization of the Guide, the new policy will be reflected in the Guide. **HCFA will clarify that the**

	Issue	Commentor	Description of issue	Resolution?
		Educational Consortium, TX IHSM, NASN, NASDSE, AASA	**of the Guide.**	**transportation time study codes cover time spent assisting or accompanying a child to a service. The actual transportation costs, whether billed as services or administration, are not part of the time study and are submitted for direct reimbursement.**
38	EPSDT	NGA, APHSA, Sara Rosenbaum, NASP, Chicago Public Schools, CEC, MeccaTech, NJ Dept. of Human Services, AASA	Clarify that covered EPSDT services must fall under 1905(a) definitions	EPSDT discussion in the Guide will be enhanced. More discussion is needed on EPSDT.
39	Child Find	APHSA, Maryland Dept. of Education, DMG-Maximus, TX Dept. of Health, TX Education Agency, Chicago Public Schools, TX IHSM, MeccaTech, CCSSO, NSBA, AASA	Child find should be Medicaid reimbursable insofar as it helps identify Medicaid-eligible children.	HCFA will expand discussion on "child find" to avoid generalizations of what is unallowable. This issue needs to be discussed further.
40	Position Descriptions	APHSA, CGCS, Maryland Dept. of Education, TX IHSM, **AASA, CCSSO**	Not all school districts job descriptions match federal descriptions under each activity—does this mean school can't bill if the job descriptions don't conform to federal descriptions? **The Guide should not require position descriptions for persons who are not making Medicaid administration claims.**	A decision needs to made on level of specificity required in job descriptions. **The Guide does not require position descriptions for personnel who are not making Medicaid admin. claims.**
41	Exclusion of	CGCS, Chicago Public	Medicaid should be the payer of first	ED and HCFA need to confer with legal

	Issue	Commentor	Description of issue	Resolution?
	Sec. 504 children	Schools, CEC, TX IHSM, NASDSE, AASA	resort for Section 504 children.	counsel on this issue. ED wants to consult with OCR staff, too.
42	"Free Care Rule" – Application in Schools	CGCS, Sara Rosenbaum, NCSBA, NASP, Chicago Public Schools, NASN, MeccaTech, AASA	There is no statutory basis for HCFA's application of the "Free Care Rule" in schools. **In addition, there are very few universal free services in schools.**	This issue needs to be discussed further. The final Guide will include appropriate statutory references. **The free care discussion in the Guide will be revised to address the issue in a way that is more meaningful to schools and provides examples.**
43	IEP Development and related activities	CGCS, Sara Rosenbaum, Hillsborough County School District (FL), MeccaTech, Macomb Ind. School District (MI), NCSBA, TX Dept. of Health, TX Education Agency, Chicago Public Schools, CEC, TX IHSM, ATAP, MeccaTech, NJ Dept. of Human Services, NASDSE, NSBA, AASA, **CCSSO**	The Guide should allow for reimbursement of administrative activities related to the development of an IEP.	We need to better understand what transpires in the IEP development process. HCFA thinks the admin. associated with IEP development may be reflected in the service cost. The Guide may include further discussion of the IEP process, and what is and is not reimbursable.
Other Unresolved Issues -- More Information is Needed				
44	Apply Title V exemptions	APHSA	Provide exemptions to reporting requirements if the admin program is an integral part of Title V program.	HCFA will get clarification on this comment.
45	Indirect cost rate	APHSA, DMG-Maximus, Macomb Ind. School District (MI), NJ Dept. of Human Services	Is this a new requirement?	HCFA believes it is not, but will discuss further with ED and ASMB.
46	Offset of	CGCS, Hillsborough	Which third party payer costs are not	HCFA needs to develop examples—

	Issue	Commentor	Description of issue	Resolution?
	revenues/ exclusion of staff from time study	County School District (FL), NSBA	considered Medicaid allowable costs? (e.g., local, State, federal, private?)	Dave will get info on federal school grants.
47	**OMB Circular A-87 Flexibility**	**IWG**	**ED indicated that methodologies are sometimes approved by ED for certain education programs, while those same methodologies are determined unallowable by HCFA for the purpose of application to the Medicaid program.**	**OMB will review whether OMB Circular A-87 addresses the situation of two Federal agencies with different approval standards for sampling methodologies in the administration of their respective programs, when these programs take place in the same setting (e.g., ED and HHS program in a public school setting).**

CJ – lots of calls from Education + Health Canary

Use of medicaid IDs in subsidy-based items

issues + appropriate uses

Deloitte guide – too general, less assistance than helpful

Tim Westmoreland

Good progress between CONTRACT + Administrative days pass

Substantive disagreements

Don't believe medicaid folks want guidance but tools other models + academics

How do you deal w/ it in absence of guidance?

Even Regs allow parts guidance cannot

Oct 7th

→ Oct. 28th Anne-marie Agnew

① How can I be helpful – outreach? alternat

② Testing, gaining info.

