

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Personal (Partial) (1 page)	02/17/2000	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Bethany Little
OA/Box Number: 18398

FOLDER TITLE:

Medicaid---School-Based [3]

2013-0371-S

ms632

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

Freedom of Information Act - [5 U.S.C. 552(b)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Spend Medicaid Funds More Wisely, Senate Aide Warns

School districts must lower the administrative costs of Medicaid reimbursements paid for special education students, an aide to a top Democratic senator told educators Monday.

Conference Report

Connie Garner, legislative assistant to Sen. Edward Kennedy, D-Mass., and a former Education Department official, said a soon-to-

be released General Accounting Office report will detail that nearly six of seven Medicaid dollars being spent by public schools are not going to the young people for whom they are intended.

Speaking to urban school administrators gathered at the annual legislative conference of the Council of the Great City Schools in Washington, D.C., Garner warned that while they may be getting the short end of the stick on federal funding, there is no excuse for the Medicaid "fraud" occurring in some districts.

"I have a boss real worried about what is going on here," she told about 100 educators yesterday. "This is beyond politics. How do you fight [for] more money for IDEA [the Individuals with Disabilities Education Act] when you look at those numbers?"

Garner said Democrats and Republicans agree that special ed students should get the services they need while in school. But that does not mean the federal government can and should do it all on its own.

Kennedy's office alone, she said, gets up to 2,000 letters a week asking for better financial accounting of the federal funding given to localities to spend on school Medicaid needs from parents who don't think it is being used wisely.

The families "question whether any of the money is ever being delivered to the kids," said Garner, a former director of the Federal Inter-agency Coordinating Council, which works to link programs at the national level.

(more)

E-Rate-Funded Schools May Be Audited, Official Says

School districts receiving e-rate funds should be prepared to account for how they are spending the money, a program administrator said yesterday.

The Universal Service Administrative Company (USAC)—the nonprofit group that runs the e-rate program—will need financial reports from some districts as part of its own federal audit, explained Kate Moore, who heads USAC's Schools and Libraries Division.

Districts should be ready to show USAC how they use their e-rate funds, even though only a few will be audited, Moore told members of the Council of the Great City Schools at the group's legislative and policy conference in Washington, D.C.

"Do track your money, do be prepared for possible audits," she said. "If anything's going to [unhinge] this program, it's going to be charges of waste, fraud and abuse."

The General Accounting Office is expected to release its report on the audit later this year.

Demand for e-rate money continues to be high.

For the upcoming, third year of e-rate funding, USAC received 36,000 applications requesting a total of \$4.7 billion, Moore explained.

The program is currently authorized at \$2.25 billion.

"The sad news is that we're going to have to say 'no' to a lot of folks," Moore said.

Barbara Pryor, legislative assistant for Sen. Jay Rockefeller, D-W.Va., urged council members to lobby against threats to the e-rate.

"It shouldn't be an annual battle. [The e-rate] should just be there," said Pryor, whose boss is an e-rate supporter. "What we want to do this year is to get this program on a very safe, stable political footing."

Some current proposals aim to make the e-rate a state-run program, let states decide how and where the money can be spent, or kill the program altogether. —Hannah R. Gladfelter

Spend Medicaid Funds More Wisely, Senate Aide Warns (Cont.)

She expects legislation to be introduced soon after the GAO report is released that will look to revamp the system, and could even ask for jurisdictions to repay the federal government some of its funding. The best thing school administrators can do now, Garner said, is to tell lawmakers about the difficulties they have with the current system.

Those problems were documented in a December 1999 GAO report, which found that many districts complained they were having trouble with, or were not getting reimbursed for, Medicaid services they provided because the process is too cumbersome and confusing.

Many said they are unsure what IDEA-related services Medicaid covers, which children qualify for such funding and how to manage the documentation.

Such findings do not sit well with the Health and Human Services Department's Health Care Financing Administration, which in a response to the earlier report said it could not do all of the advising on its own.

"HCFA is unable to provide strict guidelines to all of the states due to variations among state programs," wrote Nancy-Ann Min DeParle, its

administrator. "Coordination issues need to be resolved at the state and local levels, rather than the federal-state level."

Garner admitted more needs to be done to work out such problems, and that any legislation that may come out in the wake of the upcoming GAO report should clarify such issues.

A lack of knowledge by school authorities themselves likely does contribute to the high administrative costs currently plaguing the school Medicaid programs, Garner said. But educators cannot afford to turn a blind eye to the problem any longer, she noted: "Either we can help shape it and do it right, or we will get rolled."

Lynn Leslie, a member of the Medical Recovery Project with the Council of the Great City Schools, urged concerned members to keep a tighter leash on those they hire to work the Medicaid program.

"I don't argue there have been complexities," she said, "but I want to reinforce the need to take a serious look at what your contractor is doing and provide oversight. You need strong policies about what your contractor does."
—Ted Gotsch

Supreme Court Lets Stand Racial Enrollment Ruling (Cont. from p. 1)

Arlington, Va., school district's policy of using race in admissions via a lottery in a popular local magnet school (ED, Oct. 15, 1999).

In the Maryland case, Jeffrey Eisenberg and Elinor Merberg sought to have their son, Jacob, transferred to a science and math magnet school in 1998, when he started first grade in Montgomery County. Citing a violation of their son's equal protection rights, they sued school officials after they refused to allow Jacob to transfer from Glen Haven Elementary School, his neighborhood school.

The racial breakdown of Glen Haven was 40 percent black, 25 percent Hispanic, 24 percent white and 10 percent Asian. However, white enrollment had decreased by 15 percent during the previous four years. The school to which Jacob sought transfer, Rosemary Hills Elementary, had a racial breakdown of 66 percent white, 16 percent black, 14 percent Hispanic and 4 percent Asian.

While a federal judge would not order the school to transfer the boy, it declared the district's policy illegal.

In *Montgomery County Public Schools v. Eisenberg* (99-1069), the court ruled that student transfer requests are private decisions and that "any racial or ethnic imbalance is a product of private choices and it does not have constitutional implications."

Lawyers for Jacob argued that "integration can only be pursued as a result of a constitutional violation, not for its own sake."

But the district's lawyers argued that transfers approved without regard to the resulting racial balance will result in segregated schools. They also pointed to studies showing that diverse schools improve black-student achievement and result in students who will eventually choose diverse colleges and work environments. —Esmeralda Barnes

Amendment to the Chairman's Mark

Offered by Representatives Bentsen, Davis, Hoekstra, Green and Thornberry

Sec. __. Sense of Congress Regarding HCFA Draft Guidelines

(a) Findings.-- The Congress finds that--

(1) On February 15, 2000, the Health Care Financing Administration in the Department of Health and Human Services issued a draft Medicaid School-Based Administrative Claiming (MAC) Guide; and

(2) In its introduction, the stated purpose of the draft MAC guide is to provide information for schools, State Medicaid Agencies, HCFA staff, and other interested parties on the existing requirements for claiming Federal funds under the Medicaid program for the costs of administrative activities, such as Medicaid outreach, that are performed in the school setting associated with school-based health services programs.

(b) Sense of Congress.-- It is the sense of Congress that many school-based health programs provide a broad range of services that are covered by Medicaid, affording access to care for children who otherwise might well go without needed services. Further, school-based programs also can play a powerful role in identifying and enrolling children who are eligible for Medicaid, as well as the State Children's Health Insurance Programs.

It is the sense of Congress that undue administrative burdens may be placed on school districts and states and deter timely application approval. Therefore, it is the sense of Congress that HCFA should substantially revise or abandon the current draft MAC guide because it appears to promulgate new rules that place excessive administrative burdens on participating school districts. The goal of the revised guide should be to encourage the appropriate use of Medicaid school-based services without undue administrative burdens. The best way to ensure the continued viability of Medicaid school-based services is to guarantee that the guidelines are fair and responsible.



"Hunter, Bruce" <BHunter@aasa.org>
03/13/2000 11:04:26 AM

Record Type: Record

To: Andy Rotherham/OPD/EOP

cc:

Subject: RE: guidelines

I heard that Alabama had a payment for claims already submitted turned down and the turn down cited the draft guidelines. That may or may not be true, because it turns out that HCFA and its regional offices and the state agencies almost never give schools anything in writing. They just give verbal info which they can retract or alter when ever they wish. This is the single biggest complaint about working with HCFA and the state agencies.

On the guidelines we hear that they still plan on just running over us. They do that to state and local health care agencies all the time and get away with it. We'll see this time. I think the hill and HCFA were surprised by the response.

Our analysis is that the intrepretations of Social Security and IDEA, between HCFA and the schools are so completely different that we need a policy fix to clarify the matter just like we got in 1988 when congress clarified that schools not Mediciad was the payor of last resport regarding IDEA kids. That legislative clarification in section 1903 c of the social security act ended a decade of bickering and litigation. The legislation came after we had just won the latest round in 1987 when the supreme court let stand a first ciurcut court decision saying Mediciad had to pay for health care services to special education kids.

Once again HHS/HCFA and schools have completely different interpretations of current law. We need another fix to clarify that has at least four elements where we just read it differently than HCFA:

1. That administrative activity associated with finding and evaluating special education kids is a legitimate Medicaid expense. HCFA pays administrative claims associated with these activities for any other medicaid provider.
2. That state weighting formulas giving additional funds for special education are recognition of the additional cost and not a reason to HCFA to reduce payments to schools. IDEA is under funded at the state level also, so for HCFA to use already inadequate payments to offset FFP is an outrage.
3. That special education is a set of services aimed at producing academic success, not a single place where kids go. HCFA has entirely misunderstood how special education has evolved since 1975, and that it is now part and parcel of the school business.
4. That the separation of administrative and medical claims is artifical at best.

In addition we are going to press for another fix, making it clear that 504 kids are a legitimate medicaid expense for schools. Right now that is not clear.

We are finding huge variations in the way claims are made by state. State Medicaid plans vary and so the agreements they make with schools vary. HCFA Should try to be helpful and work with us to identify which plans have the fewest problems. But of course they set out to reduce administrative claims not make better seervices for children, who in addition to being poor do not have health insurance and are disabled. Maybe if we all focused on helping this group of kids succeed we could improve services and hold down costs.

-----Original Message-----

From: Andy_Rotherham@opd.eop.gov [mailto:Andy_Rotherham@opd.eop.gov]

Sent: Friday, March 10, 2000 3:47 PM

To: bhunter@aasa.org; npenning@aasa.org

Subject: guidelines

what are you all hearing on these guidelines? I heard that Alabama got turned down for something based on the draft guidelines, have you heard that?

AR

Memorandum

To: Bruce Hunter and Nicholas Penning, AASA

Fr: Sara Rosenbaum, Harold and Jane Hirsh Professor, Health Law and Policy, The George Washington University School of Public Health and Health Services

Re: Analysis of HCFA's Medicaid School-Based Administrative Claiming Guide

Date: February 28, 2000

This memorandum responds to your request for an analysis of HCFA's Medicaid School Based Administrative Claiming Guide. It identifies key issues for consideration by the American Association of School Administrators.

In reviewing this guide, it is important to place health care furnished in and through schools into some context, as well as recap the basic structure of the Medicaid program. The first part of this memorandum thus lays out certain contextual considerations. The second part analyzes the draft guide.

The Child Health and Medicaid Context

- Basic health care in schools (e.g., preventive health and dental care, immunizations, primary medical care for routine physical and emotional health needs, family planning services, and other forms of basic pediatric and adolescent health care) are now a routine matter in schools. As the proportion of children enrolled in publicly funded health insurance programs (e.g., Medicaid and SCHIP) grows, the role played by these programs in helping to finance the cost of pediatric and adolescent health care can be expected to grow. School health services are particularly prevalent in lower income schools, where the

proportion of children enrolled in or eligible for public health financing is high.

- School districts have a legal obligation to furnish related services to children and adolescents who qualify for assistance under the Individuals with Disabilities Education Act (IDEA). This obligation is broad in scope, since related services can be ongoing and high cost. *Cedar Rapids School District v Garret* 119 S. Ct. 992 (1999). Children who are lower income and enrolled in Medicaid are at disproportionate risk of developing the types of physical and mental disabilities that must be treated in order to make education in the most integrated setting feasible. Much of this treatment may have to occur during the school day (i.e. in or through schools).
- Medicaid offers two basic forms of federal financial assistance for state expenditures on behalf of children: medical assistance and administrative payments. These two forms of financing are designed to do different things and are subject to different sets of federal payment requirements. However, the two types of activities can overlap heavily; under current regulations, states have discretion to decide how to claim these services.
- Through the EPSDT program, Medicaid “medical assistance” funds are available to pay for virtually any preventive, medical, remedial, or treatment service needed by a child or adolescent.
- Federal Medicaid contributions for administrative costs are subject to a broad general test as to whether such activities that are necessary for the “proper and efficient administration” of state programs. Furthermore, EPSDT has its own set of required administrative activities for which federal funding also is available.
- Other provisions of the statute allow for the reimbursement as either a medical or administrative service of most of the medical care a child would need. Not only is the actual provision of care an allowable cost, but also covered by Medicaid FFP rules are expenditures related to the identification and enrollment of eligible children, and expenditures related to the management of school-located health programs, including activities related to billing and claims, recruitment and training providers, quality of care oversight, medical records management, the development of patient care standards, data reporting, and so forth. Federal accounting principles govern how these costs are apportioned to Medicaid.
- States have broad discretion over program design in administering their Medicaid programs, but certain basic rules apply. In order to

qualify for federal medical assistance payments, the expenditure must be for a covered service that is furnished by a qualified Medicaid provider in accordance with applicable provider participation standards. To be federally reimbursable, administrative activities must fall within the ambit of the statute and must be proper and efficient. Furthermore, as noted, where the activities are in support of more than Medicaid beneficiaries or program activities, the costs must be apportioned in accordance with federal accounting principles.

- Services may be either medical or administrative in nature; furthermore, certain services may have multiple characterizations under the statute. For example, arranging for necessary medical care, scheduling appointments, transporting children, and following up on referrals all constitute EPSDT administrative duties under §1902(a)(43) of the Social Security Act. They also can constitute medical assistance case management services under §1905(a)(19), to which all children are entitled as part of their EPSDT benefit. Where the service in question is a family planning benefit, it may be possible to characterize patient support as either an EPSDT administrative service or a family planning service.

The Draft Guide

In general

When completed, HCFA's guide could provide important and useful information for state Medicaid and education agencies regarding the circumstances under which federal Medicaid funds are available to assist in the medical and administrative costs associated with furnishing basic and specialized medical and health services to Medicaid enrolled children in schools. The guide also will be highly useful in helping states carry out the President's directive to use the schools as a critical means of identifying and enrolling eligible children.

In its present form, however, the guide suffers from a series of intrinsic shortcomings that are inevitable when an attempt such as this one is made to separate the administrative discussion from the medical assistance discussion. Rather than clarifying matters, the guide raises additional questions and creates a fair amount of confusion. Furthermore, and most fundamentally, the guide appears to contain incorrect statements of law and policy, particularly with respect to what is a covered medical benefit. Because the concept of what is an allowable administrative cost is necessarily so tied to what is a permissible medical assistance expenditure, it is not possible in my view to write a guide that accurately covers only "administrative claiming."

Moreover, it is absolutely essential in my view to the health and welfare of children and their continued access to health care in schools that the tone of this guide be correct. Children and adolescents who are lower income have significant health care needs, and those needs frequently must be met during the school day and potentially in the schools themselves. The pressures on schools to furnish health care thus are enormous. Yet in its current format, the guide as drafted can only be characterized as having as its principal goal the ending of Medicaid payments for the cost of health services furnished in schools. Almost no time is spent elaborating on the importance of school located services or on what can be done in schools. Any person reading this Guide would immediately pull the plug on efforts to bring Medicaid revenues to bear on school services.

This overwhelmingly negative legal message is precisely what was rejected by Congress last fall. It is utterly incompatible by the emphasis that the Administration has placed on schools as critical links for children in a wide variety of services and is fundamentally inconsistent with the purposes of other major laws for children, particularly the IDEA.

The true goal of such a guide should be to encourage the *appropriate use* of Medicaid to aid schools to identify and enroll eligible children and deliver necessary basic and advanced medical and health services. To achieve this result, the guide needs to spend at least as much time on what is reimbursable as what is not.

It is also worth noting that while the Guide indicates that its purpose is to clarify existing policy rather than make new policy, whether it achieves such a result (i.e., no new policy) is questionable. To the extent that the guide reinterprets and applies in a school context federal accounting rules in ways that previously had not been formulated, the guide may in fact represent new policy. I am not an accounting expert, but in reading the comments coming in from local and state school administrators, I was left with the distinct impression that the accounting practices prescribed in the guide differ significantly from school districts' and Medicaid agencies' general understanding of what is permissible. To the extent that the accounting principles in the guide do in fact represent new policy, then the Administrative Procedures Act would seem to require rulemaking, and the terms of the guide would be unenforceable in the absence of such a supporting and final rule.

Detailed comments

The following represent my page-by-page comments to specific sections and statements within the draft guide. I have picked up on both

erroneous and misleading statements, as well as the equally important issue of basic tone and policy. There are so many issues that arise on nearly every page of the guide, that I have chosen to focus on those that either are the most important or that hit me the hardest as I read.