Interesting –

Send thru school@ call from meeting ▷

queue

Medicaid – Administrative Reimbursements

4 Key issues

HCFA DSHs & draft guide on school-based medicaid – prior to meeting this year

Schools – suspension that we consulted in improving billing for transportation

HCFA

States misinterpret rules to keep $, for state budgets that should be spent to schools on transp

HCFA – guide that will be sensitive historical use of medicaid in schools

Policy calls – do not involve waste taxpayer $

disabled kid does not get special ed services not covered by IDEA kid in wheelchair – transport issues

① SPA kids – HCFA – medicaid will cover services for SPA kids – not legally compelled

medicaid kid's asthma

[3rd party rule – private insurance has to pay 1st

HCFA imposes duty on school districts to find c/ medicaid

school districts should be 3rd party

SPA

logic is non-sensical

We, as a gov't, have said that there has ~~most~~ reason services

↳ ~~[illegible]~~ Tegan Admin trying to restrict medicaid
HCFA staff

- Stop paying when there is legal liability for a 3rd party — in this case the schools

- town save position and Tegan in relation to IEP meds

- funding theory

Hilary Clinton, [illegible], Harkin b/c they lost at SOY

position changing that

legal position is wrong headed

State isn't 3rd party — they are a partner

Schools stand to SOY — mustn't not changing

policy [illegible]

(2) IEP process — IEP team — won't pay

Only pay for medical evaluation not IEP teams

won't pay for doctors, psychologists, etc. — won't pay for treatment

Pay for medical services

- want medical professionals not be driving the team

(3) Outreach — IDEA requires states do "child find" — find kids w/ disabilities —

HCFA - do outreach to medicaid children

Part D funds spent on this

Want kids w/ disabilities to get medical intervention

(10) Free care

HIPAA - Free care = no care

Survive w/ restricted rights

Start w/ prove - pay for services me to treat restricted rights

Must do it if you don't charge other people for services

demands + 3rd party rule

Many, many poor kids

- mechanic D should move - heal like example

Long term treatment

- Many poor should not be able to

HHS: School-based Medicaid

THE WHITE HOUSE
WASHINGTON

Enclosed is a copy of the draft guidelines for Medicaid school-based administrative claiming for your assessment. The meeting to discuss this issue is set for next Thursday, August 31, 2000 at 4:00 p.m. in Room 211 of the Old Executive Office Building.

Please call Julia Doan at 202/456-5594 or e-mail at Julia_Doan@opd.eop.gov with security information including your principal's and others' planning to attend the meeting social security number and date of birth.

- Open to schools to need consultants to do -

- Harold Ickes was deleted

- HHS A. Woods

Medicaid School-Based Administrative Claiming Guide - DRAFT

Introduction

The purpose of this Administrative Claiming Guide is to provide information to help all interested parties better understand the requirements for claiming Medicaid reimbursement for administrative activities performed in the school-based environment. An additional objective of this Guide is to promote greater consistency in claiming practices to ensure program integrity, and to assist states in the implementation of effective administrative claiming practices.

The school environment offers unique advantages and opportunities to reach children and families to inform, encourage and assist them to access needed health care services and to enroll in the Medicaid program. Collectively, the Individuals with Disabilities Education Act (IDEA), Section 504 of the Rehabilitation Act, and certain titles of the Elementary and Secondary Education Act (ESEA), contain numerous requirements related to LEAs' responsibilities to identify, evaluate, treat, and accommodate the physical and mental health needs of all children that may place them at-risk for poor school outcomes. These requirements have served to define schools as a vital link for families to needed health care and a cost effective, timely, and accessible source of service delivery

The administration of the Medicaid program depends upon an effective state and federal partnership. Federal Medicaid guidelines provide a framework for each State to establish and administer its Medicaid program to best meet the needs of its people. States have flexibility to:

1. Establish eligibility standards;
2. Determine the provider, type, amount, duration and scope of service;
3. Set the rate of payment for services; and
4. Administer its own program, including development of administrative requirements to verify claims.

Federal law permits reimbursement of allowable administrative activities when necessary for the proper and efficient administration of the Medicaid State plan. The determination of allowable administrative activities requires close coordination between the LEAs, State Medicaid Agency, State Department of Education, providers and other public agencies.

The Health Care Financing Administration (HCFA) is legally responsible for assessing all such programs in accordance with the applicable Federal Medicaid requirements. Therefore, state's

programs for administrative claiming for school-based activities should be reviewed and approved by HCFA, prior to implementation, in the same manner and timeframe as that afforded state's proposals for administrative claiming by other non-educational public agencies. This Guide should be useful for LEAs, State Medicaid Agencies, and HCFA staff in the process of development, review, approval, and implementation of school-based Medicaid administrative claiming programs.

I. Program Basis and Authority

This Guide provides the basic Federal requirements for administrative claiming in the Medicaid program and is intended to foster better understanding of program parameters and the applicable statutory and regulatory provisions. This Guide lists the relevant legal and programmatic bases and authorities, including sections of the Social Security Act, Parts 42 and 45 of the Code of Federal Regulations (CFR), and the Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments." In addition, OMB mandated in Circular A-87 that the Department of Health and Human Services (DHHS) issue implementing material for Circular A-87 on behalf of the federal government. The resulting document issued by DHHS, ASMB C-10, is intended to assist state, local, and Indian tribal governments in applying OMB Circular A-87. The Guide also references HCFA policy issuances, such as the Medicaid and School Health: A Technical Assistance Guide, issued in 1997.

Please see Appendix A for a detailed list of statutory, regulatory and other federal government references/authorities applicable to claiming federal funding under the Medicaid program for the costs of school-based administrative activities.