- Page 1. The next to the last sentence says that “FFP may be available” for administrative activities that are “found necessary by the Secretary for the proper and efficient administration of the state plan.” In fact, when activities meet the “proper and efficient” test, they *are* reimbursable. The secretary does not have the further discretion to deny FFP if federal conditions are met. Medicaid is an entitlement program in states, as much as it is one for individuals.
- Page 2: At the bottom of the page there is no mention of the EPSDT state plan requirements (§1902(a)(43)) as part of the legal basis and authority for FFP for administrative costs associated with health care in or by schools. The EPSDT administration requirements cover a full range of activities from identifying children who need health services (a major overlapping function with the IDEA) to costs associated with supporting health services that are furnished.
- Page 4: in the middle of the page HCFA states that administrative activities must be directly related to the administration of the state’s Title XIX plan for the activity to be covered. EPSDT is technically beyond the scope of the state plan in the way in which HCFA has interpreted the program. Thus, where activities are in support of EPSDT administration, they also would qualify for FFP.
- The time activity codes discussion (part IV, beginning on p. 5). This section also suffers from the absence of any EPSDT discussion. Since EPSDT and IDEA in particular overlap so heavily, the time code discussion must be reconceived to be specific to EPSDT. What is proper and efficient in carrying out EPSDT duties may be significantly broader than what would be proper and efficient for lesser services.
- Allowable activities claiming (p. 6): It is fine to indicate that certain services are not allowable administrative activities. But these very services (helping a child gain access to needed medical, educational, social and other services) are all allowable as medical assistance case management under §1905(a)(19). Unless the guide spells out how states can use the case management benefit to furnish such services in and through schools, the guide ends up appearing to prohibit an activity that is not only permissible but in fact is required for children under §1905(r).

- The free care issue (p. 6): this is such a limited exclusion in Medicaid that unless HCFA is going to be more specific about what indicia a service has to have to be considered “free” it should not be included. Almost no states provide universal free services in schools; even the IDEA does not classify the services at issue here as free, and schools are expected to collect revenue where available. This is a *de minimus* limiting factor in my view. I have no idea what “referral and coordination services that are provided free to the general population” refers to. If HCFA means medical assistance case management services these are expressly a required service for children. I know of no situation where such assistance is furnished to the “general population.” If the agency is referring to a school system’s obligation to furnish such support within the IDEA, then the IDEA provisions of the Medicaid statute specifically contemplate that they will be billed if the need for case management is part of the child’s IEP.
- The last sentence in the allowable activities section (p. 6) is confusing and misleading. It states that “administrative expenditures in support of EPSDT are reimbursable under Medicaid so long as the providers who furnish such services participate in the program.” A provider of EPSDT support services most certainly does not have to be a qualified medical assistance provider. Indeed, it would be a waste of limited medical and nursing resources to expect the medical assistance provider to furnish the administrative service, which can be carried out by a trained paraprofessional. What does HCFA mean?
- Duplicate payments (p. 8): HCFA notes that Medicaid payments should not be made “for an activity already paid for or otherwise reimbursable” under another mechanism. I have no idea what this means, and it contravenes settled Medicaid law. Medicaid covers services that may be reimbursable under IDEA (related services that also are case management or a recognized administrative service). 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 (e.g., the Title V maternal and child health services block grant, the mental health services block grant, title XX, program grants administered by the CDC, the health centers statute). The list goes on and on. Medicaid pays for many services that are “reimbursable” under other laws. This sentence has a chilling effect on a broad range of school activities and is not correct.
- The effect of managed care (p. 9, 10, and other locations). HCFA’s view of the effects of a managed care contract is, in my opinion, legally incorrect. This entire section has to be rethought and re-formulated. A state may dump many dollars into its managed care rate; the

dollars alone tell us nothing about what the contractor must do. In this regard, the legally binding document is the contract with the managed care organization. In our large-scale reviews of state MCO contracts, we have found that almost none covers medical, remedial, preventive and other health services furnished in schools, services furnished in an IEP or IFSP, administrative support services furnished by school personnel, or any other services relevant to this topic.¹ Because the question of coverage is so complex, a state education agency would have to consult with the Medicaid agency with respect to every service covered under the interagency agreement in order to determine for which services the Medicaid MCO contracts make the MCOs liable. In the absence of specific language, MCOs would have complete discretion as to whether to contract with the schools in their service area for any of these services. They also have discretion regarding which providers and agencies they use to furnish medical and supporting administrative services.

It *may be* that a school district has a contract with one or more managed care organizations to provide medical and administrative services, in which case the Medicaid agency should not pay again. It may also be that in the case of a particular child, the service is being furnished in a non-school setting or is not medically necessary within the meaning of the MCO's operations, in which case there is a factual dispute regarding whether there is still residual liability for the service. In any event, there is nothing about the premium paid to the MCO alone that would answer this question. The contract is the operational legal instrument here for deciding whether the MCO is already on the hook for the medical and administrative services in question and if so, whether the schools need to look to the MCO for payment.

- Direct versus administrative services (p. 10-11). I have no idea what an administrative service that is part of a direct service is in the context of children. Targeted case management to assist children obtain access to needed medical, educational, social and other services is an independent medical assistance service under the law, as are EPSDT administrative services. These are not services incident to the medical encounter themselves but are recognized under the statute as independent activities in their own right. This section needs to be rethought and restructured. The administrative case management discussion on p. 11 omits any discussion of EPSDT administrative costs.

¹ Sara Rosenbaum et. al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (3rd ed., GWU/CHSRP, Washington D.C., 1999)

- Apportioning administrative costs (p. 12-13). I absolutely agree that costs must be apportioned so that Medicaid payments are in proportion to the value of the administrative service at issue to the Medicaid program. Nonetheless, I cannot even begin to understand the discussion on this page, since the example on p. 13 seems to describe a fully Medicaid allocable activity (i.e., coordinating and supporting Medicaid services). Why wouldn't the cost of supporting Medicaid services be 100% allocable to Medicaid (as opposed to the cost of the IEP coordinator's time, for example, which would be allocable among his or her Medicaid and non-Medicaid students)?
- Skilled medical professional services (p. 14). Why must the SMP work for the Medicaid agency (bullet IV?). I am unaware of any provision in the statute that requires an employment (as opposed to a contractual) relationship. Maybe they mean something else.
- Family planning (p. 16). I have no idea why HCFA is reading the "and" here as all-inclusive. A sensible reading of the statute is that 90% is available for three activities, each one of which may be done separately. Are they saying that a school can be paid only if the school offers, arranges and furnishes the care? What if the school offers and arranges but send the child to a family planning clinic operating under the PHS program? Does this mean that the school cannot be paid for the cost of the person who actually made the appointment, counseled the students, etc? How many schools actually "furnish" family planning and thus are able to meet this test, as stated?
- Provider participation (p. 17) the first full paragraph on this page again suggests that only qualified Medicaid providers can furnish administrative services. This is simply not true and would be a waste of qualified Medicaid provider time. Example 3 (bottom of page) makes no sense.
- The IEP discussion (p. 18 and other locations). This entire topic needs to be much more carefully formulated. Identifying children who need special education services and getting them evaluated is so intermingled with the EPSDT obligation to find children with health problems, screen them, treat them, and provide medical assistance targeted case management (which includes assistance in obtaining needed educational services) that the guide does not even begin to do justice to the question of apportionment. This entire section needs to be rewritten in the context of a thorough Medicaid analysis that considers both medical assistance and administrative costs. The final paragraph on this page would virtually prohibit Medicaid payments for any services associated with the management of health and related services for children covered by IDEA, since §504 is simply a parallel

enforcement statute. The analysis is legally flawed and potentially will shut off Medicaid coverage for a broad range of reimbursable services.

- The cost allocation materials and coding: I reviewed these briefly. This is where the policy may be new (i.e., existing and allowable allocation methodologies may no longer be permissible). In addition, various services that are listed as not attributable to Medicaid in fact would be attributable to Medicaid were the program understood to include EPSDT. For example general health education and outreach may be a perfectly permissible cost to be partially allocated to EPSDT (p. 23). The agency has literally reams of EPSDT guidelines that cover general education aimed at promoting the use of EPSDT benefits. Code 5a (p. 28) is at odds with the definition of medical assistance case management in the statute. The many pages of coding all suffer from this problem of understating allocable costs (although I have no quarrel with the notion of apportionment).

Please let me know if you have additional questions.



"Penning, Nick" <NPenning@aasa.org>

02/28/2000 05:07:19 PM

Record Type: Record

To: Andy Rotherham/OPD/EOP

cc:

Subject: FW: Medicaid analysis

> FYI, the following will be used to present AASA's official analysis,
> prepared by an expert in the field, of the Health Care Financing
> Administration's "Medicaid School-Based Administrative Claiming Guide."
> We will file this with HCFA. Use this however you may wish. (I am
> sending it as a "Microsoft Word" file and as text, in case you can't open
> this document.)
> nick
> <<00MEDICAIDanalysisRosenbaum2.28.doc>>
>
>
>
>
>
> Memorandum
>
> To: Bruce Hunter and Nicholas Penning, AASA
>
> Fr: Sara Rosenbaum, Harold and Jane Hirsh Professor, Health Law and
> Policy, The George Washington University School of Public Health and
> Health Services
>
> Re: Analysis of HCFA's Medicaid School-Based Administrative Claiming
> Guide
>
> Date: February 28, 2000
>
> This memorandum responds to your request for an analysis of HCFA's
> Medicaid School Based Administrative Claiming Guide. It identifies key
> issues for consideration by the American Association of School
> Administrators.
>
> In reviewing this guide, it is important to place health care furnished in
> and through schools into some context, as well as recap the basic
> structure of the Medicaid program. The first part of this memorandum thus
> lays out certain contextual considerations. The second part analyzes the
> draft guide.
>
>

> The Child Health and Medicaid Context

>

> * Basic health care in schools (e.g., preventive health and dental care, immunizations, primary medical care for routine physical and emotional health needs, family planning services, and other forms of basic pediatric and adolescent health care) are now a routine matter in schools. As the proportion of children enrolled in publicly funded health insurance programs (e.g., Medicaid and SCHIP) grows, the role played by these programs in helping to finance the cost of pediatric and adolescent health care can be expected to grow. School health services are particularly prevalent in lower income schools, where the proportion of children enrolled in or eligible for public health financing is high.

>

> * School districts have a legal obligation to furnish related services to children and adolescents who qualify for assistance under the Individuals with Disabilities Education Act (IDEA). This obligation is broad in scope, since related services can be ongoing and high cost. Cedar Rapids School District v Garret 119 S. Ct. 992 (1999). Children who are lower income and enrolled in Medicaid are at disproportionate risk of developing the types of physical and mental disabilities that must be treated in order to make education in the most integrated setting feasible. Much of this treatment may have to occur during the school day (i.e. in or through schools).

>

> * Medicaid offers two basic forms of federal financial assistance for state expenditures on behalf of children: medical assistance and administrative payments. These two forms of financing are designed to do different things and are subject to different sets of federal payment requirements. However, the two types of activities can overlap heavily; under current regulations, states have discretion to decide how to claim these services.

>

> * Through the EPSDT program, Medicaid "medical assistance" funds are available to pay for virtually any preventive, medical, remedial, or treatment service needed by a child or adolescent.

>

> * Federal Medicaid contributions for administrative costs are subject to a broad general test as to whether such activities that are necessary for the "proper and efficient administration" of state programs. Furthermore, EPSDT has its own set of required administrative activities for which federal funding also is available.

>

> * Other provisions of the statute allow for the reimbursement as either a medical or administrative service of most of the medical care a child would need. Not only is the actual provision of care an allowable cost, but also covered by Medicaid FFP rules are expenditures related to the identification and enrollment of eligible children, and expenditures related to the management of school-located health programs, including activities related to billing and claims, recruitment and training providers, quality of care oversight, medical records management, the development of patient care standards, data reporting, and so forth. Federal accounting principles govern how these costs are apportioned to Medicaid.

>

> * States have broad discretion over program design in administering
> their Medicaid programs, but certain basic rules apply. In order to
> qualify for federal medical assistance payments, the expenditure must be
> for a covered service that is furnished by a qualified Medicaid provider
> in accordance with applicable provider participation standards. To be
> federally reimbursable, administrative activities must fall within the
> ambit of the statute and must be proper and efficient. Furthermore, as
> noted, where the activities are in support of more than Medicaid
> beneficiaries or program activities, the costs must be apportioned in
> accordance with federal accounting principles.

>
> * Services may be either medical or administrative in nature;
> furthermore, certain services may have multiple characterizations under
> the statute. For example, arranging for necessary medical care, scheduling
> appointments, transporting children, and following up on referrals all
> constitute EPSDT administrative duties under §1902(a)(43) of the Social
> Security Act. They also can constitute medical assistance case management
> services under §1905(a)(19), to which all children are entitled as part of
> their EPSDT benefit. Where the service in question is a family planning
> benefit, it may be possible to characterize patient support as either an
> EPSDT administrative service or a family planning service.

>
>
> The Draft Guide

>
> In general

>
> When completed, HCFA's guide could provide important and useful
> information for state Medicaid and education agencies regarding the
> circumstances under which federal Medicaid funds are available to assist
> in the medical and administrative costs associated with furnishing basic
> and specialized medical and health services to Medicaid enrolled children
> in schools. The guide also will be highly useful in helping states carry
> out the President's directive to use the schools as a critical means of
> identifying and enrolling eligible children.

>
> In its present form, however, the guide suffers from a series of intrinsic
> shortcomings that are inevitable when an attempt such as this one is made
> to separate the administrative discussion from the medical assistance
> discussion. Rather than clarifying matters, the guide raises additional
> questions and creates a fair amount of confusion. Furthermore, and most
> fundamentally, the guide appears to contain incorrect statements of law
> and policy, particularly with respect to what is a covered medical
> benefit. Because the concept of what is an allowable administrative cost
> is necessarily so tied to what is a permissible medical assistance
> expenditure, it is not possible in my view to write a guide that
> accurately covers only "administrative claiming."

>
> Moreover, it is absolutely essential in my view to the health and welfare
> of children and their continued access to health care in schools that the
> tone of this guide be correct. Children and adolescents who are lower
> income have significant health care needs, and those needs frequently must
> be met during the school day and potentially in the schools themselves.
> The pressures on schools to furnish health care thus are enormous. Yet in

- > its current format, the guide as drafted can only be characterized as
- > having as its principal goal the ending of Medicaid payments for the cost
- > of health services furnished in schools. Almost no time is spent
- > elaborating on the importance of school located services or on what can be
- > done in schools. Any person reading this Guide would immediately pull the
- > plug on efforts to bring Medicaid revenues to bear on school services.

- >
- > This overwhelmingly negative legal message is precisely what was rejected
- > by Congress last fall. It is utterly incompatible by the emphasis that the
- > Administration has placed on schools as critical links for children in a
- > wide variety of services and is fundamentally inconsistent with the
- > purposes of other major laws for children, particularly the IDEA.

- >
- > The true goal of such a guide should be to encourage the appropriate use
- > of Medicaid to aid schools to identify and enroll eligible children and
- > deliver necessary basic and advanced medical and health services. To
- > achieve this result, the guide needs to spend at least as much time on
- > what is reimbursable as what is not.

- >
- > It is also worth noting that while the Guide indicates that its purpose is
- > to clarify existing policy rather than make new policy, whether it
- > achieves such a result (i.e., no new policy) is questionable. To the
- > extent that the guide reinterprets and applies in a school context federal
- > accounting rules in ways that previously had not been formulated, the
- > guide may in fact represent new policy. I am not an accounting expert,
- > but in reading the comments coming in from local and state school
- > administrators, I was left with the distinct impression that the
- > accounting practices prescribed in the guide differ significantly from
- > school districts' and Medicaid agencies' general understanding of what is
- > permissible. To the extent that the accounting principles in the guide do
- > in fact represent new policy, then the Administrative Procedures Act would
- > seem to require rulemaking, and the terms of the guide would be
- > unenforceable in the absence of such a supporting and final rule.

- >
- > Detailed comments

- >
- > The following represent my page-by-page comments to specific sections and
- > statements within the draft guide. I have picked up on both erroneous and
- > misleading statements, as well as the equally important issue of basic
- > tone and policy. There are so many issues that arise on nearly every page
- > of the guide, that I have chosen to focus on those that either are the
- > most important or that hit me the hardest as I read.

- >
- > * Page 1. The next to the last sentence says that "FFP may be
- > available" for administrative activities that are "found necessary by the
- > Secretary for the proper and efficient administration of the state plan."
- > In fact, when activities meet the "proper and efficient" test, they are
- > reimbursable. The secretary does not have the further discretion to deny
- > FFP if federal conditions are met. Medicaid is an entitlement program in
- > states, as much as it is one for individuals.

- >
- > * Page 2: At the bottom of the page there is no mention of the EPSDT
- > state plan requirements (§1902(a)(43)) as part of the legal basis and
- > authority for FFP for administrative costs associated with health care in

> or by schools. The EPSDT administration requirements cover a full range
> of activities from identifying children who need health services (a major
> overlapping function with the IDEA) to costs associated with supporting
> health services that are furnished.

>
> * Page 4: in the middle of the page HCFA states that administrative
> activities must be directly related to the administration of the state's
> Title XIX plan for the activity to be covered. EPSDT is technically beyond
> the scope of the state plan in the way in which HCFA has interpreted the
> program. Thus, where activities are in support of EPSDT administration,
> they also would qualify for FFP.