II. Program Agreements

A. Interagency Agreements

In order to claim Federal matching funds for the costs of Medicaid administrative activities performed in schools, the State Medicaid Agency should enter into an interagency agreement with the state education agency or another appropriate entity with oversight of LEAs in accordance with regulations at (Insert citation). The interagency agreement serves to describe and define the responsibilities of each party under the agreement. Additionally, the interagency agreement should describe the relationship between the LEAs and the parties to the interagency agreement. For example, the agreement should address whether LEAs will participate in preparing and submitting Medicaid Administrative Claims independently or as participants in a consortium of LEAs.

The interagency agreement should include:

- A statement regarding the general purpose, basis and mission for the agreement
- The mutual objectives and responsibilities of all parties with respect to this program
- Provisions for a participation agreement with LEAs, either through a consortium or independently
- The activities or services each party performs and under what circumstances
- The general principles of reimbursement
- General guidelines regarding how the program will be structured and administered
- Provisions regarding program oversight and monitoring
- The cooperative and collaborative relationships at the state and local levels
- The methods of payment or reimbursement, exchange of reports and documentation, and a continuous liaison between the parties, including the designation of state and local liaison staff
- A cost allocation plan amendment is required and a copy should be provided as an attachment to the interagency agreement to provide more specific details regarding claim calculation methodology and reimbursement

Please see Section B below for more information regarding cost allocation plans.

B. Cost Allocation Plan

1. Overview

Federal regulations[1] require that under the Medicaid State plan, the single state agency shall have an approved public assistance cost allocation plan (CAP) on file with the Federal Department of Health and Human Services (DHHS) that meets certain regulatory requirements.[2] As indicated in OMB Circular A-87, Attachment D, a state's public assistance cost allocation plan is an official document which describes the grouping and allocation of administrative costs to federal awards performed by the State under such programs as Temporary Assistance to Needy Families (TANF), Medicaid, Food Stamps, Child Support Enforcement, adoption assistance, Foster Care and Social Service Block Grants.

There are certain items that should be included in the public assistance CAP that a State Medicaid Agency must submit in order to claim reimbursement for administrative activities performed by LEAs. The public assistance CAP should reference the methodologies, claiming mechanisms, interagency agreements, and other relevant approaches that will be used by the LEAs for making such claims and appropriately allocating costs.

[1] 42 CFR 433.34
[2] Subpart E of 45 CFR part 95

2. General Principles

School district employees routinely engage in activities that involve providing direct medical services and/or the performance of administrative activities, as well as other social programs, and educational programs. Time spent on activities associated with the administration of the Medicaid program may be reimbursed by following an appropriate claiming methodology.

The CAP amendment provides details regarding the method used to allocate the costs associated with Medicaid administrative activities. The CAP amendment should specify that all claims for reimbursement will be made in accordance with OMB Circular A-87, the State Medicaid Plan, Early and Periodic Screening Diagnosis and Treatment (EPSDT) regulations, and all appropriate Federal regulations. The CAP amendment should contain the following information:

- Identify the LEA personnel who are performing Medicaid administrative activities.
- A mechanism to identify and categorize activities performed by personnel who are eligible for administrative reimbursement.
- A method to identify the level and amount of reimbursable activity performed by eligible personnel.
- A method to identify and allocate costs based upon the level of reimbursable activity being performed.

3. Time Allocation Methodology

Overview

In order to ascertain the portion of time and activities that are related to administering the Medicaid program, States must develop a time allocation methodology that adheres to acceptable cost allocation principles. This methodology should meet acceptable statistical sampling standards and may use contemporaneous time sheets or other quantifiable measures of employee effort.

Time Study Surveys

OMB A-87 provides a variety of options for collecting data to allocate the time spent by individuals who work on multiple activities and cost objectives. The most common mechanism for identifying and categorizing activities performed by the LEA employees is a time study.[3] A time study is a survey documenting how personnel eligible for

[3]While activity reports are the most common method used to allocate time, they are impractical for purposes of this program. For individuals who work on multiple activities and cost objectives, OMB Circular A-87 permits the use of "a statistical sampling system (see subsection (6)) or other substitute system . . . approved by the cognizant Federal agency" for allocating salaries and wages as an alternative to an activity report. [OMB A-87 Attachment B, Section 11, (h) (4)]

OMB Circular A-87 states that, with regard to sampling:

reimbursement (or a sample of eligible personnel) are spending their time. Activities are recorded based upon predefined activity codes, over a predetermined period of time. The time study should incorporate a comprehensive, all-inclusive list of the activities performed by staff whose costs are to be claimed under Medicaid. The time study should account for 100% of the time and activities (whether allowable or unallowable) performed during the time study period by employees participating in the Medicaid administrative claiming program.[4]

Sample Universe

A basic step in the development of a time study is the determination of the sampling universe, (i.e., identifying all of the LEA personnel whose activities may be reimbursed under the Medicaid Administrative Claim). Medicaid administrative activities may be performed by staff who provide any direct medical services (for example, nurses and physical therapists), as well as any staff who focus on activities related to special education, exceptional children's programs, or other administrative duties related to the Medicaid program. The sampling universe should include individuals who spend a portion of non-federally reimbursed time on Medicaid administrative activities.

It may also be appropriate to exclude some personnel from the sample universe. For example, there may be medical providers in the LEA under contract who furnish specific services to students and who are paid on a fixed fee per service (for example, audiologists who are paid a set amount for each hearing test performed) and who do not perform any other activities that would be claimable. These providers should not be included in the sample universe and their costs should be excluded from the base to be allocated.

The sampling universe must include all employees whose salaries are to be allocated to the Medicaid program (e.g., physical therapists or speech therapists). Costs associated with direct support personnel[5], are allocable and reimbursable at the same level as the employees they support. Direct support personnel would not need to be included in the sample population since they do not directly perform Medicaid administrative activities. However other paraprofessional staff who do perform Medicaid administrative activities, such as physical therapy aides, or speech therapy aides, should be included since they do not qualify as direct support personnel.

"Substitute systems for allocating salaries and wages to Federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort." [OMB A-87 Attachment B, Section 11, (h) (6)]

[4] See OMB A-87 Attachment B, Section 11 for additional guidance.

[5] **42 CFR §432.2 Definitions.**
"Directly supporting staff" means secretarial, stenographic, and copying personnel and file and records clerks who provide clerical services that directly support the responsibilities of skilled professional medical personnel, who are directly supervised by the skilled professional medical personnel, and who are in an employer-employee relationship with the Medicaid agency.

Sampling Guidelines

In accordance with OMB Circular A-87, valid statistical sampling methods may include, but are not limited to: random interval sampling, random moment sampling, case counts, or other quantifiable measures of employee effort or outcomes.

In order to meet acceptable "statistical sampling methods", the sample method should be valid for application to the entire sampled period, such as a quarter, but should not include weeks when schools are not in session. It should be structured to meet a high confidence level for statistical compliance. For time studies, all activities need to be documented in the sample even if they are not strictly related to Medicaid.

Training

All personnel who complete a time study should be trained in advance of completing the survey. Training should cover all aspects of the time study process and should assist the LEA personnel to understand the Medicaid program and the relationship of the activities and services they routinely provide in the school setting to services covered by the Medicaid State plan and EPSDT. Staff should be sufficiently familiar with how to complete forms, how to determine the appropriate activity designation, the difference between Medicaid health related and other activities, and where to obtain technical assistance if there are questions. In addition, skilled professional medical personnel should be trained to document when their professional medical knowledge and skill was required in performing a particular function or activity.

Documentation

The State Medicaid Agency shall determine the required documentation to be maintained to support the claims submitted to the State. Time study documentation to be retained will be based on the time study methodology and instructions, as well as the cost allocation requirements issued by the State Medicaid Agency to the LEAs and should include the following: the population to be included in the time study, sample selection, results, and forms as appropriate for the method utilized.

The documentation for administrative activities should clearly demonstrate that the activities are performed for administering services covered under the Medicaid State plan.[6]

Reimbursable Activities

"There is much flexibility in what services may be properly claimed as administrative, and some activities can be billed as either medical services or administration."[7]

[6] In accordance with the statute, the regulations, and the State Plan, the State is required to retain adequate source documentation to support the Medicaid payments for administrative claiming. See §1902(a)(4) of the Act and 42 CFR 431.17; see also 45 CFR 74.53 and 42 CFR 433.32(a) (requiring source documentation to support accounting records) and 45 CFR 74.20 and 42 CFR 433.32(b and c) (retention period for records). The administrative claiming records must be made available for review by State and Federal staff upon request during normal working hours (§1902(a)(4) of the Social Security Act, implemented at 42 CFR 431.17).

According to section 1903(a)(7) of the Act and the implementing regulations at 42 CFR 430.1 and 42 CFR 431.15, for the cost of any activities to be allowable and reimbursable under Medicaid, the activities must be "found necessary by the Secretary for the proper and efficient administration of the plan" (referring to the Medicaid State plan).

In order for Medicaid to reimburse for health services provided in schools, the services must either be included among those listed in the Medicaid statue (section 1905(a) of the Act) and included in the State's Medicaid plan or be available under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. Correspondingly, the administrative expenditures appropriate for reimbursement by Medicaid are those that are in *support of* the health services defined in the state's Medicaid plan and/or EPSDT.

Non-Reimbursable Activities

Activities and services that are direct, face-to-face medical services, including but not limited to, those paid as part of an established fee-for-service reimbursement rate, should be clearly delineated in the activity codes. These activities cannot be included in claims for reimbursement for administrative activities.

Additionally, administrative activities that support the provision of or access to non-medical or non-health related services such as: academic instruction, healthy lifestyle education programs, and social service programs including the free and reduced price meal program, TANF, WIC, child abuse and neglect, and employment assistance, are non-reimbursable activities.

Activity Codes

General Guidelines

A key objective of these HCFA guidelines is to help States address certain basic tenets with regard to Administrative Claiming. HCFA and States determine allowable Medicaid administrative activities in accordance with the regulations related to reimbursable administrative activities.[8] However, because the Medicaid Administrative Claim program is a Federal Medicaid program implemented by the State Medicaid Agency, each State should implement a program that reflects the unique delivery model in that State.

Activity Code Categories

It is essential to develop activity codes, with recognition and consideration of the actual functions and responsibilities being performed by LEA employees, the requirements of the programs, and in accordance with principles that appropriately distinguish between and account for all these factors.