>
> * The time activity codes discussion (part IV, beginning on p. 5).
> This section also suffers from the absence of any EPSDT discussion. Since
> EPSDT and IDEA in particular overlap so heavily, the time code discussion
> must be reconceived to be specific to EPSDT. What is proper and efficient
> in carrying out EPSDT duties may be significantly broader than what would
> be proper and efficient for lesser services.

>
> * Allowable activities claiming (p. 6): It is fine to indicate that
> certain services are not allowable administrative activities. But these
> very services (helping a child gain access to needed medical, educational,
> social and other services) are all allowable as medical assistance case
> management under §1905(a)(19). Unless the guide spells out how states can
> use the case management benefit to furnish such services in and through
> schools, the guide ends up appearing to prohibit an activity that is not
> only permissible but in fact is required for children under §1905(r).

>
> * The free care issue (p. 6): this is such a limited exclusion in
> Medicaid that unless HCFA is going to be more specific about what indicia
> a service has to have to be considered "free" it should not be included.
> Almost no states provide universal free services in schools; even the IDEA
> does not classify the services at issue here as free, and schools are
> expected to collect revenue where available. This is a de minimus limiting
> factor in my view. I have no idea what "referral and coordination
> services that are provided free to the general population" refers to. If
> HCFA means medical assistance case management services these are expressly
> a required service for children. I know of no situation where such
> assistance is furnished to the "general population." If the agency is
> referring to a school system's obligation to furnish such support within
> the IDEA, then the IDEA provisions of the Medicaid statute specifically
> contemplate that they will be billed if the need for case management is
> part of the child's IEP.

>
> * The last sentence in the allowable activities section (p. 6) is
> confusing and misleading. It states that "administrative expenditures in
> support of EPSDT are reimbursable under Medicaid so long as the providers
> who furnish such services participate in the program." A provider of
> EPSDT support services most certainly does not have to be a qualified
> medical assistance provider. Indeed, it would be a waste of limited
> medical and nursing resources to expect the medical assistance provider to
> furnish the administrative service, which can be carried out by a trained
> paraprofessional. What does HCFA mean?

>

> * Duplicate payments (p. 8): HCFA notes that Medicaid payments should
> not be made "for an activity already paid for or otherwise reimbursable"
> under another mechanism. I have no idea what this means, and it
> contravenes settled Medicaid law. Medicaid covers services that may be
> reimbursable under IDEA (related services that also are case management or
> a recognized administrative service). 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 (e.g., the Title V maternal and child health services block grant,
> the mental health services block grant, title XX, program grants
> administered by the CDC, the health centers statute). The list goes on and
> on. Medicaid pays for many services that are "reimbursable" under other
> laws. This sentence has a chilling effect on a broad range of school
> activities and is not correct.

> * The effect of managed care (p. 9, 10, and other locations). HCFA's
> view of the effects of a managed care contract is, in my opinion, legally
> incorrect. This entire section has to be rethought and re-formulated. A
> state may dump many dollars into its managed care rate; the dollars alone
> tell us nothing about what the contractor must do. In this regard, the
> legally binding document is the contract with the managed care
> organization. In our large-scale reviews of state MCO contracts, we have
> found that almost none covers medical, remedial, preventive and other
> health services furnished in schools, services furnished in an IEP or
> IFSP, administrative support services furnished by school personnel, or
> any other services relevant to this topic. Because the question of
> coverage is so complex, a state education agency would have to consult
> with the Medicaid agency with respect to every service covered under the
> interagency agreement in order to determine for which services the
> Medicaid MCO contracts make the MCOs liable. In the absence of specific
> language, MCOs would have complete discretion as to whether to contract
> with the schools in their service area for any of these services. They
> also have discretion regarding which providers and agencies they use to
> furnish medical and supporting administrative services.

> It may be that a school district has a contract with one or more managed
> care organizations to provide medical and administrative services, in
> which case the Medicaid agency should not pay again. It may also be that
> in the case of a particular child, the service is being furnished in a
> non-school setting or is not medically necessary within the meaning of the
> MCO's operations, in which case there is a factual dispute regarding
> whether there is still residual liability for the service. In any event,
> there is nothing about the premium paid to the MCO alone that would answer
> this question. The contract is the operational legal instrument here for
> deciding whether the MCO is already on the hook for the medical and
> administrative services in question and if so, whether the schools need to
> look to the MCO for payment.

> * Direct versus administrative services (p. 10-11). I have no idea
> what an administrative service that is part of a direct service is in the
> context of children. Targeted case management to assist children obtain
> access to needed medical, educational, social and other services is an
> independent medical assistance service under the law, as are EPSDT
> administrative services. These are not services incident to the medical

> encounter themselves but are recognized under the statute as independent
> activities in their own right. This section needs to be rethought and
> restructured. The administrative case management discussion on p. 11
> omits any discussion of EPSDT administrative costs.

>
> * Apportioning administrative costs (p. 12-13). I absolutely agree
> that costs must be apportioned so that Medicaid payments are in proportion
> to the value of the administrative service at issue to the Medicaid
> program. Nonetheless, I cannot even begin to understand the discussion on
> this page, since the example on p. 13 seems to describe a fully Medicaid
> allocable activity (i.e., coordinating and supporting Medicaid services).
> Why wouldn't the cost of supporting Medicaid services be 100% allocable to
> Medicaid (as opposed to the cost of the IEP coordinator's time, for
> example, which would be allocable among his or her Medicaid and
> non-Medicaid students)?

>
> * Skilled medical professional services (p. 14). Why must the SMP work
> for the Medicaid agency (bullet IV?). I am unaware of any provision in the
> statute that requires an employment (as opposed to a contractual)
> relationship. Maybe they mean something else.

>
> * Family planning (p. 16). I have no idea why HCFA is reading the
> "and" here as all-inclusive. A sensible reading of the statute is that
> 90% is available for three activities, each one of which may be done
> separately. Are they saying that a school can be paid only if the school
> offers, arranges and furnishes the care? What if the school offers and
> arranges but send the child to a family planning clinic operating under
> the PHS program? Does this mean that the school cannot be paid for the
> cost of the person who actually made the appointment, counseled the
> students, etc? How many schools actually "furnish" family planning and
> thus are able to meet this test, as stated?

>
> * Provider participation (p. 17) the first full paragraph on this page
> again suggests that only qualified Medicaid providers can furnish
> administrative services. This is simply not true and would be a waste of
> qualified Medicaid provider time. Example 3 (bottom of page) makes no
> sense.

>
> * The IEP discussion (p. 18 and other locations). This entire topic
> needs to be much more carefully formulated. Identifying children who need
> special education services and getting them evaluated is so intermingled
> with the EPSDT obligation to find children with health problems, screen
> them, treat them, and provide medical assistance targeted case management
> (which includes assistance in obtaining needed educational services) that
> the guide does not even begin to do justice to the question of
> apportionment. This entire section needs to be rewritten in the context of
> a thorough Medicaid analysis that considers both medical assistance and
> administrative costs. The final paragraph on this page would virtually
> prohibit Medicaid payments for any services associated with the management
> of health and related services for children covered by IDEA, since §504 is
> simply a parallel enforcement statute. The analysis is legally flawed and
> potentially will shut off Medicaid coverage for a broad range of
> reimbursable services.

>

> * The cost allocation materials and coding: I reviewed these briefly.
> This is where the policy may be new (i.e., existing and allowable
> allocation methodologies may no longer be permissible). In addition,
> various services that are listed as not attributable to Medicaid in fact
> would be attributable to Medicaid were the program understood to include
> EPSDT. For example general health education and outreach may be a
> perfectly permissible cost to be partially allocated to EPSDT (p. 23). The
> agency has literally reams of EPSDT guidelines that cover general
> education aimed at promoting the use of EPSDT benefits. Code 5a (p. 28)
> is at odds with the definition of medical assistance case management in
> the statute. The many pages of coding all suffer from this problem of
> understating allocable costs (although I have no quarrel with the notion
> of apportionment).

> Please let me know if you have additional questions.

> Senior Legislative Analyst
> American Association of School Administrators
> 703.875.0775
> npenning@aasa.org
> I have always been delighted at the prospect of a new day, a fresh try,
> one more start, with perhaps a bit of magic waiting somewhere behind the
> morning.

FAX COVER SHEET

La Porte Independent School District
John E. Sawyer, Ed.D., Superintendent
301 E. Fairmont Parkway
La Porte, TX 77571

Phone: 281.604.7015

Fax: 281.604.7020

Send to: ANDY ROTHERTRANS Spec. Asst. for Education	From: John E. Sawyer
School/Company The White House	Fax #: (202) 456-5581
Date: 2/25/00	# Pages: 15

FYI

Reply Requested

As Per Your Request

Urgent

Comments:

Dear Andy:

WOW! I am suprised by your faithfulness to returning calls! I know you understand how important funding is to public schools, so I won't belabor the point, except to say that any funding changes are difficult, and change during a fiscal year is devastating.

Attached please find:

1. Some communication I sent earlier to Bruce Hunter. They are explained in the cover.
2. Behind that, a draft impact letter of national scope; and
3. Behind that, a draft impact letter more peculiar to Texas.

Texas has an approved program. We are administering it as approved. Changes for programs coming on line are much more acceptable, in my opinion. Others should grandfather. I am particularly am distressed by what appears to be subterfuge and miscommunication (purposeful?)

4. The next attachment is a letter to Ken Bentsen; and lastly,
5. My communication following a phone conversation with a more recent

(see next page)

FAX COVER SHEET

La Porte Independent School District
John E. Sawyer, Ed.D., Superintendent
301 E. Fairmont Parkway
La Porte, TX 77571

Phone: 281.604.7015
Fax: 281.604.7020

Send to: Andy Rothertran	From: John Sawyer
School/Company	Fax #:
Date:	# Pages:

FYI

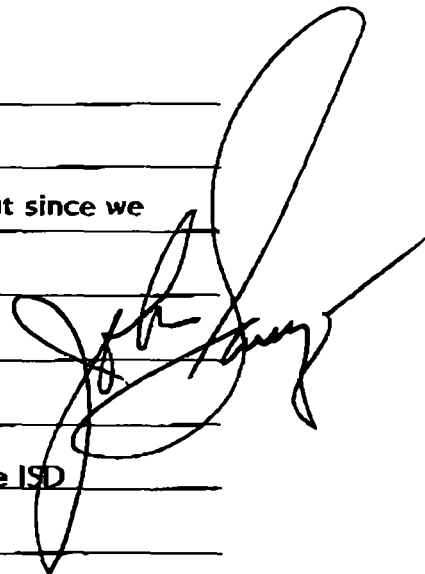
~~Reply Requested~~

As Per Your Request

Urgent

CONTINUED , page 2

Comments:

communication on top...a. I have received no responseb. I believe we clearly were told that Texas would have input since we
are one of (only two, I think) : the approved programs!HELP ---and thanks.pc: Buck Wood/Jim ShearGary Mauro (through Ray, Wood & Fine)Debra Anderson, Director of Special Populations, La Porte ISD

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Personal (Partial) (1 page)	02/17/2000	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Bethany Little
OA/Box Number: 18398

FOLDER TITLE:

Medicaid---School-Based [3]

2013-0371-S

ms632

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]



La Porte Independent School District

February 17, 2000

FOR YOUR INFORMATION

John E. Sawyer, Ed. D.
Superintendent of Schools

BOARD OF TRUSTEES

Mike McLaughlin
President
Rachel H. Hampton
Vice President
Charlie G. Perry
Secretary

Henrietta Allen
Bill Baker
Jay Guillot
Gordon Westmorland
Trustees

Mr. Bruce Hunter
American Association of School Administrators
1801 North Moore St.
Arlington, VA 22209-1813

VIA FAX: (703) 528-2146

Dear Bruce,

What a pleasure visiting with you! We'll see Jerry in the next few weeks and will "fill him in" on our conversation.

Thank you for your help. I will contact Andy Rotherham late today or tomorrow after you have had a chance to alert him.

Please note the response to Alabama's query. What a deal!

I included a copy of my cover too. Ken Bentsen's new staff (filling in for Bradley Edgell

(b)(6)

(b)(6)

Keep me posted and I'll do the same.

Sincerely,

John E. Sawyer, Ed.D.
Superintendent

jw

Attachments

1a

La Porte Independent School District
301 E. Fairmont Parkway
La Porte, TX 77571

Telephone: (281) 604-7015

MEMO from...

JOHN E. SAWYER, Ed.D.
Superintendent of Schools

Fax: (281) 604-7020

February 15, 2000

TO: Ms. Rosaline Cohen, *Legislative Aide*
Representative Ken Bentsen's Office

Via Fax: (202) 225-2947

Rosaline:

Thank you for your help. As per your request, I am sending the attached two (2) pages. Please look at these pages. The first is a response to Alabama's "implementation plan" which directly refers to "draft" guidelines which restrict the program significantly.

Why have any input period if the draft is already enforceable? Similarly, I simply believe the method of input is misleading; the time frame is too short; and the notification nil.

I know Gary Mauro has already discussed some issues with you. Please review and discuss with Gary as soon as possible. He and I will stay in contact.

/jw

Attachment

pc: Buck Wood/Jim Shear, Ray, Wood & Fine (Via Fax)

3342700000

AFSB

HCFA Comments to Alabama's proposal for Administrative Outreach Claiming for School Based Services (submitted by the State 11/17/99)

1. Page 1, Paragraph 2: The Cluster Sampling technique does not meet OMB Circular A-87 requirements. [see Attachment B #11, h (6)(a)(i)(ii)].
2. Page 2, Paragraph 1, Time Study: Please provide support that the week is randomly selected. Also provide us with your sampling plan.
3. Page 4, Paragraph 1, "Allocation of Salaries and Benefits of Direct Personnel and Contracted (Direct) Personnel Expenditures": (A) Please provide us a definition of "contract personnel" with a sample contract. (B) Describe past outreach efforts. Was outreach a "campaign" or "one-to-one"?
4. Page 4, Paragraph 3, "Other Operating Expenditures": Please provide a complete definition including examples of "purchased professional services".
5. Page 5, Paragraph 1: Define "Medicaid Outreach" and describe past efforts. How were they limited to only Medicaid youth?
6. Page 5, Paragraph 3: How will administrative outreach activities be documented?
7. Page 5, Last Bullet, "Allocation of Time Study Results": Alabama's plan appears to have much 75% activity - the HCFA guide is geared towards most activities at 50%. Under the guide - all 75% activity should have prior approval as it occurs. The 75 % issue is still under review. We need to discuss this.
8. Page 6, Last Bullet, "Indirect Costs": Will the school districts and/or schools establish their own indirect cost rates? What methodology will be used?
9. Page 7, 3rd Bullet, "Retention of Supporting Documentation": Describes in detail - who maintains what type of documentation.
10. Page 12, Rate: 75% - This rate requires medical expertise - what type of credential support will be used for SPMP designation? Also - documentation for 75% claims must be provided and this specifically means something showing what child was being worked on and what function was performed (see page 17 of the HCFA draft guide). 90% - please explain in detail who can claim and for what activities. If doing Family Planning activities, will this be considered a "direct service"?
11. Attachment 1 - CODES:
 - Code A2: The HCFA draft guide does not allow any outreach at 75% - only 50%.
 - Code E2: The draft guide does not contain any allowable 75% activity. All must be requested and approved.
 - Code F: The draft guide calls it "Medicaid Specific Training" which is a discounted, 50% FFP item. Basically, two functions are allowed: (1) the first bullet in the example minus EPSDT and (2) the fourth bullet in the example.
 - Code F2: There is no such activity. If training is performed by Non-SPMP, how could someone claim 75%? If audience has Non-SPMP, how can 75% be claimed?
 - Code G: There is no such activity in the Guide (or in Florida's program).
 - Code H2: Same as E2 - No 75% in draft guide. Must be requested, justified and documented.
 - Code J: Does Alabama dedicated staff for Family Planning? If so, are they included in the cost pool for salaries?

② Note guideline
reference by HCFA

TOTAL P.02

CHILDREN AT RISK: RECENT HCFA GUIDELINES DRAMATICALLY REDUCE FUNDING FOR SCHOOL-BASED HEALTH CARE SERVICES FOR POOR CHILDREN

February 14, 2000

In November 1999, the House of Representatives defeated Section 407 of H.R. 1180. This Section contained provisions which would have substantially eliminated school district participation in the Medicaid program. What Congress voted against in November, HCFA is now trying to circumvent by issuing guidelines.

Despite the removal of Section 407 from H.R. 1180, HCFA has found it necessary to prepare and issue a set of guidelines that will result in a significant loss of funding for school-based health care services for poor children. Once again, HCFA has acted to the detriment of our children. A set of proposed guidelines has been prepared.

The Devastating Reality:

The proposed guidelines will:

- **Reduce the current program level of funding in the states up to 85%;**
- **Remove states' and school districts' rights to develop and implement a program that meets the distinct needs of small and large school districts;**
- **Significantly increase the level of administration (federal & state) necessary to manage the program; and**
- **Alter existing state programs without adequate and meaningful input from the concerned parties (HCFA is already formally using the proposed guidelines to set alleged federal policy in states and school districts).**

Unfortunately, despite the strong message sent by Members of Congress in November of 1999, HCFA has found it necessary to prepare and issue a set of guidelines containing provisions which will, in effect, substantially eliminate school district participation in the Medicaid program. These guidelines are being used to void existing and approved HCFA policy and circumvent the goals and intent of Congress with respect to IDEA children.