In general, activity codes should be developed and organized to capture time spent on activities according to the following general categories of allocable cost:

[7] Medicaid And School Health: A Technical Assistance Guide, p. 72
[8] (Various citations to be brought in here)

- **100% Medicaid Share** - the activity fully supports the administration of the State Medicaid plan and/or EPSDT program and as such is fully reimbursable.
- **Proportional Medicaid Share** - the activity is reimbursable as administration under the Medicaid program, but the Medicaid allocable share of costs must be determined by the application of the percentage of the Medicaid eligible population.
- **Reallocated** – the activity supports the general requirements of the position and is partially reimbursable based on the percentage of time spent on reimbursable versus non-reimbursable administrative activities.
- **Non-reimbursable** - the activity is not reimbursable as a Medicaid administrative cost.

Activity codes should be designed to effectively differentiate and distinguish between the types of activities that fall into each of these categories. Appendix B provides general examples of appropriate activities for each designation. However, specific activity codes should reflect the distinct characteristics of each state and be compatible with the State Medicaid plan.

Capture 100 Percent of Time

Time study activity codes must be developed to capture all of the possible activities performed by the time study participants. This may be accomplished through a variety of coding conventions, such as detailed examples with respect to reimbursable and non-reimbursable activities, or through development of a parallel coding structure that can differentiate between similar activities performed for multiple purposes, some of which may be non-reimbursable. Regardless of convention, however, thorough training on coding procedures is integral to appropriate differentiation.

In order to ensure that 100% of the activities performed by staff participating in the time study are reflected in the time study results, the staff classifications and associated supporting documentation (such as position descriptions) for time study participants should be reviewed and considered in developing the time study activity codes.

Administrative Case Management

While some case management activities may fall within the scope of both administrative and targeted case management, a State may not claim the same costs both as targeted case management and administrative case management for a given population.

Identification of Activities Eligible for Enhanced FFP

Skilled professional medical personnel (SPMP) perform many Medicaid administrative activities that are reimbursable. They may require their professional medical knowledge and skills to perform specific Medicaid and non-Medicaid activities. However, some activities may not necessitate skilled medical knowledge. The coding structure and/or time study documentation should include a means to differentiate allowable activities for which the SPMP required his/her specialized training and knowledge.

4. Cost Reporting Methodology

General Overview

Cost reporting methodology should capture the allowable costs associated with personnel who perform Medicaid administrative activities. OMB Circular A-87, which contains the cost principles for state and local governments for the administration of federal awards, provides that "Governmental units are responsible for the efficient and effective administration of federal awards." Under these provisions, costs must be reasonable and necessary for the operation of the governmental unit for the performance of the federal award.

Claim calculation methodology should be developed which supports the ability to isolate costs that will be claimed as Medicaid administration from all other costs incurred for those same personnel.

Duplicate Payments

Claims for allowable administrative activities should not duplicate payments that are included and paid as part of a rate for services, part of a capitation rate, or through some other federal program. The methodology used to calculate claims related to allowable administrative activities should eliminate costs related to non-reimbursable activities, and costs already reimbursed using federal funds. The State must provide assurances to HCFA of non-duplication through their administrative claims and the claiming process to HCFA.

Indirect cost rates

Claims for the LEA's indirect costs are allowable and may be allocated based on an approved indirect cost rate issued by the cognizant agency, or the use of predetermined rates, as defined by the state, where the cognizant agency has reasonable assurance based on past experience and reliable projection of the costs, that the rate is not likely to exceed a rate based on actual costs.

Offset of Revenue

It may be necessary to offset costs allocated to the Medicaid program by amounts received from other funding sources. Federal Financial Participation (FFP) may not be claimed by applying federal funds as matching funds. Any federal funds relating to costs claimed for Medicaid administrative activities must be offset from the claim prior to submission. Also, costs may only be included net of applicable credits such as discounts, rebates, recoveries or adjustments.[9] The following include some of the revenue-offset categories that must be applied in developing the net costs:

- All federal funds, along with any state/local matching funds required by the federal grant.

[9] See OMB Circular A-87, Attachment A, Part C., Items 4.a.and 4.b.

- All state expenditures which have been previously matched by the federal government (includes Medicaid funds for medical assistance (e.g., fee-for-service funds).

Documentation

As with all administrative costs that are related to time study activities, there must be documentation of the costs that will be claimed for reimbursement. LEAs should maintain copies of the cost information reported for eligible personnel, and any supporting documentation related to developing these costs. The state should determine an appropriate method to assure that costs reported by LEAs are accurate and adhere to relevant regulations.

Additional guidance regarding documentation for compensation of salary and wages is found in OMB Circular A-87, Attachment B, Section 11.h.

5. Claim Calculation Methodology

Overview

The Claim Methodology should be designed to allocate reimbursable costs based on the selected time allocation methodology and apply the appropriate Federal Financial Participation (FFP) rates and Medicaid share percentages to develop a claim. The methodology must be designed to apply the rates and percentages that are appropriate to the activity type, the skill level of the personnel performing the activity, and the medical credentials employed.

Criteria for Enhanced FFP for Skilled Professional Medical Personnel

Federal Financial Participation (FFP) at the enhanced rate of 75 percent may be available for state claims for expenditures related to the costs of activities performed by SPMPs (and their directly supporting staff) in the administration of the Medicaid program if the appropriate criteria are met (see Appendix __).[10]

Federal regulations contain specific requirements for SPMPs, including that SPMPs have completed a two-year or longer program leading to an academic degree or certificate in a medically related program. State qualification requirements for SPMPs can differ from (be more or less stringent than) the qualification requirements for participating as a Medicaid provider. The State is responsible to provide assurances to HCFA that the appropriate criteria for claiming enhanced reimbursement for qualifying activities have been met.

When the individual meets the SPMP qualifications, those administrative activities that require the use of medical knowledge are eligible to be reimbursed at the enhanced rate of 75 percent. The coding structure and/or time study methodology should include the means to differentiate allowable activities for which the SPMP required his/her

[10] Law: Section 1903(a)(2) of the Social Security Act. Regulations: 42 CFR 432.2 - Definition of SPMP; 42 CFR 432.50 - FFP rates (personnel); 42 CFR 433.15 - FFP rates (program); SPMP Review Guide (dated June 1986)

specialized training and expertise. Allowable administrative activity codes are discussed on page 7 and in Appendix B.

Criteria for Reimbursement of Family Planning at 90 Percent FFP

The enhanced family planning matching rate of 90 percent is available for the administrative activities associated with family planning services.[11] In order to be reimbursed at the enhanced rate, the time study methodology utilized should differentiate allowable administrative activities related to family planning from similar activities unrelated to family planning.

Allocable Share of Costs

Many school-based medical or medical-related activities are provided to both Medicaid and non-Medicaid eligible students. Some activities fully support the administration of the State Medicaid plan and/or EPSDT program and as such do not require the application of the Medicaid share percentage. For certain activities, however, costs are reimbursable only to the extent that they are allocable to activities performed on behalf of Medicaid eligible students. For these activities, it is necessary to develop and apply a Medicaid share percentage.

The Medicaid share percentage is the number of Medicaid eligible students in the relevant claiming population as a percentage of the total number of students in that same population. The State will determine the relevant population. The Medicaid share is then applied to the total costs applicable to those activities that are categorized as "proportional Medicaid share" to determine the costs applicable to Medicaid administrative activities. The purpose of applying a proportional Medicaid share is to determine the amount to be allocated between Medicaid and non-Medicaid students.

Whatever method is used to determine the rate, the number of Medicaid eligible students and the total number of students must be identified for the same time period.

6. Review / Approval Requirements

Prior approval by HCFA of the administrative claiming programs and codes is not explicitly required in Medicaid statute and regulations, HCFA is required to and will review claims made by State Medicaid Agencies for federal reimbursement related to Medicaid administrative activities. In situations relating to the establishment of a new program such as a school-based administrative claiming program, the review will focus on determining the allowability of such claims for federal matching funds. States are required to submit amendments to cost allocation plans and have them approved before they may be reimbursed for Medicaid administrative costs.

In accordance with federal regulations and OMB Circular A-87, a public assistance CAP must be amended and approved by the Division of Cost Allocation (DCA) within DHHS before FFP would be available for school-based administrative claims in the Medicaid

[11] **Law:** Section 1903 (a)(5) of the Social Security Act. **Regulations**: 42 CFR 432.50(b)(5) as referenced by 42 CFR 433.15(b)(2)

program. The public assistance CAP amendment must provide (in accordance with the approved interagency agreements) for reimbursement of the administrative activities performed in the school setting and for claims which will be made on behalf of the LEAs by the State Medicaid Agency. The public assistance CAP amendment must make explicit reference to the methodologies, claiming mechanisms, interagency agreements, and other relevant criteria that will be used by the LEAs for making such claims and appropriately allocating costs. HCFA does not have direct authority for approval of the public assistance CAPs; that is the purview of the DCA. However, HCFA works directly with the DCA in the public assistance CAP review and approval process; under this process, the DCA will not approve such public assistance CAPs without HCFA's review and approval of the methodologies referenced in the public assistance CAP.

The required elements of public assistance CAPs are further discussed in the Cost Allocation section on page 3 as is the review and approval process for such plans.

Timely Filing

Section 1132(a) of the Act requires that a claim by a State for FFP with respect to an expenditure made during any calendar quarter must be filed within the two-year period that begins on the first day of the calendar quarter immediately following such quarter. This section also provides that no payment shall be made for expenditures not claimed within this period.

State Law Requirements

FFP for school-based services and administrative outreach claims is not available if the State is not in compliance with its own statutes. The OMB Circular A-87 states in item 1.c. of Attachment A, "General Principles for Determining Allowable Costs," Section C, Basic Guidelines: "To be allowable under Federal grants, costs must meet the following criteria: ... c. Be authorized or not prohibited under state or local laws and regulations." A question of state law may surface during a review of state practices or be brought to light by other means; however, it is not expected that an exhaustive review of all state laws be conducted. If there is a question of whether the state agency is in violation of state law, a legal opinion should be sought.

III. Program Integrity

State oversight is the cornerstone to maintaining the integrity of the Medicaid School-based Administrative Claiming program. Through appropriate reviews, the State can be assured that claims are accurate and that methodology adheres to the provisions specified in the Cost Allocation Plan. Ideally, maintaining claim integrity should be a joint responsibility shared by HCFA, LEAs, the state agencies and any claims processing agents involved.