The HCFA guidelines have taken the concepts described in the defeated Section 407 to the next level. The intended negative impact of Section 407 will now be realized as state Medicaid departments are forced to alter existing funded programs to conform with the HCFA guidelines. The guidelines will effectively eliminate a necessary funding mechanism for the mandates established by Congress related to the identification and care of our Medicaid eligible school children.

Medicaid School-Based Administrative Claiming Guide

National Impact Assessment

PRELIMINARY DRAFT - FOR DISCUSSION PURPOSES ONLY

Preliminary analysis of the Draft Medicaid School-Based Administrative Claiming Guide suggests a drastic impact upon reimbursement level and administrative burden to the schools. Depending upon the program model currently in place, this impact can represent up to an 85% reduction in reimbursement. This devastating impact is likely to have a further deterrent effect, as many districts may no longer find it cost effective to participate, given the increased burden and limited reimbursement.

While many complicated factors contribute to these reductions, the following represent the key drivers of the reductions to reimbursement:

Elimination of Enhanced Reimbursement for Skilled Professional Medical Personnel (SPMPs):

- In a global sense, the guidelines *allude* to the ability for states to obtain enhanced FFP (75%) for administrative outreach activities that require the credentials of skilled medical professionals. However, the proposed outreach activity code definitions do not specifically provide for SPMP reimbursement at enhanced rates.
- In order for states to obtain enhanced reimbursement, onerous documentation and approval requirements must be met and HCFA reserves the right to deny these alternatives.

Drastic Reductions Due to Application of Medicaid Eligibility Rates:

- The proposed activity codes represent a significant reduction in reimbursable activity as compared to models currently operating in several HCFA regions, including those that have received formal HCFA approval. The revisions to the activity codes have caused a larger proportion of Medicaid Administrative activity to be discounted by the Medicaid eligibility rate.

Administratively Burdensome Time Study Sampling Methodology:

- We believe that the proposed random moment sampling (RMS) methodology would be administratively more complex than the current model. To ensure that reporting takes place on the designated days, additional administrative oversight would be needed within the district, addition significant cost and burden. Randomly selected days would also impair district compliance to the process and undermine accuracy of results.

Reductions to Allowable Administrative Expenditures

- The proposed guidelines would reduce current levels of reimbursement by disallowing some designated state and local expenditures from being included in

Medicaid School-Based Administrative Claiming Guide Impact Assessment

(2c)

PRELIMINARY DRAFT – FOR DISCUSSION PURPOSES ONLY

claim calculation. The proposed guidelines eliminate any state expenditures that have been matched by the Federal government (such as fee-for-service funds) as well as many targeted state and local funds from being included in a cost allocation for the MAC Program.

Elimination of these currently allowable expenditures could have devastating effects on reimbursements to schools as a large percentage of expenditures related to administrative outreach activities include funds that are matched by the Federal government through fee-for-service programs or those that may designated for special education or health programs.

Curtailed Provider Participation

- The proposed guidelines limit reimbursement for administrative activities performed by school staff to only those medical activities reimbursable under the State's Medicaid Plan. The implication of this limitation is that the only reimbursable administrative activities are those performed by a Medicaid-enrolled provider who also bills for the Medicaid-covered services. Therefore, all administrative outreach activities performed by school staff other than those who bill for Medicaid-covered services, could potentially be unallowable. In addition, it is possible that if a school district did not seek reimbursement through a fee-for-service program, it would not be eligible for administrative outreach reimbursement. Limiting reimbursement in this manner would significantly reduce participation in the program and have detrimental effects on districts' reimbursement for administrative outreach activities.

Limitations on Flexibility Provided to States and Schools:

- While the guidelines suggest that States and schools maintain flexibility in program design, this flexibility is primarily focused upon the following areas:
 - Establishment of eligibility standards;
 - Determination of provider type, amount, duration and scope of services;
 - Rate setting; and
 - Administration of the program, including development of administrative requirements
- However, in order for states to take advantage of this implied flexibility, extensive approval requirements must be met.
- While the guidelines are, in theory, proposed to clarify and simplify the program, they effectively *redirect* the onus onto the State via the required approval process. In addition to the development of the proposed guidelines, HCFA has proposed further steps in an approval process that appears even more elaborate and protracted than that which is currently in place.

Medicaid School-Based Administrative Claiming Guide

Texas Impact Assessment

3

PRELIMINARY DRAFT – FOR DISCUSSION PURPOSES ONLY

The Draft Medicaid School-Based Administrative Claiming Guide significantly limits Texas schools' ability to identify Medicaid-eligible children with health risks or special needs due to a 20% to 40% reduction in current levels of funding for these services. This impact, when coupled with the additional administrative requirements suggested in the draft guide, will likely deter many Texas school districts from participating in the Medicaid Administrative Claiming (MAC) Program altogether.

Following are some examples of the changes to the current Texas MAC Program that potentially reduce reimbursement and increase administrative burden for schools:

Administrative Outreach Activity Code Definitions:

- The proposed activity code definitions designate several activities that are currently reimbursable under the Texas MAC Program as unallowable for reimbursement.
- In addition, the proposed definitions limit reimbursement to the Medicaid-eligible population for some activities that are currently reimbursable for the entire student population. In many cases, these are activities that occur prior to the determination of Medicaid eligibility and currently being fully reimbursed through the Texas MAC Program.

Reimbursement Limitations for Skilled Professional Medical Personnel (SPMPs):

- In a global sense, the guidelines *allude* to the ability for states to obtain enhanced FFP (75%) for administrative outreach activities that require the credentials of skilled medical professionals. However, the proposed outreach activity code definitions do not specifically provide for SPMP reimbursement at enhanced rates. Currently, the Texas MAC Program reimburses activities related to Medicaid outreach, provider relations, and interagency coordination at a 75% rate.
- In the event SPMP-reimbursement would be allowed, the guidelines propose onerous documentation and approval requirements to access this rate of funding.

Complex Time Study Sampling Methodology:

- The proposed random moment sampling (RMS) methodology would be more administratively complex than the current model that samples select participants for a one-week period. Additional administrative oversight would be needed within school districts to ensure that that reporting takes place on the designated days. This proposed methodology could impair district compliance to the process and undermine accuracy of results as well as deter many schools from participation.

Medicaid School-Based Administrative Claiming Guide Texas Impact Assessment

PRELIMINARY DRAFT – FOR DISCUSSION PURPOSES ONLY

3a

Administrative Expenditure Limitations

The proposed guidelines would reduce current levels of reimbursement by disallowing some designated state and local expenditures from being included in the claim calculation. The proposed guidelines eliminate the state matching expenditures (such as the state match of fee-for-service reimbursements) as well as many targeted local funds from being included in a cost allocation for the MAC Program. This could have devastating effects on reimbursements to Texas schools as a large percentage of expenditures related to administrative outreach activities include funds that are matched by the Federal government through the SHARS Program or those that may be designated for special education or health programs.

Limitations on Provider Participation

- The proposed guidelines limit reimbursement for administrative activities performed by school staff to only those medical activities reimbursable under the State's Medicaid Plan. The implication of this limitation is that the only reimbursable administrative activities are those performed by a Medicaid-enrolled provider who also bills for the Medicaid-covered services. Therefore, all administrative outreach activities performed by school staff other than those who bill for Medicaid-covered services could potentially be unallowable. This would seriously limit the outreach program to Medicaid-eligible children only.



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20491

DEC 15 1999

The Honorable Ken Bentsen
House of Representatives
Washington, D.C. 20515

Dear Mr. Bentsen:

Thank you for your recent inquiry regarding the claiming of Federal funds under the Medicaid program for the costs of administrative activities performed in school settings. Your letter addresses our efforts to consolidate current guidance on the administrative claiming process, as was noted in the May 21, 1999 letter to State Medicaid Directors. This consolidated guidance document is intended to provide clear information for schools, State Medicaid agencies, HCFA staff, and other interested parties, on the requirements associated with school-based administrative activities.

It is important to note that the purpose of the Medicaid administrative claiming guide (referred to here as the Guide) is not to revise existing policy or to establish new policy. Instead, the Guide is being developed to consolidate current policy into a single document that can be used as a resource by various stakeholders. In addition, this guidance is intended to promote consistency in administrative claiming practices.

As you may know, the Government Accounting Office (GAO) has also been looking at the issue of Medicaid claiming for school-based health services and related administrative expenditures. Both HCFA and the GAO testified on this issue at a hearing in June, and GAO released a report at this hearing which noted a dramatic increase in Medicaid claims for school-based administrative costs, and that those charged with program oversight at the State and Federal level must be vigilant in guarding against unauthorized billing practices.

Subsequent to the hearing, the GAO has been asked to further study the issue of administrative claiming. Given these recent trends in Medicaid spending, the guidance document is critical to promote the fiscal integrity of the program, and we appreciate your recognition of these complex issues.

From S. S. S. S.

4d

Page 2 - The Honorable Ken Bentsen

While this guidance is only consolidating current policy, we intend to share a draft version with the States (including school districts) and other Federal agencies because input and participation by the various stakeholders is essential in order for the Guide to accurately reflect the many issues brought to light in recent months. In addition, I will be sharing a copy of the draft guide with you so that you will also have a chance to review it and to ensure that your concerns are addressed.

Sincerely,



Donna E. Shalala



La Porte Independent School District

February 8, 2000

Mr. Richard Strauss
Division of Financial Management
Health Care Financing Administration
7500 Security Boulevard
Baltimore, MD 21244-1850

John E. Sawyer, Ed. D.
Superintendent of Schools

BOARD OF TRUSTEES
Mike McLaughlin
President
Rachel H. Hampton
Vice President
Charlie G. Perry
Secretary

Henrietta Allen
Bill Baker
Jay Guillot
Gordon Westmoreland
Trustees

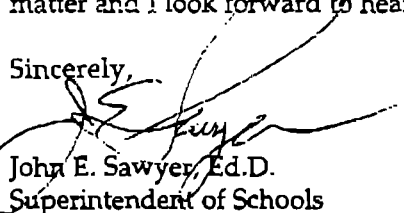
Re: Draft Guidelines for the *Medicaid Administrative Claiming* (MAC) Program

Dear Mr. Strauss:

I am writing as a follow-up to our telephone conversation (and subsequent correspondence to you) last September during which we discussed your agency's efforts to draft guidelines pertaining to the MAC program. Since then, I was furnished a copy of a December, 1999 letter from Secretary Shalala to Congressman Ken Bentsen in which she states, in part, "...that the purpose of the administrative claiming guide is not to revise existing policy or to establish new policy. Instead, the Guide is being developed to consolidate current policy...to promote consistency in administrative claiming practices." While these statements are somewhat reassuring, I remain concerned about the possibility of "unintended consequences" we both know often occur any time complex administrative guidelines are subject to recodification.

You said at the time of our September conference call, that you were willing to meet with me and representatives of other Texas school districts so that we can provide, as we discussed, direct input into this process. I believe that such a meeting could be very timely at this moment, especially since we are in the beginning stages of formulating our 2000-01 school year budgets, including a forecast of future MAC reimbursements based on the current Texas guideline requirements. If we could arrange this meeting for sometime in the next thirty (30) days, it would greatly facilitate our local budget planning efforts for the upcoming year. I would gratefully appreciate your prompt attention to this matter and I look forward to hearing from you in the immediate future.

Sincerely,


John E. Sawyer, Ed.D.
Superintendent of Schools

/jw

pc: Secretary Donna Shalala
Representative Ken Bentsen
Sarah Bianchi, The White House
Quinn Dodd, office of the Honorable Kay Bailey Hutchinson (via Fax)
The Honorable Martin Frost (via Fax)
Al Haight, Deloitte Consulting Group
Gary Mauro (via Fax)
Buck Wood/Jim Shear (via Fax)



La Porte Independent School District

September 30, 1999

Mr. Richard Strauss
Division of Financial Management
Health Care Financing Administration
7500 Security Boulevard
Baltimore, MD 21244-1850

John E. Sawyer, Ed. D.
Superintendent of Schools

BOARD OF TRUSTEES

Mike McLaughlin
President
Rachel H. Hampton
Vice President
Charlie G. Perry
Secretary

Henrietta Allen
Bill Baker
Jay Guillot
Gordon Westmoreland
Trustees

Dear Mr. Strauss:

This letter is a follow up to our conference call on September 8, 1999, related to the *Texas Medicaid Administrative Claiming (MAC) Program* and the proposed HCFA guidelines. First, let me express our sincere appreciation for the time you and your colleagues afforded us to discuss this important matter. We also appreciate your agreement to a face-to-face meeting with a representative group of school districts to review, discuss, and receive our districts' recommendations regarding your draft guidelines after their preliminary release.

We fully understand your agency's efforts with regard to the drafting of these guidelines, is a response to several issues raised by the GAO in its June 1999 report to the Senate Committee on Finance. In turn, we hope you understand and appreciate the gravity of our concerns regarding any potential changes to the existing Texas program.

We firmly believe that the Texas MAC program and the La Porte ISD Consortium specifically, was designed and implemented in a manner totally consistent with the GAO's recommended standards. As you know, it took almost two (2) years to finalize the MAC program HCFA formally approved in a January 1996 letter provided to the *Texas Health and Human Services Commission*. The process was an extensive, collaborative effort between our state Medicaid agency, your regional HCFA office in Dallas, several state agencies, including the *Texas Education Agency*, and the participating school districts. I feel it is fair to say that the activity codes and cost allocation methodology approved by your agency--after several specific revisions were made pursuant to HCFA's initial program review--considerably narrowed the scope of the Texas program even further.

Our program also incorporates extensive training and quality control measures to ensure maximum statistical accuracy and minimum human error. All of La Porte's claims have been carefully scrutinized by the *Texas Health and Human Services Commission*, *Texas Department of Human Services*, and the *Texas Education Agency*, as well as having been subject to review by the Dallas regional HCFA office. All passed muster and all have been approved.

Based upon our conference call discussion, it is our understanding that while you believe our existing program is unlikely to be changed by the proposed guidelines, you did need additional time to review the program components. Our expectation is that the Texas program will be allowed to continue as currently approved. However, if you are contemplating that the proposed guidelines will result in any changes in the existing program, it is imperative that we be advised of those potential changes no later than October 15, 1999. The urgency of this request is due to the increasing

Letter - Richard Strauss
Page 2

frequency and severity of concerns being raised about this matter by the some 300 school districts with which I am directly associated. I am committed to providing a status report regarding the potential impact of the proposed guidelines on our program at our steering committee meeting the week of October 18, 1999.

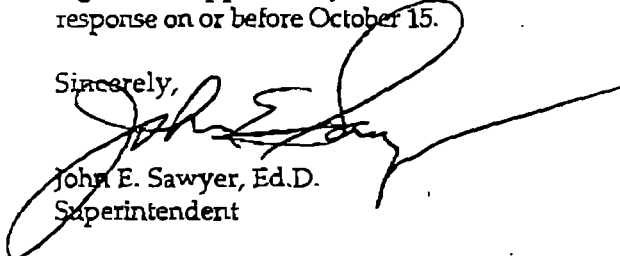
Our primary concerns are focused on any changes the proposed guidelines may impose upon our existing program relative to: (1) allowable activities; (2) definition and/or reimbursement rates for SPMP eligible activities; and (3) the application of the Medicaid eligibility rate to the activity codes, or any other changes that would have a negative economic impact upon the program or would increase the administrative burden on the districts. With complete certainty, we can assure you that any changes which are more restrictive than the current requirements will seriously impair, if not effectively end our program.

Furthermore, any adverse changes implemented before August 31, 2000, would impose a significant hardship on Texas school districts. They have factored their estimated FY 2000 MAC reimbursements into their current year budgets based on previously HCFA approved Texas program. I hope you would agree that such a retroactive policy decision would be grossly unfair.

Additionally, given the detailed and complex nature of the reporting requirements associated with the preparation of claims, coupled with the extreme diversity of the school districts participating in this consortium, we feel it is imperative that we be given at least six (6) weeks, and preferably 60 days, to thoroughly analyze these proposed guidelines for possible adverse impacts on the three issues referenced above.

Again, we appreciate your time and consideration and anxiously look forward to receiving your response on or before October 15.

Sincerely,



John E. Sawyer, Ed.D.
Superintendent

/jw

cc The Honorable Ken Bentsen

HCFA	Beneficiaries	Plans & Providers	States	Researchers	Students
Medicare	Medicaid	CHIP	Customer Service	FAQs	Search

DRAFT MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING GUIDE

The Health Care Financing Administration (HCFA) is requesting assistance from the States, school districts, national education organizations, and other interested stakeholders in obtaining review and comment on the Draft Medicaid School-Based Administrative Claiming Guide (referred to hereafter as the Guide). This website has been made available to facilitate dissemination of the Guide to the various stakeholders. It can be downloaded following the instructions listed below. This is a general solicitation of comments from the public. It should be noted that no commenter is required to provide specific information other than that necessary for self-identification as a condition of the agency's full consideration of the comment.

This Guide will provide information for schools, State Medicaid Agencies, HCFA staff, and other interested parties on the existing requirements for claiming Federal funds under the Medicaid program for the costs of administrative activities, such as Medicaid outreach, that are performed in the school setting. The Guide is not intended to provide new policy; rather, it is intended to consolidate and clarify existing policy to foster better understanding of program requirements and the applicable statutory and regulatory provisions. By issuing this guidance nationally we hope to promote consistency in administrative claiming practices and the fiscal integrity of the program.

The consultation that HCFA is now requesting from the States and their school districts, as well as national education organizations and other interested stakeholders, is meant to build upon review efforts at the Federal level. The U.S. Department of Health and Human Services and the U.S. Department of Education are among those Federal agencies reviewing the Guide. This comprehensive review process is essential to ensure that the significant issues related to this subject area are identified and accurately and sufficiently addressed in the Guide.

Due to the extensive nature of this consultation process and the need for final publication on a timely basis, HCFA has established time frames and procedures that are intended to be both reasonable and conducive to a productive collaboration with the various stakeholders. There are several organizations that are collaborating with HCFA to obtain consultation with the various stakeholders. Those organizations (listed below) have been asked to provide a focal point for coordinating, receiving, and compiling comments on the Guide from their respective constituencies for submission to and consideration by HCFA. In addition to the availability of the Guide on this website, the Guide will be made available through these coordinating organizations.

All comments on the Guide should be submitted directly to the coordinating organization through which the Guide was made available to you, or to one of the coordinating organizations below that best represents your affiliation, if the Guide was not provided directly to you. **The comment period will close on March 6, 2000. Therefore, we recommend you give your comments to one of these organizations by March 1.**

We appreciate your assistance in the development of the Guide, and will consider your input on this important effort to provide clarification on national policy for Medicaid school-based administrative claiming programs.

The following information provides the contact names, phone numbers, fax numbers and e-mail addresses (where available) of the various coordinating agencies. Please address all comments and inquiries to the appropriate entity.

EDUCATION ORGANIZATIONS

American Association of School Administrators (Represents chief executive officers of local school

districts (all sizes), e.g., superintendents)

1801 North Moore Street
Arlington, VA 22209

Contact:

Bruce Hunter, Director of Public Affairs
Phone: (703) 528-0700 Fax: (703) 528-2146
E-mail address: bhunter@aasa.org

Council of Chief State School Officers (Represents State Departments of Education)

1 Massachusetts Ave., N.W.
Suite 700
Washington, D.C. 20001

Contact:

Cynthia Brown, Director, Resource Center on Education Equity
Phone (202) 336-7007 Fax: (202) 408 8072
E-mail address: cindyb@ccsso.org

Council of the Great City Schools (Represents schools for 58 largest cities in the U.S.)

1301 Pennsylvania Ave., N.W.
Suite 702
Washington, D.C. 20004

Contact:

Jeff Simering, Director of Legislative Services
Phone (202) 393-2427 Fax: (202) 393-2400
E-mail address: ICAP@cgcs.org

National Association of State Directors of Special Education (NASDSE)

1800 Diagonal Road
Suite 320
Alexandria, VA 22314

Contact:

Bill East, Executive Director
Phone (703) 519-3800 Fax: (703) 519-3308
E-mail address: east@nasdse.org

National School Boards Association (Represents School Boards)

1680 Duke Street
Alexandria, VA 22314

Contact:

Reggie Felton, Director of Federal Relations
Phone: 703 838-6722 Fax: (703) 683-7590
E-mail address: medicaid@nsba.org

STATE MEDICAID AGENCIES**American Public Human Services Association (APHSA)**

Suite 500

810 First St., N.E.
Washington, D.C. 20002

Contact:

Lee Partridge, Health Policy Director
Phone: (202) 682-0100 Fax: (202) 289-6555
E-mail address: lpartridge@aphsa.org

You should submit your comments through one of the e-mail addresses indicated above, based on your affiliation. However, if you are not represented by, or affiliated with, any of the organizations listed above, you may submit your comments to HCFA at the following e-mail address: sbrown4@hcfa.gov

Instructions for downloading and viewing the Guide:

The Guide is available in Adobe Acrobat format (pdf) and requires Adobe Acrobat Reader software to view. This software can be obtained for free directly from the Adobe Website (www.adobe.com).

[Click here](#) to view or download the Guide (macguide.pdf).



[Return to Medicaid Professional/Technical Information Page](#)

Last Updated February 17, 2000

HCFA	Beneficiaries	Plans & Providers	States	Researchers	Students
Medicare	Medicaid	CHIP	Customer Service	FAQs	Search



Department of Health
& Human Services

HCFA

MEDICARE • MEDICAID
Health Care Financing Administration

MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING GUIDE

DRAFT

FEBRUARY 2000

MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING GUIDE

TABLE OF CONTENTS

I.	INTRODUCTION	1
II.	BASIS/AUTHORITY	2
A.	Statute/Regulations	2
B.	OMB Circular A-87	3
III.	INTERAGENCY AGREEMENTS	3
A.	General	3
B.	Requirements	4
IV.	CONSTRUCTING TIME ACTIVITY CODES	5
A.	General	5
B.	Operational Principles	5
1.	Proper and Efficient Administration	5
2.	Claiming for Allowable Activities Only	6
3.	Capture 100 Percent of Time	6
4.	Parallel Coding Structure: Medicaid and Non-Medicaid Codes for Each Activity	8
5.	Duplicate Payments	8
6.	Coordination of Activities	9
7.	Performing Direct Services v. Administrative Activities	10
8.	Allocable Share of Costs	11
9.	Enhanced FFP Rates	13
a.	Skilled Professional Medical Personnel (SPMP) School Administrative Claiming	13
i.	Basis	13
ii.	SPMP Criteria for Enhanced FFP	13
b.	Claiming for Administration of Family Planning Services	16
10.	Provider Participation in the Medicaid Program	16
11.	Individualized Education Program (IEP) Activities	18
12.	Review and Approval of Programs and Codes by HCFA	20
C.	Activity Codes: Descriptions and Examples	21
1.	Introduction	21

CODE 1.a.	NON-MEDICAID OUTREACH	23
CODE 1.b.	MEDICAID OUTREACH	23
CODE 2.a.	FACILITATING APPLICATION FOR NON-MEDICAID PROGRAMS	24
CODE 2.b.	FACILITATING MEDICAID ELIGIBILITY DETERMINATION	25
CODE 3.	SCHOOL RELATED AND EDUCATIONAL ACTIVITIES	26
CODE 4.	DIRECT MEDICAL SERVICES	27
CODE 5.a.	TRANSPORTATION FOR NON-MEDICAID SERVICES	28
CODE 5.b.	TRANSPORTATION-RELATED ACTIVITIES IN SUPPORT OF MEDICAID COVERED SERVICES	28
CODE 6.a.	NON-MEDICAID TRANSLATION	29
CODE 6.b.	TRANSLATION RELATED TO MEDICAID SERVICES	29
CODE 7.a.	PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO NON- MEDICAL SERVICES	30
CODE 7.b.	PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO MEDICAL SERVICES	31
CODE 8.a.	NON-MEDICAID TRAINING	32
CODE 8.b.	MEDICAID SPECIFIC TRAINING	32
CODE 9.a.	REFERRAL, COORDINATION, AND MONITORING OF NON-MEDICAID SERVICES	33
CODE 9.b.	REFERRAL, COORDINATION, AND MONITORING OF MEDICAID SERVICES	34
CODE 10.	GENERAL ADMINISTRATION	35
V.	CLAIMING ISSUES	36
A.	Documentation	36
B.	Sampling/Time Studies	37
1.	Sample Universe	38
2.	Sampling Plan Methodology	38
3.	Time Study Documentation	39
4.	Training for Staffing Time Study	39
5.	Monitoring Process	40
C.	Offset of Revenues	40
D.	Cost Allocation	40
E.	Administrative Claiming Implementation Plan	41
F.	Timely Filing Requirements	43
G.	State Law Requirements	44

H.	Contingency Fees	44
I.	Provider Agreements	44
J.	Third Party Liability (TPL)/Medicaid as payor of last resort/Free Care ..	45
K.	Transportation as Administration	46

DRAFT FEBRUARY 2000 DRAFT

MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING GUIDE

I. INTRODUCTION

The purpose of this Medicaid School-Based Administrative Claiming Guide (referred to hereafter as the Guide) is to provide information for schools, State Medicaid Agencies, the Health Care Financing Administration (HCFA) staff, and other interested parties on the existing requirements for claiming Federal funds under the Medicaid program for the costs of administrative activities, such as Medicaid outreach, that are performed in the school setting. This guide is not intended to supersede guidance on requirements for the provision in the school setting of medical assistance; that is, medical services, such as may be provided in school-based health clinics (SBHCs). Furthermore, this guide does not supersede any statutory or regulatory requirements, and is subject to any subsequent policy issuance or clarifications. For purposes of the Guide, a “school-based health services program” refers to any type of Medicaid-covered health service provided in a school-based setting.

As noted throughout this Guide, Federal Medicaid requirements provide only a framework for State Medicaid Programs. Since each State establishes and administers its Medicaid program within this framework, Medicaid programs vary considerably from State to State, and within each State over time. States have considerable flexibility to:

- 1) establish eligibility standards;
- 2) determine the provider of and the type, amount, duration, and scope of services;
- 3) set the rate of payment for services; and
- 4) administer its own program, including development of administrative requirements to verify claims.

The school setting offers unique advantages and opportunities to reach children and families to inform and encourage them to enroll in the Medicaid program as well as to provide assistance to students in accessing medical services. The Health Care Financing Administration (HCFA) recognizes that certain members of a school staff may spend a significant amount of time on such activities for its students. When administrative activities are “found necessary by the Secretary for the proper and efficient administration of the State plan” and the students are Medicaid-eligible or potentially eligible for Medicaid (if the activity is Medicaid eligibility outreach), Federal Financial Participation (FFP) may be available. While Federal Medicaid requirements are administered by HCFA, to determine specific State Medicaid program requirements, schools should contact their State Medicaid Agency.

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. The Guide is not intended to provide new policy; rather, it is intended to consolidate and clarify existing policy. 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.

HCFA envisions this Guide will be useful for schools or school districts, State Medicaid Agencies, and HCFA staff in the process of development, review, approval, and implementation of programs involving school-based services. Since HCFA is responsible for assessing these programs in accordance with the Federal Medicaid requirements, States' programs for Medicaid administrative claiming for school-based activities will be formally reviewed and approved by HCFA prior to implementation. States may realize after reading this Guide that some of what they are or have been claiming as administrative costs is unallowable, and in those cases HCFA will work with the State(s) to develop acceptable administrative claiming procedures.

II. BASIS/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.

A. 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)
- Regulatory citations related to documentation:

<u>42 CFR</u>	<u>Description</u>
---------------	--------------------

430.1	Scope of subchapter C - Proper and efficient administration
431.1(d)	Agreement with Federal or State agencies
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
432.50	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
<u>45 CFR</u>	
Part 95	Subpart A - Time Limits for States to File Claims
Part 95	Subpart E - Cost Allocation Plans

B. 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).

III. INTERAGENCY AGREEMENTS

A. General

In order to claim Federal matching for the costs of Medicaid administrative activities performed in schools, the State Medicaid Agency must have an interagency agreement with the State Department of Education or separate agreements with participating school districts in accordance with regulations at CFR 431.10(d). Such interagency agreements serve to describe and define the relationship between the State Medicaid Agency, the entities for which claims will be made, and the responsibilities of each party to the agreements. While the State Medicaid Agency is the only

entity that may submit claims to HCFA for reimbursement, every entity that is generating administrative claims needs to be covered by an interagency agreement.

The requirement that every entity submitting claims must be covered under an interagency agreement does not necessarily require their parent agency to be party to the agreement. For example, schools and/or school districts which will be submitting claims directly to the State Medicaid Agency would need to enter into an interagency agreement with the State Medicaid Agency. However, the State Department of Education may not need to be party to the agreement, if they have no involvement or responsibilities related to the claims or activities. An individual school may not need to be party to the interagency agreement if its employees are all part of the school district or county, and such school district/county itself is party to the agreement directly with the State Medicaid Agency. These interagency agreements should list the allowable administrative activities for which school districts will be reimbursed and specify that all claims will be in accordance with OMB Circular A-87, the State Medicaid Plan and all Federally approved public assistance cost allocation plans. The administrative activities must be directly related to the administration of the State's Title XIX Plans for FFP to be available.

B. Requirements

Any local education agency (LEA) or school that receives payments for administrative activities under Medicaid may be acting as an agent or contractor for the State Medicaid Agency. To claim Federal funding for allowable administrative activities, there must be a formal intergovernmental/interagency agreement between the LEAs or schools and the State Medicaid Agency. While prior approval by HCFA of the interagency agreement is not required, HCFA is required to and will review claims pursuant to that agreement to determine their allowability for Federal matching funds. Therefore, HCFA strongly encourages that States consult with HCFA as early as possible in the development of their school-based administrative claiming programs and the associated interagency agreements, and prior to the submission of claims for Federal matching to HCFA, to ensure that claims are in accordance with Federal requirement and can be paid without delay.

The interagency agreements must include:

- the mutual objectives and responsibilities of all parties to the agreement;
- the activities or services each party offers and under what circumstances;
- the specific activity codes (by reference or inclusion) approved by HCFA for administrative costs that will be claimed;
- the specific description and methodology (by reference or inclusion) approved by HCFA for building the claim for administrative costs;

- the cooperative and collaborative relationships at the State and local levels; and
- the methods for payment or reimbursement, exchange of reports and documentation, and continuous liaison between the parties, including designation of State and local liaison staff.

IV. CONSTRUCTING TIME ACTIVITY CODES

A. General

School or school district employees may engage in activities which involve furnishing direct services and/or the performance of other administrative activities required and covered by education programs, other social programs, and the Medicaid program. Some or all of the costs of these services and administrative activities may be claimed under these programs; however, an appropriate claiming mechanism must be used. The primary mechanism for identifying and categorizing activities performed by the school or school district employees, and for developing claims for the costs of these administrative activities that may be properly reimbursed under these programs, is the time study. Because employees work on multiple activities and cost objectives, OMB Circular A-87 permits the use of “substitute systems” for allocating salaries and wages to Medicaid in place of an activity report. Any substitute mechanism must be approved by HCFA.

It is essential to develop the elements of the time study, including activity codes, with recognition and consideration of the actual functions and responsibilities being performed by the school or school district employees, the requirements of the programs, and in accordance with principles that appropriately distinguish between and account for all these factors. Section IV, subsection B of the Guide discusses the principles for developing the elements of the time study mechanism, the activity codes. Subsection C provides standard activity codes developed in accordance with these principles. These codes may be used by States, school districts, and schools as the basis for time studies which would be used to allocate administrative costs for purposes of making claims under the Medicaid program.

B. Operational Principles

1. Proper and Efficient Administration

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). Additionally, OMB Circular A-87, which contains the cost principles for State, Local and Indian Tribal Governments for the administration of Federal awards, provides that “Governmental units are responsible for the efficient and effective administration of Federal awards.” Therefore, this principle is applicable

for other Federal government programs in addition to the Medicaid program. Under these provisions, costs must be reasonable and necessary for the operation of the governmental unit for the performance of the Federal award.

The principle of proper and efficient administration must be applied in developing time study activity codes. For example, outreach activities would be considered to be in support of the Medicaid program if they were in regard to explaining Medicaid requirements. By contrast, outreach with respect to explaining the requirements of education program requirements would not be in support of the Medicaid program and must be separately accounted for.

2. Claiming for Allowable Activities Only

Medicaid does not pay for administrative expenditures related to, or in support of, services that are not included in the State Medicaid plan or services which are not reimbursed under Medicaid. For example, where school employees assist a Medicaid-eligible child to obtain medical services that are included in the child's Individualized Education Plan (IEP), if the provider furnishing such services is not participating in the State's Medicaid program or is not part of a managed care organization (MCO) participating in the State's Medicaid program, FFP would not be available for the services; furthermore, FFP would not be available for the administrative activities to assist the child in accessing such services. These activities would be not be claimable because they would not be considered in support of the operation of the Medicaid State plan (even if the services are included in the State's Medicaid program).

In addition, Medicaid does not pay for health care services that are rendered free of charge to the general population. Consequently, any administrative activity which supports the referral, coordination, planning of screens or services that are provided free to the general population would not be considered as Medicaid administration. This type of activity is subject to the free care principle, discussed in Section V.J.

Note, as required by Medicaid statute, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services must be offered to a child whether or not a State has included such services in its State Medicaid plan. Administrative expenditures related to, or in support of, EPSDT are reimbursable under Medicaid, so long as the providers who furnish such services participate in the Medicaid program.

3. Capture 100 Percent of Time

In order to ascertain the portion of time and activities that are related to administering the Medicaid program, States must develop an allocation methodology that is approved by DHHS. The approved allocation methodology, which may use random moment sampling (RMS), contemporaneous time sheets, or other quantifiable measures of employee effort, is often referred to as a time study. The time study must incorporate a comprehensive, all-inclusive list of the activities performed by staff whose costs are to be claimed under Medicaid. That is, the time

study must reflect **all** of the time and activities (whether allowable or unallowable) performed by employees participating in the Medicaid administrative claiming program.