HCFA may review the results of the state oversight on a periodic basis. This review can be based on a report submitted by the State. This annual report can be augmented if the situation warrants more detailed and/or on-site review.

Please see Appendix C for recommended monitoring parameters.

IV. Conclusion

This Guide contains information for LEAs, State Medicaid Agencies, HCFA offices and staff, and other interested parties about the existing requirements by which LEAs can claim Medicaid reimbursement for activities that are performed under the administrative claiming program. It is important to note that to minimize the possibility of confusion, this Guide does not, except where there are potential issues of overlap or duplication, address requirements related to LEAs' provision of direct medical services, commonly referred to as fee-for-service (FFS) programs. With regard to the school-based administrative claiming program, this Guide does not supercede or reinterpret any existing statutory or regulatory requirements. This Guide is intended to support and enhance the goals shared by Medicaid and education of ensuring that all children, especially those who are economically disadvantaged or disabled, have access to needed health care; that all eligible children are enrolled in Medicaid, and that LEAs have equal access to the resources available to support those efforts.

Appendix A: Details Regarding Basis and Authority

The following sections provide selected statutory, regulatory and other Federal Government references/authorities applicable to claiming Federal funding under the Medicaid program for the costs of school-based administrative activities.

Statute/Regulations

- Proper and efficient methods of administration: section 1903(a)(7) of the Social Security Act (the Act)
- Federal matching rate for administration: section 1903(a)(7) of the Act
- Timely filing: section 1132 of the Act, Title 45 of the Code of Federal Regulations (CFR) Subpart A 95.1 ff
- Skilled Professional Medical Personnel (SPMP): section 1903(a)(2)(A) of the Act, 42 CFR 432.50
- Family Planning: section 1903(a)(5) of the Act, 42 CFR 433.15(b)(2), 432.50(b)(5)
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT): section 1902(a)(43) of the Act; 42 CFR Part 441, Subpart B
- Medical Assistance Case Management: section 1905(a)(19) and 1905(r)
- Section 504 of the Rehabilitation Act: 34 CFR Part 104, Subparts A and D
- Individuals with Disabilities Education Act (IDEA): section 612(A)(B) and (C)
- Regulatory citations related to documentation

42 CFR	**Description**
430.1	Scope of subchapter C - Proper and efficient administration
430.12	Submittal of State plans and plan amendments
430.30(b)	Grants procedures - Program estimates (HCFA-37)
430.30(c)	Grants procedures - Expenditure reports (HCFA-64)
430.32	Program reviews
430.33	Audits - OIG audits including cost efficiency
430.40	Deferral of claims for FFP
430.42	Disallowance of claims for FFP
431.15	Methods of Administration
431.53	Assurance of transportation
431.107	Required provider agreements
432.2	***Both of these relate to Training – need to check***
432.30	
432.50	FFP: Staffing and training costs - Availability of FFP at various rates, allocation basis for personnel costs
432.55	Reporting training and administrative costs

433.15	Rates of FFP for administration
433.32	Fiscal policies and accountability
433.34	Cost allocation
433.51	Public funds as the state share of financial participation
433.53	State plan requirements - for state funds

45 CFR

Part 95	Subpart A - Time Limits for States to File Claims
Part 95	Subpart E - Cost Allocation Plans

OMB Circular A-87

The OMB Circular A-87 establishes cost principles and standards for determining costs for Federal awards carried out through grants, cost reimbursement contracts, and other agreements with state and local governments and Federally recognized Indian tribal governments (governmental units).

Citations

Skilled Medical Personnel

42 CFR §432.50

(1) *Medicaid agency personnel and staff.* The rate of 75 percent FFP is available for skilled professional medical personnel and directly supporting staff of the Medicaid agency if the following criteria, as applicable, are met:

(i) The expenditures are for activities that are directly related to the administration of the Medicaid program, and as such do not include expenditures for medical assistance;

(ii) The skilled professional medical personnel have professional education and training in the field of medical care or appropriate medical practice. "Professional education and training" means the completion of a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is demonstrated by possession of a medical license, certificate, or other document issued by a recognized National or State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. Experience in the administration, direction, or implementation of the Medicaid program is not considered the equivalent of professional training in a field of medical care.

(iii) The skilled professional medical personnel are in positions that have duties and responsibilities that require those professional medical knowledge and skills.

(iv) A State-documented employer-employee relationship exists between the Medicaid agency and the skilled professional medical personnel and directly supporting staff; and

(v) The directly supporting staff are secretarial, stenographic, and copying personnel and file and records clerks who provide clerical services that are directly necessary for the completion of the professional medical responsibilities and functions of the skilled professional medical staff. The skilled professional medical staff must directly supervise the supporting staff and the performance of the supporting staff's work.

(2) *Staff of other* public *agencies.* The rate of 75 percent FFP is available for staff of other public agencies if the requirements specified in paragraph (d)(1) of this section are met and the public agency has a written agreement with the Medicaid agency to verify that these requirements are met.

Timely Filing

45 CFR §In which quarter we consider an expenditure made.

(d) We consider a State agency's expenditure for administration or training under title I, IV-A, IV-B, IV-D, IV-E, X, XIV, XVI (AABD), or XIX to have been made in the quarter payment was made by a State agency to a private agency or individual; or in the quarter to which the costs were allocated in accordance with the regulations for each program. We consider a State agency's expenditure under these titles for non-cash expenditures such as depreciation to have been made in the quarter the expenditure was recorded in the accounting records of any State agency in accordance with generally accepted accounting principles.