In order to ensure that the time study reflects all of the activities performed by the time study participants, HCFA, the State, and the school districts must work together to establish the master list of activities by program. HCFA and the State would then determine which of the activities in each program are allowable Medicaid administrative activities.

HCFA and States determine allowable Medicaid administrative activities in accordance with the following guidelines found in OMB Circular A-87 Attachment B, section 11.h.(5):

Personnel activity reports or equivalent documentation must meet the following standards:

- (a) They must reflect an after-the-fact distribution [i.e., distribution following completion of the activity] of the actual activity of each employee,
- (b) They must account for the total activity for which each employee is compensated,
- (c) They must be prepared at least monthly and must coincide with one or more pay periods, and
- (d) They must be signed by the employee as being a true statement of activities and the employee/office will retain documentation to support the report.

Note, the requirement to document costs monthly does not mean that time studies must be conducted monthly. ASMB C-10 provides guidance on the circumstances dictating the frequency of time and effort reporting.

If a portion of a sampled employee's time is also billed as medical services, then the administrative time study results should be validated by comparing the time coded to direct medical services (Code 4) to the actual amount of hours billed directly. The results should be within a reasonable tolerance or else the time study may result in an effective double payment.

In order to ensure that all of the time study participants are reflected in the time study, the staff classifications and associated supporting documentation (such as position descriptions) for time study participants should also be reviewed and considered in developing the time study activity codes. This will also ensure that the unique responsibilities and functions performed by the participants, as well as the special factors and programs applicable to the participating schools or school districts are accounted for and included in the time study codes. As these codes are formulated, they should be compared against the staff classifications and supporting position descriptions to ensure that all functions being performed are identified and incorporated into the codes.

4. Parallel Coding Structure: Medicaid and Non-Medicaid Codes for Each Activity

The time study activity codes must be developed to capture all of the activities performed by the time study participants, as indicated by Principle 3., as well as carefully balance and present similar activities in relation to the programs for which they are performed. This is accomplished by developing parallel time study activity codes which reflect the particular activity functions and which clearly distinguish between, and incorporate, the requirements of the various programs as relates to the function. Parallel coding is a method for identifying and categorizing activities which are generally similar, but are also different with respect to specific elements. Developing parallel activity codes for the different programs ensures that all activities are accounted for, and clarifies reporting with respect to similar activities. As noted in Section V.B.4., all staff in the sample universe should be trained on proper coding procedures, including reporting activities under the parallel codes, before sampling begins.

There may be overlap between activities attributable to different programs, and the time study methodology should determine which code is appropriate for reporting purposes. For example, school employees may perform an outreach function for both the education (IDEA) program and the Medicaid program. By establishing two (or even more) activity codes for outreach, time study participants will be able to clearly distinguish and identify the appropriate codes under which to report. Code 1.a. (for non-Medicaid outreach) and Code 1.b. (for Medicaid outreach), discussed in subsection C. below illustrate two parallel activity codes.

5. Duplicate Payments

Duplicate payments are **not** allowable when determining allowable administrative costs under Medicaid. Payments for allowable administrative activities must not duplicate payments that have been or should have been included and paid as part of a rate for services, part of a capitation rate, or through some other local, State or Federal program. Medicaid administrative costs may not be claimed for activities that are integral parts or extensions of services. Furthermore, in no case should a program or claiming unit in a local jurisdiction be reimbursed more than the actual cost of that program or claiming unit, including State, local, and Federal funds. The State must provide assurances to HCFA of non-duplication through their administrative claims and the claiming process to HCFA. The State may dispute HCFA's position on what is a duplicate payment through appeal of any disallowance to the Departmental Appeals Board (DAB).

The Medicaid program should not pay for an activity already paid for or otherwise reimbursable under another mechanism, for example:

- An activity that has been, or will be, paid for as a medical assistance service (or as a service of another (non-Medicaid) program) should not be paid again as a Medicaid administrative cost.

- An activity that has been, or will be, paid for as a Medicaid administrative cost should not be paid again as Medicaid administration.
- An activity that is included as part of a managed care rate and is reimbursed by the managed care organization should not be reimbursed again through a claim for Medicaid administration, or through a fee-for-service reimbursement rate.

As appropriate, the mechanism under which managed care rates are set and adjusted should address the activities and services being furnished in the school setting.

6. Coordination of Activities

In addition to avoiding duplicate payments, as indicated in Principle 5., duplication of activities or effort should also be avoided. Under Principle 1., allowable administrative activities must be necessary “for the proper and efficient administration of the [Medicaid] State plan” (emphasis supplied), as well as for the operation of all governmental programs. Therefore, it is important in the design of school-based administrative claiming programs that the local education agency (LEA) or school not perform activities that are already being offered or should be provided by other entities, or through other programs. As appropriate, this requires the close coordination between the LEAs, schools, State Medicaid Agency, State Department of Education, providers, community and non-profit organizations, and other entities related to the activities performed.

The following are examples of activities that should be coordinated:

- Activities performed by a managed care organization (MCO) for the Medicaid or other program enrollees of the MCO, such as case management functions. To avoid duplication of these functions by school personnel, coordination mechanisms should be established between the school and appropriate entities, such as the MCO and State Medicaid Agency.
- Reimbursement rate setting mechanism. As appropriate, the rate setting mechanism under which the rates for functions which are performed by schools, but reimbursed by other entities, may need to reflect such functions. For example, the capitation rate paid to an MCO may include amounts for the performance of functions performed by schools; that is, such functions are the responsibility of the MCO. However, after coordination efforts, such functions may still need to be performed by the schools. In such cases, the MCO reimbursement rates may need to be adjusted to reflect the activities and services being furnished in the school setting.
- An activity that is provided/conducted by another governmental component. For example, it is not necessary for EPSDT educational materials, such as pamphlets and flyers that have already been developed by the State Medicaid Agency, to be

redeveloped by schools. It would be inefficient in the allocation of Medicaid program and school resources to do so. In order to avoid this, school districts/schools should coordinate and consult with the Medicaid State agency to determine the appropriate activities related to EPSDT and to determine the availability of existing materials.

7. Performing Direct Services v. Administrative Activities

Activities performed in the school setting can include the provision of program services, administrative activities, or both. The related programs for which these activities are performed may include education, social, medical (Medicaid), or other programs. Typically there are different funding sources and mechanisms related to each program or type of activity. As a result of these factors, in constructing the time study activity codes under which participating staff will report, it is essential to distinguish between activities that represent the provision of services or administrative functions, and the program for which they are performed. It is also necessary to identify activities that support a service that is a routine action customarily included as part of the payment for a service, such as filling out a billing claim form. The time study methodology should identify the costs of direct medical and other services and ensure that those costs are not included in the claims for administrative activities.

For example, the school or school district may be a participating Medicaid provider. Covered Medicaid services provided by school employees for Medicaid eligible children will be reimbursed through the mechanism for billing services. The time study must identify direct services and ensure that these services are not included in administrative claims. Additionally, certain school employees may be performing Medicaid related outreach activities. Finally, school employees may also be performing educational services or outreach for education programs. The time study codes must distinguish between each of these activities. Therefore, as indicated in subsection C., Medicaid program outreach would be reported under Code 1.b., the education program outreach under Code 1.a., the Medicaid services under Code 4., and the educational services under Code 3.

As indicated in Principle 5., payments for allowable Medicaid administrative activities must not duplicate payments that have been, or should have been, included as part of a **direct** medical service, capitation rate, or through some other State or Federal program (as specified in OMB Circular A-87). It is the State's responsibility to ensure there is no duplication in a claim prior to the claim's submission to HCFA.

Activities that are considered integral to, or an extension of, the specified covered service are included in the rate set for the direct service. These activities are properly paid for as part of the medical service and reimbursed at the Federal Medical Assistance Percentage (FMAP), and may not be claimed as an additional cost through administrative case management defined below.

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 at the same time.

The State Medicaid Manual (SMM) Section 4302 identifies certain activities which may be properly claimed as **administrative** case management. An allowable administrative cost must be directly related to a Medicaid State plan or waiver service, and be necessary for the “proper and efficient administration of the State plan.”

Some examples of administrative case management services addressed at SMM Section 4302.2 (G)(2), are:

- Medicaid eligibility determinations and redeterminations;
- Medicaid intake processing;
- Medicaid preadmission screening for inpatient care;
- Prior authorization for Medicaid services;
- Utilization review;
- Medicaid outreach.

As indicated in the SMM, HCFA may make determinations regarding other activities as to whether or not they are necessary for the administration of the State plan. More specific examples of these types of activities performed in a school-based setting may be found in the time study activity codes included in this Guide.

Skilled professional medical personnel (SPMP) can perform activities that are either administrative in nature, or which represent the provision of direct medical services (although SPMP cannot provide direct medical services when using the SPMP designation). Therefore, the activity codes should clearly distinguish between SPMP activities that would be reported as an administrative activity and those that, for example, are ancillary to a direct medical service and should be reported as part of the direct service (which would be reimbursed under the services reimbursement rate).

8. Allocable Share of Costs

Since many school-based medical activities are provided to both Medicaid and non-Medicaid eligible students, the costs applicable to these activities must be allocated to both groups. This allocation of costs is sometimes referred to as “discounting” and involves the determination and application of a proportional share of Medicaid students to the total students and the total costs applicable to a specific activity in a particular school or school district. Development of the proportional Medicaid share (also referred to as the Medicaid percentage) should relate to and be based on the claiming unit (the entity submitting the claim). For example, claims may be developed on an individual school basis, a school district wide basis, or a specific unit of

government such as a county.

Through the use of time studies which contain specific activity codes, the cost of school personnel is distributed to certain activities (time study codes) to determine the administrative cost allocable to the Medicaid program. Each code used in the time study must capture the following categories of costs:

- (1) **Unallowable** - the activity is unallowable as administration under the Medicaid program,
- (2) **100% Medicaid Share** - the activity is solely attributable to the Medicaid program and as such is not subject to the application of the Medicaid share percentage (this is sometimes referred to as “not discounted”),
- (3) **Proportional Medicaid Share** - the activity is allowable as administration under the Medicaid program, but the allocable share of costs must be determined by the application of the percentage of the Medicaid eligible population for each school or school district included in the time study, or
- (4) **Reallocated Activities** - those activities which are reallocated across other codes based on the percentage of time spent on allowable/unallowable administrative activities.

OMB Circular A-87 states “a cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective **in accordance with relative benefits received**” (emphasis added). To arrive at the Medicaid share percentage, the number of Medicaid eligible students must be determined for each school/school district or governmental unit that is submitting a claim. This number is the numerator in a fraction with the denominator being the total number of students in the same entity. This fractional value is then applied to the total costs applicable to the proportional Medicaid share time codes to determine the costs applicable to Medicaid administrative activities. Note that the number of Medicaid eligibles and the total number of students must be identified for the same time period. For example, total enrollment at the opening of school, compared with Medicaid enrollment in November, may not be used.

$$\text{Medicaid Costs} = \frac{\text{Total Number of Medicaid Students}}{\text{Total Number of Students}} \times \text{Costs to be allocated}$$

The number of Medicaid eligible students must be either obtained from or verified with the State Medicaid Agency. This may be done through a matching of school/school district enrollment data to Medicaid eligibility files.

In the following example, administrative claims are developed on a school district basis. The

purpose of applying a proportional Medicaid share is to determine the amount to be allocated between Medicaid and non-Medicaid students. The following example establishes how much of the costs related to the activity should be allocated to Medicaid. The amount of Federal reimbursement is then determined based on the resulting amount.

EXAMPLE OF MEDICAID SHARE

Gross Claimable Amount = \$1,500

Number of Medicaid Students in District = 1,000

Number of Total Students in District = 5,000

Activity = referral, coordination, and monitoring of Medicaid Services (Proportional Medicaid /50 Percent Federal Financial Participation)

Medicaid Share Factor: Number of Medicaid Students/Total Students = 1,000/5,000 = 20 percent

Gross Claimable Amount	\$1,500
Medicaid Share Rate <u> X </u> .20	
	\$300
FFP Rate <u> </u> .50	
Net Claimable Amount	\$150

9. Enhanced FFP Rates

a. Skilled Professional Medical Personnel (SPMP) School Administrative Claiming

i. Basis

The following provides the basic statutory and regulatory authorities and guidelines related to SPMPs:

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)

ii. SPMP Criteria for Enhanced FFP

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 individuals in the administration of the Medicaid program if each of the following criteria are met:

- (I). The expenditures are for the costs of activities that are directly related to the administration of the Medicaid program, and as such, do not include expenditures for the direct provision of a medical service.
- (II). The SPMP has professional education and training in the field of medical care or appropriate medical practice.
- (III). The SPMPs have duties and responsibilities that require those professional medical knowledge and skills.
- (IV). A State documented employer-employee relationship exists between the State Medicaid Agency and the SPMP and staff directly supporting the SPMP.
- (V). The directly supporting staff are secretarial, stenographic, 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 SPMP staff. The SPMP must directly supervise the supporting staff and be responsible for the performance of the supporting staff's work.
- (VI). The enhanced FFP rate of 75 percent is available for SPMP and directly supporting staff *of other public agencies* if all of the applicable criteria i. through v. are met, and the public agency has a written agreement with the State Medicaid Agency verifying that those requirements are met.
- (VII). The costs of activities performed by SPMP and those of directly supporting staff which benefit more than one program must be allocated in accordance with the principles contained in the OMB Circular A-87. FFP under the Medicaid program is available only for the SPMP and related costs which are allocable to the Medicaid program.

Federal regulations contain specific mandates for SPMPs, including the requirement 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 (be more stringent than) from the qualification requirements for participating as a Medicaid provider.

Similarly, State provider qualification standards for a particular service provided in the school setting (such as rehabilitation services described in Federal Medicaid regulations at 42 CFR 440.130(d)) may be less stringent than the provider qualification standards for the same service provided in the community setting. Therefore, individuals who qualify to provide certain services in the school might not qualify as an SPMP, or might not qualify to provide the same services in the community. Similarly, school health aides, counselors, and other staff in the schools may be allowed to provide medical services in the school setting but might not qualify as an SPMP, or might not qualify to provide such services in the community.

There are two basic criteria applied to determine whether school staff qualify as SPMPs:

- State Standards. First, it is necessary to determine the State's standards for provider qualifications, especially where the State Department of Education (DOE) certification may be accepted as well as State Licensure.
- Professional Education and Training. The next step is to determine whether an individual meets the SPMP criteria for "professional education and training." This can be demonstrated by determining whether the provider has a medical license, certificate, or other document issued by a national or State medical licensure organization, or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. The Medicaid State Agency may have copies of a provider's credentials since it issues provider numbers. If not, credentials may have to be reviewed onsite.

Even if the individual meets the SPMP qualifications, only those administrative activities which require the use of medical expertise are matchable at the enhanced rate of 75 percent. In a school setting, an example of an administrative activity which potentially could be matched at the higher rate is assessing the necessity for and adequacy of medical care and services required by an individual child. If the administrative activity does not require medical expertise to complete, such as making an appointment for the child with another provider, the activity is not matchable at the enhanced SPMP rate. Activities which are an inherent part of a medical service furnished (for example, the development of a treatment plan), or the actual Medicaid covered service provided by the SPMP, would potentially be claimed as a medical service and, accordingly, be matched at the FMAP specific to each State. Activities which are actually parts of medical services are claimable as services, not as Medicaid administration.

Claims for SPMP activities must be supported by documentation which demonstrates that:

- (1) the claims activities were performed by individuals with the appropriate qualifications, and
- (2) the activities performed required medical training and expertise of the SPMP.

There must be appropriate documentation to support all claims for enhanced FFP. Routinely maintained supporting records -- day logs, case notes, case records, etc. -- are needed to support the claim. The record should contain such basic information as:

- the activity that was completed,
- the provider of the activity,
- the date of the activity,
- the amount of time, and
- the purpose of the activity.

These supporting records must be available when claims are audited. If the records available do not support the payment of the enhanced rate, the claim will be reduced to regular FFP. Checking a box on a time study form is insufficient to support a SPMP claim for it does not allow for verification.

Allowable administrative activity codes are discussed in Section IV.C. below. For the most part these codes indicate that these activities can only be claimed at the regular FFP rate of 50 percent; most administrative activities do not require the skills of an SPMP.

Any State wishing to claim an activity at 75 percent SPMP rate must submit appropriate documentation for HCFA approval in accordance with regulations at CFR 432.50.

b. Claiming for Administration of Family Planning Services

The enhanced family planning matching rate of 90 percent is available only for the “offering, arranging and furnishing” of family planning services (Section 1903 (a)(5), emphasis added). This enhanced rate is available to personnel who administer as well as directly provide certain family planning services and supplies (42 CFR 432.50(b)(5) as referenced by 42 CFR 433.15(b)(2)). This type of administrative activity would be reported under Code 9.b., “Referral, Coordination, and Monitoring of Medicaid Services.” Payment for some or all of the costs of family planning services may also be available under Medicaid as a direct service. These costs are not allowable as administrative expenditures and would be reported under time study Code 4., “Direct Medical Services.”

10. Provider Participation in the Medicaid Program

With respect to certain administrative activities that support medical services, Federal matching is available only if the medical services are covered and reimbursable under the State’s Medicaid plan. That is, in order for FFP under the Medicaid program to be available for the costs of administrative activities which are performed by school staff and which are related to the delivery of medical services (e.g., referral and coordination of medical services), those medical services must be ultimately reimbursable under the plan. In order for the medical services to be reimbursable under the Medicaid State plan the following requirements must be met:

- The medical services must be furnished to a Medicaid eligible individual.
- The medical services must be included in the State's Medicaid State plan or available and required through the EPSDT program.
- The provider must furnish services as a participating provider in the Medicaid program, with a provider agreement and a Medicaid provider identification number, or must furnish such services as a provider for Medicaid enrollees of a Medicaid MCO.

Therefore, the medical services covered under the State's Medicaid plan must be reimbursable under the plan and also must be performed by a Medicaid provider who bills for the covered services. Costs of administrative activities related to medical services performed in the school or community setting and included in the State's Medicaid plan are not available for FFP unless the provider of services is a Medicaid provider who will bill for Medicaid covered services, or is part of an MCO participating in the State's Medicaid program. If the provider is not participating in the Medicaid program (through a provider agreement or as a network provider in a Medicaid MCO), then the services cannot be reimbursed, and the administrative expenditures would not be considered performed in the proper and efficient administration of the Medicaid program.

Examples of this principle are:

Example 1. A school is a Medicaid participating provider and provides and bills for medical services listed in Medicaid eligible children's IEPs and which are covered under the State's Medicaid State plan. Expenditures for school administrative activities related to school children's services billed to Medicaid by community providers are allowable. The activities would be reported under Code 9.b. below, "Referral, Coordination and Monitoring of Medicaid Services."

Example 2. A school is not a Medicaid participating provider and consequently, even though it provides medical services, it does not bill for any direct medical services, including those listed in children's IEPs. In this example, the costs of the administrative activities performed with respect to the medical services would not be allowable under the Medicaid program, and such activities would be reported under Code 9.a. below, "Referral, Coordination and Monitoring of Non-Medicaid Services."

Example 3. Regardless of whether the school is a Medicaid participating provider, the school program refers Medicaid eligible children to Medicaid participating providers in the community. If the school performs administrative activities related to the services which are billed to Medicaid by community providers, the costs of such activities may be allowable under the Medicaid program, and such administrative activities would be reported under Code 9.b. below, "Referral, Coordination and Monitoring of Medicaid Services."

Example 4. Irrespective of whether a school participates in the Medicaid program or not, school children's services referred to community providers that do not participate in Medicaid are not billed to Medicaid. In this case, the costs of administrative activities related to medical services would not be allowable under Medicaid. These activities would be reported under Code 9.a. below, "Referral, Coordination and Monitoring of Non-Medicaid Services."

Care must be taken in the definition of both the medical services provided and administrative activities performed to ensure that no claim is made for administrative functions performed by a school which are related to services rendered by a provider not participating in Medicaid.

11. Individualized Education Program (IEP) Activities

Under Part B of the Individuals with Disabilities Education Act (IDEA), States may receive grants from the Federal Department of Education (DOE) for the purpose of assisting them in providing special education and related services to children with disabilities. IDEA provisions require school staff to perform a number of education related activities which can generally be characterized as child find, evaluation (initial) and reevaluation, and development of an Individualized Education Program (IEP). For purposes of the Medicaid program, these IDEA/IEP related activities are considered to be education program related activities; that is, in determining whether the costs of such activities are allowable under the Medicaid program, in general, they would not be considered necessary for the proper and efficient administration of the Medicaid State plan. In developing and reporting under time study activity codes, these education related activities must be clearly identified and distinguished; in general, they could be reported under time study Codes 1.a., 2.a., and 3.

However, as noted in the 1997 technical assistance guide, if medical evaluations or assessments are conducted to determine a child's health-related needs for purposes of the IEP development, payment for some or all of the costs may be available under Medicaid as a direct service. These costs are not allowable as administrative expenditures and would be reported under time study Code 4. And if the evaluations or assessments are for educational purposes, Medicaid reimbursement is not available.

Various education-related statutes obligate schools to furnish or make payment for services provided in the school setting for which Medicaid payment is not available. While there are exceptions set forth in section 1903(c) of the Social Security Act. With respect to Parts B and C of IDEA, no other education-related statutes obligate Medicaid payment. For example, Section 504 of the Rehabilitation Act of 1973 requires local school districts to provide or pay for certain services to make education accessible to handicapped children; these services are described in an Individualized Service Plan (ISP). The 1903(c) exception does not include ISP services, and therefore, to the extent a local school district is obligated to furnish or make payment for such services, no Medicaid payment is available.

The IEP/IDEA related activities conducted by school staff, are briefly described below:

- “Child Find.” All children with disabilities residing in the State who are in need of special education and related services must be identified, located, and evaluated.
- “Initial Evaluation/Reevaluation.” Before special education and related services are provided, an initial evaluation must be conducted by the State educational agency, another State agency or LEA in order to determine whether a child has a disability, and their special/specific educational needs. A re-evaluation would be a determination as to whether the child continues to be disabled, and for the continuing educational needs of the child. Reevaluations must be done at least once every 3 years.
- “Individualized Education Program (IEP).” For children identified and determined to be disabled in accordance with IDEA requirements, an IEP must be developed by an IEP team. The IEP team can include the parents of the disabled child, the regular education teacher, a special education teacher, a representative of the LEA, an individual who can interpret instructional implications of evaluation results, other individuals with special knowledge or expertise, and whenever possible the child.

The IEP is a written statement for each child with a disability that includes:

- a statement of the child’s present levels of educational performance
- a statement of measurable annual goals, including benchmarks or short term objectives
- a statement of the special education and related services and supplementary aids and services to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided for the child
- an explanation of the extent, if any, to which the child will not participate with nondisabled children in the regular class and in the activities described above
- the projected date for the beginning of services and modifications and the anticipated frequency, location, and duration of services and modifications
- for children age 14 and above, a statement of transition service needs
- a statement of the child’s progress toward annual goals and how the child’s parents will be informed of the progress toward the annual goals

The related activities listed above are for the purpose of fulfilling education related mandates under

education statutes (e.g., IDEA); as such, the associated costs of these activities are not allowable as administrative costs under the Medicaid program.

12. Review and Approval of Programs and Codes by HCFA

Although prior approval by HCFA of the administrative claiming programs and codes is not explicitly required in Medicaid statute and regulations, there is implicit authority for HCFA to do so. Specifically, HCFA is required to and will review claims made by State Medicaid Agencies, particularly in situations of the establishment of a new program such as a school-based administrative claiming program, in order to determine the allowability of such claims for Federal matching funds. Furthermore, as discussed below and in section V.D. on Cost Allocation, the Division of Cost Allocation in DHHS (in coordination and consultation with HCFA) is required to approve public assistance cost allocation plans that must incorporate, by reference, the time study and cost allocation methodology adopted by the State Medicaid Agency for schools to develop and document claims submitted to the States. States are required to submit amendments to cost allocation plans and have them approved before they begin operating under them. Therefore, States should consult with HCFA as early as possible in the development of their school-based administrative claiming programs in order to have such programs and the associated time study codes reviewed and approved by HCFA prior to submission for Federal matching to HCFA and prior to submitting their CAP amendments to DCA. This will help ensure that such amendments are approved on a timely basis and that subsequent claims are in accordance with Federal requirements.

Federal regulations (42 CFR 433.34) require that under the Medicaid State plan, the single State agency have an approved public assistance cost allocation plan on file with the Federal Department of Health and Human Services (DHHS) that meets certain regulatory requirements (Subpart E of 45 CFR part 95). As indicated in OMB Circular A-87, Attachment D, a State's public assistance cost allocation plan (CAP) is an official document which describes the grouping and allocation of administrative costs to Federal awards performed by the State under such programs as TANF, Medicaid, Food Stamps, Child Support Enforcement, adoption assistance, and Foster Care and Social Service Block Grant.

Furthermore, there are certain items that must be in the public assistance CAP which a State Medicaid Agency must submit **before** providing reimbursement to school districts for administrative claiming, if it chooses to use schools to provide such services. The public assistance CAP must make explicit reference to the methodologies, claiming mechanisms, interagency agreements, and other relevant issues that will be used by the LEAs, school districts, and schools for making such claims and appropriately allocating costs. Depending on the nature of the referenced time study and costing methodology, they may have to be amended to comply with documentation requirements. States should consult with the HCFA Regional Office in the development of time study and allocation methodologies used for their school-based administrative claiming programs.

The required elements of public assistance CAPs are further discussed in the Cost Allocation section of the Guide (Section V.D.), as is the review and approval process for such plans.

C. Activity Codes: Descriptions and Examples

1. Introduction

When staff perform duties related to the proper administration of the State's Medicaid program, Federal funds may be drawn as reimbursement for the costs of providing these administrative services. To identify the cost of providing these services, a time study of staff, or an acceptable substitute system, must be conducted. The time study identifies the time and subsequent costs spent on Medicaid administrative activities that are allowable and reimbursable under the Medicaid program. The following is a suggested coding scheme. It may not reflect all the activities undertaken by an LEA.

Staff Activity and Codes - the indicators below, which follow each Code, provide the application of the Federal Financial Participation (FFP) rate, the allowability or non-allowability designation, and the proportional Medicaid share status of the Code. In order to maintain coding objectivity by time study participants, time study sheets used by employees should not include references to rates of FFP, proportional or total Medicaid, or whether such codes are allowable, or unallowable under Medicaid. This listing of activity codes should be modified when activities listed as allowable duplicate activities are considered a part of a service per the State's Medicaid plan. See Section IV.B.7. on duplicate payments.

Application of FFP rate

- | | |
|------------|--|
| 50 percent | Refers to an activity which is allowable as administration under the Medicaid program and claimable at the 50 percent non-enhanced FFP rate. |
| 75 percent | Refers to an activity meeting the requirements of 42 CFR 432.50 for Skilled Professional Medical Personnel (SPMP) and their directly supporting staff which is allowable as administration under Medicaid and claimable at the 75 percent enhanced FFP rate. |

Unallowable Activities

- | | |
|---|---|
| U | Refers to an activity which is unallowable as administration under the Medicaid program. This is regardless of whether or not the population served includes Medicaid eligible individuals. |
|---|---|

Application of Medicaid Share

TM (Total Medicaid) Refers to an activity which is 100 percent allowable as administration under the Medicaid program.

PM (Proportional Medicaid) Refers to an activity which is allowable as administration under the Medicaid program, but for which the allocable share of costs must be determined by the application of the proportional Medicaid share (the Medicaid percentage). The Medicaid share is determined as the ratio of Medicaid eligible students to total students.

Reallocated Activities

R Refers to those general administrative activities performed by time study participants which must be reallocated across the other activity codes on a pro rata basis. These reallocated activities are reported under Code 10, General Administration. Note that certain functions, such as payroll, maintaining inventories, developing budgets, executive direction, etc., are considered overhead and, therefore, are only allowable through the application of an approved indirect cost rate.

Staff should document time spent on each of the following coded activities:

- CODE 1.a. Non-Medicaid Outreach - U
- CODE 1.b. Medicaid Outreach - TM/50 Percent FFP
- CODE 2.a. Facilitating Application for Non-Medicaid Programs - U
- CODE 2.b. Facilitating Medicaid Eligibility Determination-TM/ 50 Percent FFP
- CODE 3. School Related and Educational Activities - U
- CODE 4. Direct Medical Services - U
- CODE 5.a. Transportation for Non-Medicaid Services - U
- CODE 5.b. Transportation-Related Activities in Support of Medicaid Covered Services - PM/50 Percent FFP
- CODE 6.a. Non-Medicaid Translation - U
- CODE 6.b. Translation Related to Medicaid Services - PM/50 Percent FFP
- CODE 7.a. Program Planning , Policy Development, and Interagency Coordination Related to Non-Medical Services - U
- CODE 7.b. Program Planning , Policy Development, and Interagency Coordination Related to Medical Services -PM/50 Percent FFP
- CODE 8.a. Non-Medicaid Training - U
- CODE 8.b. Medicaid Specific Training - PM/50 Percent FFP
- CODE 9.a. Referral, Coordination, and Monitoring of Non-Medicaid Services - U
- CODE 9.b. Referral, Coordination, and Monitoring of Medicaid Services - PM/50 Percent FFP
- CODE 10. General Administration - R

The following activity codes represent a generic set of activity categories including administrative and direct services that may be used and adapted to reflect the State's specific program titles, etc. These codes were developed in accordance with the principles discussed in other sections and are therefore recommended for state usage. States may, however, modify and/or amend these codes to reflect their unique situation and other codes or examples may be added to the categories, as long as such changes are made in accordance with the principles set forth in this Guide.

CODE 1.a. NON-MEDICAID OUTREACH - U

This code should be used by all school staff when performing activities that inform eligible or potentially eligible individuals about non-Medicaid social, vocational and educational programs (including special education) and how to access them; describing the range of benefits covered under these non-Medicaid social, vocational and educational programs and how to obtain them. Both written and oral methods may be used. Include related paperwork, clerical activities or staff travel required to perform these activities.

- Informing families about wellness programs and how to access these programs.
- Scheduling and promoting activities which educate individuals about the benefits of healthy life-styles and practices.
- Conducting general health education programs or campaigns addressed to the general population.
- Conducting outreach campaigns directed toward encouraging persons to access social, educational, legal or other services not covered by Medicaid.
- Assisting in early identification of children with special medical/mental health needs through various child find activities.
- Outreach activities in support of programs which are 100 percent funded by State general revenue.

CODE 1.b. MEDICAID OUTREACH - TM/50 percent FFP

This code should be used by school staff when performing activities that inform eligible or potentially eligible individuals about Medicaid and how to access it. Activities would include bringing potential eligibles into the Medicaid system for the purpose of determining eligibility and arranging for the provision of Medicaid services. LEAs may only conduct outreach for the populations served by their school districts, i.e., students and their parents or guardians.

The following are examples of activities that are considered Medicaid outreach:

- Informing Medicaid eligible and potential Medicaid eligible children and families about the benefits and availability of services provided by Medicaid (including preventive, treatment, and screening) including services provided through the EPSDT program.
- Informing children and their families on how to effectively access, use, and maintain participation in all health resources under the Federal Medicaid Program.
- Assisting in early identification of children who could benefit from the health services provided by Medicaid as part of a Medicaid outreach campaign. This activity is distinguished from “child find” activities that are required under IDEA. Child find activities should be reported under Code 1.a. (Non-Medicaid Outreach).
- Informing children and their families on how to effectively use and maintain participation in all health resources under the Federal Medicaid program.
- Contacting pregnant and parenting teenagers about the availability of Medicaid prenatal, and well baby care programs and services.
- Conducting a family planning health education outreach program or campaign if it is targeted specifically to family planning Medicaid services that are covered in the State and offered to Medicaid eligible individuals.
- Providing referral assistance to families where Medicaid services can be provided.
- Notifying families of EPSDT program initiatives, such as screenings conducted at a school site. (Note: This type of activity is subject to the free care principle, discussed in Section V.J.)
- Providing information regarding Medicaid managed care programs and health plans to individuals and families and how to access that system.

Activities which are not considered Medicaid outreach under any circumstances are: (1) General preventive health education programs or campaigns addressed to life-style changes in the general population (e.g., dental prevention, anti-smoking, alcohol reduction, etc.) are not Medicaid outreach activities and (2) Outreach campaigns directed toward encouraging persons to access social, educational, legal or other services not covered by Medicaid.

CODE 2.a. FACILITATING APPLICATION FOR NON-MEDICAID PROGRAMS - U

This code should be used by school staff when informing an individual or family about programs such as TANF, Food Stamps, WIC, day care, legal aid, and other social or educational programs and referring them to the appropriate agency to make application.

- Explaining the eligibility process for non-Medicaid programs.
- Assisting the individual or family collect/gather information and documents for the non-Medicaid program application.
- Assisting the individual or family in completing the application, including necessary translation activities.
- Developing and verifying initial and continuing eligibility for the Free and Reduced Lunch Program. When a school district employee is verifying a student's eligibility or continuing eligibility for Medicaid for the purpose of developing, ascertaining or continuing eligibility under the Free and Reduced Lunch program, report that activity under this code.
- Providing necessary forms and packaging all forms in preparation for the NON-Medicaid eligibility determination.

CODE 2.b. FACILITATING MEDICAID ELIGIBILITY DETERMINATION -TM/50 percent FFP

School staff should use this code when assisting an individual in becoming eligible for Medicaid. Include related paperwork, clerical activities, or staff travel required to perform these activities. This activity does not include the actual determination of Medicaid eligibility.

- Verifying an individual's current Medicaid eligibility status.
- Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
- Assisting individuals or families to complete a Medicaid eligibility application.
- Gathering information related to the application and eligibility determination for an individual, including resource information and third party liability (TPL) information, as a prelude to submitting a formal Medicaid application.
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.

- Referring an individual or family to the local Assistance Office to make application for Medicaid benefits.
- Assisting the individual or family in collecting/gathering required information and documents for the Medicaid application.
- Participating as a Medicaid eligibility outreach outstation, but does not include determining eligibility.

CODE 3. SCHOOL RELATED AND EDUCATIONAL ACTIVITIES - U

This code should be used for any other school-related activities that are not health related, such as social services, educational services, and teaching services; employment and job training. These activities include the development, coordination, and monitoring of a student's education plan. Include related paperwork, clerical activities, or staff travel required to perform these activities.