45 CFR §95.4 Definitions.

State agency for the purposes of expenditures for financial assistance under title IV-A and for support enforcement services under title IV-D means any agency or organization of the State or local government which is authorized to incur matchable expenses; for purposes of expenditures under title XIX, means any agency of the State, including the State Medicaid agency, its fiscal agents, a State health agency, or any other State or local organization which incurs matchable expenses; for purposes of expenditures under all other titles, see the definitions in the appropriate program's regulations.

Appendix B: Activity Code Categories

The manner by which each state establishes a comprehensive and detailed set of activity codes for the school-based administrative claiming program will vary based upon each state's existing Medicaid program organization and delivery, applicable demographics, state and local funding levels and mechanisms. The following defines the broad range of activities by category of allocable cost that should be accommodated in each State's set of activity codes. The specific activity code definitions that a State proposes to use must be included in the cost allocation plan amendment.

100% Medicaid Share:

Activities are not subject to the application of the Medicaid share percentage

- Informing children, parents/guardians, LEA staff, and the community about the benefits and availability of the Medicaid program and Medicaid covered services.
- Seeking out and identifying children within the general student population or within a targeted student population(s) who are in need of Medicaid covered health services.
- Assisting potentially eligible students and their families to enroll in Medicaid.
- Providing or participating in training designed specifically to enhance the effectiveness of Medicaid outreach and the identification and referral of children in need of Medicaid covered services.
- Identifying and coordinating program planning and development of Medicaid covered services with individual providers and provider agencies.

Proportional Medicaid Share:

The proportional Medicaid share rate must be applied to allocable costs associated with these activities.

- Referring, coordinating, planning and monitoring health services designed to address an individual child's health needs.
- Arranging and/or providing translation or transportation services to enable a student to access needed medical care.
- Arranging or referring for family planning services.

Reallocated Activities

Activities that support the general requirements of the position and are partially reimbursable.

- Performing administrative or clerical duties relating to the general functions or operations of the LEA including paid time off and breaks.

Non-Reimbursable Activities

These activities are not reimbursed under the Medicaid Administrative Claim program.

- Providing direct medical care, treatments or counseling interventions.
- Performing activities relating to the provision of a direct health service that is included in a fee-for-service rate for which the LEA is claiming reimbursement.
- Providing instruction, supervising students, or conducting extra-curricular activities.
- Arranging or providing services associated with social service programs, or other programs that do not yield health-related outcomes.

Appendix C: State Oversight

To ensure that the Medicaid School-based Administrative Claiming program is relevant to the "proper and efficient administration of the State's Medicaid plan" and that it complies fully with all applicable federal and state requirements, the State Medicaid Agency should administer certain oversight mechanisms on a periodic basis.

Oversight, as described below, should be maintained in the following areas: time allocation methodology, cost reporting methodology, verification of Skilled Medical Professional Personnel (SPMP) eligibility and utilization standards, and claims processing. State reviews should be frequent enough to maintain the integrity of the program, while taking into account the objectives of the effort, the resources of the agency, and the administrative burden upon the LEAs.

As appropriate, the State may utilize independent professional services firms in its oversight of the Program. The LEAs should provide assurance that resources shall be reasonably available if a more detailed audit of the program is required.

Time Allocation Methodology

In order to ensure that the time study is statistically valid (for example, at the 95 percent confidence level), the State Medicaid Agency should monitor the compliance of the LEAs to the requirements of the time allocation methodology. The description of this effort should include information on the frequency of reviews at the local level, staff performing the reviews, and the review protocol.

Recommended activities may include:

- Review of training materials used to instruct the time study participants.
- Periodic observations of time study training.
- Interviews with a sample of personnel who completed time study surveys.
- Random examination of a representative sample of time study surveys.

Cost Reporting Methodology

School district auditors provide assurance of cost reporting procedures through the annual audit process, which includes adherence to requirements of the A-133 Single Audit Act. In addition, the following or similar measures are recommended:

- Desk reviews of a sample of LEAs conducted by an independent audit professional services firm to determine the accuracy of submitted data.
- Periodic on-site visits to verify that reported expenditures conform to OMB Circular A-87, applicable claim guidelines and Generally Accepted Accounting Procedures.

Verification of SPMP Criteria

Federal Financial Participation (FFP) may be available at the enhanced 75 percent for activities performed by SPMP based on the activities of SPMP (see "Criteria for Enhanced FFP for Skilled Professional Medical Personnel", page 10). The State Medicaid Agency, or its designated agent should verify that SPMP providers have met all of the requirements for the SPMP designation as outlined in 42 CFR 432.50.

Claims Processing

To ensure that the claim calculation methodology as defined in the cost allocation plan is adhered to, the State Medicaid Agency may require any claims processing contractor to engage in a SAS 70 Review (Statement of Auditing Standards Review). This annual review provides independent validation that the controls, policies and procedures employed in the development and calculation of claims are sufficient to ensure accurate claim results. The review also addresses design, and description of the reliability of the security, control or processing techniques implemented in processing claims.