- Providing classroom instruction (including lesson planning).
- Testing, correcting papers.
- Developing, coordinating, and monitoring the Individualized Education Plan (IEP) for a student, which includes ensuring annual reviews of the IEP are conducted, parental sign-offs are obtained, and the actual IEP meetings with the parents.
- Compiling attendance reports.
- Performing activities that are specific to instructional, curriculum, student-focused areas.
- Reviewing the education record for students who are new to the school district.
- Providing general supervision of students (e.g., playground, lunchroom).
- Monitoring student academic achievement.
- Providing individualized instruction (e.g., math concepts) to a special education student.
- Conducting external relations related to school educational issues/matters.
- Compiling report cards.

- Applying discipline activities.
- Performing clerical activities specific to instructional or curriculum areas.
- Activities related to the immunization requirements for school attendance.
- Performing activities that are specific to instructional, curriculum, student-focused areas.
- Compiling, preparing, and reviewing reports on textbooks or attendance.
- Enrolling new students or obtaining registration information.
- Conferring with students or parents about discipline, academic matters or other school related issues.
- Evaluating curriculum and instructional services, policies, and procedures.
- Participating in or presenting training related to curriculum or instruction (e.g., language arts workshop, computer instruction).
- Translating an academic test for a student.
- Performing clerical activities specific to instructional or curriculum areas.

CODE 4. DIRECT MEDICAL SERVICES - U

School staff should use this code when providing care, treatment, and/or counseling services to an individual in order to correct or ameliorate a specific condition. As noted in the 1997 technical assistance guide, if medical evaluations or assessments are conducted to determine a child's health-related needs for purposes of the IEP development, payment for some or all of the costs may be available under Medicaid as a direct service. This code also includes all related paperwork, clerical activities, or staff travel required to perform these activities. Note, some of the following activities may be subject to the free care principle (discussed in Section V.J. of the Guide).

- Providing health/mental health services contained in an IEP.
- Medical/health assessment and evaluation as part of the development of an IEP.
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports.

- Providing health care/personal aide services.
- Providing speech, occupational, physical and other therapies.
- Administering first aid, or prescribed injection or medication to a student.
- Providing direct clinical/treatment services.
- Performing developmental assessments.
- Providing counseling services to treat health, mental health, or substance abuse conditions.
- Performing routine or mandated child health screens including but not limited to vision, hearing, dental, scoliosis, and EPSDT screens.
- Providing immunizations.
- Targeted Case Management (if provided or covered as a medical service under Medicaid).
- Transportation (if covered as a medical service under Medicaid). See section on claiming for Transportation as an administrative cost.
- Activities which are services or components of services listed in the State's Medicaid plan.

CODE 5.a. TRANSPORTATION FOR NON-MEDICAID SERVICES - U

School district employees should use this code when assisting an individual to obtain transportation to services not covered by Medicaid, or accompanying the individual to services not covered by Medicaid. Include related paperwork, clerical activities or staff travel required to perform these activities.

- Scheduling or arranging transportation to social, vocational, and/or educational programs and activities.

CODE 5.b. TRANSPORTATION-RELATED ACTIVITIES IN SUPPORT OF MEDICAID COVERED SERVICES -PM/50 percent FFP

School district employees should use this code when assisting an individual to obtain

transportation to services covered by Medicaid. This does not include the provision of the actual transportation service, but rather the administrative activities involved providing transportation. This activity also does not include activities which contribute to the actual billing of transportation as a medical service. Nor does it include accompanying the Medicaid-eligible individual to Medicaid services as an administrative activity.

Include related paperwork, clerical activities or staff travel required to perform these activities. See Section V.M. for a more detailed and thorough discussion of Medicaid transportation policy.

- Scheduling or arranging transportation to Medicaid covered services.

CODE 6.a. NON-MEDICAID TRANSLATION - U

This code should be used by school employees who provide translation services related to social, vocational, or educational programs and activities as an activity separate from the activities referenced in other codes. Include related paperwork, clerical activities or staff travel required to perform these activities.

- Arranging for or providing translation services that assist the individual to access and understand non-medical services.
- Arranging for or providing translation services that assist the individual to access and understand non-medical programs and activities.
- Arranging for or providing signing services that assist the individual or family access and understand non-medical programs and activities.

CODE 6.b. TRANSLATION RELATED TO MEDICAID SERVICES -PM/50 percent FFP

Translation may be allowable as an administrative activity, if it is not included and paid for as part of a medical assistance service. However, it must be provided by separate units or by separate employees performing solely translation functions for the school and it must facilitate access to Medicaid covered services.

This code should be used by school employees who provide translation services related to Medicaid covered services as an activity separate from the activities referenced in other codes. Include related paperwork, clerical activities or staff travel required to perform these activities.

- Arranging for or providing translation services that assist the individual to access and understand necessary care or treatment;

- Arranging for or providing signing services that assist the individual or family access and understand necessary care or treatment.

**CODE 7.a. PROGRAM PLANNING, POLICY DEVELOPMENT, AND
INTERAGENCY COORDINATION RELATED TO NON-MEDICAL
SERVICES - U**

This code should be used by school staff when performing activities associated with the development of strategies to improve the coordination and delivery of non-medical/non-mental health services to school age children, and when performing collaborative activities with other agencies. Non-medical services may include social, educational, and vocational services. Only employees whose position descriptions include program planning, policy development, and interagency coordination should use this code. Include related paperwork, clerical activities or staff travel required to perform these activities.

- Identifying gaps or duplication of other non-medical services (e.g., social, vocational and educational programs) to school age children and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of non-medical school programs.
- Monitoring the non-medical delivery systems in schools.
- Developing procedures for tracking families' requests for assistance with non-medical services and the providers of such services.
- Evaluating the need for non-medical services in relation to specific populations or geographic areas.
- Analyzing non-medical data related to a specific program, population, or geographic area.
- Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical problems.
- Defining the scope of each agency's non-medical service in relation to the other.
- Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services to the school populations.

- Developing non-medical referral sources.
- Coordinating with interagency committees to identify, promote and develop non-medical services in the school system.

**CODE 7.b. PROGRAM PLANNING, POLICY DEVELOPMENT, AND
INTERAGENCY COORDINATION RELATED TO MEDICAL SERVICES
-PM/50 percent FFP**

This code should be used by school staff when performing activities associated with the development of strategies to improve the coordination and delivery of Medicaid coverable medical/mental health services to school age children, and when performing collaborative activities with other agencies. Only employees whose position descriptions include program planning, policy development, and interagency coordination should use this code. Include related paperwork, clerical activities or staff travel required to perform these activities.

- Identifying gaps or duplication of medical/mental services to school age children and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of school medical/mental health programs.
- Monitoring the medical/mental health delivery systems in schools.
- Developing procedures for tracking families' requests for assistance with Medicaid services and providers. (This does not include the actual tracking of requests for Medicaid services.)
- Evaluating the need for Medicaid services in relation to specific populations or geographic areas.
- Analyzing Medicaid data related to a specific program, population, or geographic area.
- Working with other agencies providing Medicaid services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligibles, and to improve collaboration around the early identification of medical problems.
- Defining the scope of each agency's Medicaid service in relation to the other.

- Working with Medicaid resources, such as the managed care plans, to make good faith efforts to locate and develop EPSDT health services referral relationships.
- Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services to the school populations.
- Developing medical referral sources such as directories of Medicaid providers and managed care plans, who will provide services to targeted population groups, e.g., EPSDT children.
- Coordinating with interagency committees to identify, promote and develop EPSDT services in the school system.

CODE 8.a. NON-MEDICAID TRAINING - U

This code should be used by school staff when coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefit of the programs other than the Medicaid program such as educational programs; for example, how to assist families to access the services of the relevant programs, and how to more effectively refer students for those services. Include related paperwork, clerical activities, or staff travel required to perform these activities.

Training can be coded in three ways: As a separate code (Code 8.a.); as General Administration (Code 10); or as part of a specific activity code. If claimed as part of a specific activity code, the State should add a relevant bullet to the applicable code.

- Participating in or coordinating training which improves the delivery of services for programs other than Medicaid.
- Participating in or coordinating training which enhances IDEA child find programs.

CODE 8.b. MEDICAID SPECIFIC TRAINING -PM/50 percent FFP

This code should be used by school staff when coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefit of the Medicaid program, how to assist families to access Medicaid services, and how to more effectively refer students for services. Include related paperwork, clerical activities, or staff travel required to perform these activities.

Training can be coded in three ways: As a separate code (Code 8.b.); as General Administration

(Code 10); or as part of a specific activity code. If claimed as part of a specific activity code, the State should add a relevant bullet to the applicable code.

- Participating in or coordinating training which improves the delivery of Medicaid services.
- Participating in or coordinating training which enhances early identification, intervention, screening and referral of students with special health needs to EPSDT services (This is distinguished from IDEA child find programs.)

CODE 9.a. REFERRAL, COORDINATION, AND MONITORING OF NON-MEDICAID SERVICES - U

School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of non-medical, such as educational services.

- Making referrals for and coordinating access to social and educational services such as child care, employment, job training, and housing.
- Making referrals for, coordinating, and/or monitoring the delivery of State education agency mandated child health screens (vision, hearing, scoliosis).
- Making referrals for, coordinating, and monitoring the delivery of scholastic, vocational, and other non-health related examinations.
- Gathering any information that may be required in advance of these non-Medicaid related referrals.
- Participating in a meeting/discussion to coordinate or review a student's need for scholastic, vocational, and non-health related services not covered by Medicaid.
- Monitoring and evaluating the non-medical components of the individualized plan as appropriate.

Case Management. Note that case management as an administrative activity involves the facilitation of access and coordination of program services. Such activities may be provided under the term Case Management or may also be referred to as Referral, Coordination, and Monitoring of non-Medicaid Services.

Case management may also be provided as an integral part of the service and would be included in the service cost.

School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of NON-Medicaid covered services. Include related paperwork, clerical activities or staff travel required to perform these activities.

CODE 9.b. REFERRAL, COORDINATION, AND MONITORING OF MEDICAID SERVICES -PM/50 percent FFP

School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of medical (Medicaid covered) services. Activities that are part of a direct service are not claimable as an administrative service. Include related paperwork, clerical activities, or staff travel necessary to perform these activities.

- Identifying and referring adolescents who may be in need of Medicaid family planning services.
- Making referrals for and/or coordinating medical or physical examinations and necessary medical/mental health evaluations.
- Making referrals for and/or scheduling EPSDT screens, interperiodic screens, and appropriate immunization, but NOT to include the State-mandated health services.
- Referring students for necessary medical health, mental health, or substance abuse services covered by Medicaid.
- Arranging for any Medicaid covered medical/mental health diagnostic or treatment services which may be required as the result of a specifically identified medical/mental health condition based on the findings other than when provided as a direct service.
- Gathering any information that may be required in advance of these referrals.
- Participating in a meeting/discussion to coordinate or review a student's needs for health-related services covered by Medicaid.
- Providing follow-up contact to ensure that a child has received the prescribed medical/mental health services.
- Coordinating the completion of the prescribed services, termination of services, and the referral of the child to other Medicaid service providers as may be required to provide continuity of care.
- Providing information to other staff on the child's related medical/mental health

services and plans.

- Coordinating the delivery of community-based medical/mental health services for a child with special/severe health care needs.
- Providing information about Medicaid EPSDT screening (e.g., dental, vision) in the schools that will help identify medical conditions that can be corrected or improved by services through Medicaid.
- Monitoring and evaluating the Medicaid service components of the IEP as appropriate.
- Coordinating medical/mental health service provision with managed care plans as appropriate.

Case Management. Note that case management as an administrative activity involves the facilitation of access and coordination of services which are covered under the State's Medicaid program. Such activities may be provided under the term Administrative Case Management or may also be referred to as Referral, Coordination, and Monitoring of Medicaid Services.

Case management may also be provided as an integral part of a medical service and would be included in the service cost. The State may also cover targeted case management as an optional service under Medicaid.

School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of Medicaid covered services. Include related paperwork, clerical activities or staff travel required to perform these activities.

CODE 10. GENERAL ADMINISTRATION - R

This code should be used by time study participants when performing activities that are not directly assignable to program activities. Include related paperwork, clerical activities, or staff travel required to perform these activities. Note that certain functions, such as payroll, maintaining inventories, developing budgets, executive direction, etc., are considered overhead and, therefore, are only allowable through the application of an approved indirect cost rate.

Below are typical examples of general administrative activities, but they are not all inclusive.

- Taking lunch, breaks, leave, or time not at work.
- Establishing goals and objectives of health-related programs as part of the school's

annual or multi-year plan.

- Reviewing school or district procedures and rules.
- Attending or facilitating school or unit staff meetings, training, or board meetings.
- Performing administrative or clerical activities related to general building or district functions or operations.
- Providing general supervision of staff, including supervision of student teachers or classroom volunteers, and evaluation of employee performance.
- Reviewing technical literature and research articles.
- Other general administrative activities of a similar nature as listed above which cannot be specifically identified under other activity codes.

V. CLAIMING ISSUES

A. Documentation

The time study methodology and instructions, as well as the cost allocation requirements issued by the State Medicaid Agency to the schools, must stipulate the documentation the schools must maintain to support the claims submitted to the State. The documentation for administrative activities must clearly demonstrate that the activities are provided to Medicaid applicants or eligibles, and are connected with application assistance and the gathering of documentation for a complete eligibility determination or for administering services covered under the State Plan. 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).

Additional guidance regarding documentation for compensation of salary and wages is found in OMB Circular A-87, Attachment B, Section 11.h.(5):

Personnel activity reports or equivalent documentation must meet the following standards:

- (a) They must reflect an after-the-fact distribution [i.e., distribution following completion of the activity] of the actual activity of each employee,

(b) They must account for the total activity for which each employee is compensated,

(c) They must be prepared at least monthly and must coincide with one or more pay periods, and

(d) They must be signed by the employee as being a true statement of activities and the employee/office will retain documentation to support the report.

Other principles related to documentation and documentation requirements that apply in addition to the above requirements are:

- Salaries and wages, including personnel activity reports;
- Accounting records should be supported by source documentation such as canceled checks, paid bills, payrolls, contract and subgrant award documents;
- Foster care payments and administrative costs ;
- Case management services based on time studies are an acceptable form of documentation for a given period; ;
- Costs must be verified as being incurred in a particular Federal program;
- Undocumented personnel costs are not allowed; and
- Adequate documentation for labor costs is required.

B. Sampling/Time Studies

Recognizing the necessity of using a sample to develop administrative claims, OMB Circular A-87 permits the use of “substitute systems” for allocating salaries and wages to Federal awards to be used in place of activity reports when employees work on multiple activities or cost objectives. Any such system must be approved by the funding agency. These sampling systems (or time studies) may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort or outcomes. For time studies, all activities need to be sampled even if they are not strictly related to Medicaid. A summary of the relevant sections of OMB Circular A-87 follows:

- Attachment A, Section A.1: Each awarding grant bears its fair share of costs; C, Basic Guidelines, 1.h: Not included as match for another Federal program. 1. J: Be adequately documented. 3.c: Costs cannot be shifted from one grant to another to avoid restrictions.
- Attachment B, Selected Items of Cost, 11. Compensation for personnel services, h (1-4): Standards for payroll documentation. (6) Substitute Systems are: subject to approval; include random moment sampling or other quantifiable measures; (a) must meet acceptable statistical sampling standards including (i) include all salaries of employees to be allocated, (ii) the entire time period involved must be covered; (c) less than full compliance with statistical sampling standards may be accepted by the agency if it concludes that the proposal will result in lower costs to Federal awards than the compliant

system.

The major issues involved in time studies include the following: development and approval of the activity codes to be used (discussed in Section IV of this Guide), the participants to be sampled, the sampling plan, statistical validity (95 percent confidence level or higher), documentation, training for staff in the sample universe, and monitoring. The following subsections discuss those issues in greater detail:

1. Sample Universe

A basic step in the approval of a time study is the determination of the sample universe, i.e., the LEA staff person(s) who will participate (be sampled under) the time study. Although Medicaid administrative activities may be performed by LEA staff who provide direct medical services (for example, nurses and physical therapists and educational staff, such as the Director of Exceptional Student Education and teachers aides), only those staff whose costs are not met by other funding sources may be included in the sample universe. For example, if 100 percent of the costs of social workers were met by Federal funding sources or third party payers other than Medicaid, then there would be no reason to include such workers in the time study and they must be excluded from participation. Furthermore, the costs of such workers should not be included in the costs.

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

Costs allocated to the Medicaid program should be offset by other funding sources. LEA staff whose salary costs are not entirely met by one or more Federal grants may be eligible to be included in the sample. Thus, if funds from an educational grant pay only a percentage of the individual's costs, that person can be sampled as long as the costs are offset by the funds from the educational grant. Also to be excluded are any matching funds required by the educational grant. In addition, staff members such as physical therapy aides need to be included in the sample universe and not simply allocated based on the activities of professionals (e.g., physical therapists).

2. Sampling Plan Methodology

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

“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.”

As indicated, one of the most commonly used sampling methodologies for time studies is random moment samples (RMS). For the reasons that follow, the RMS method represents an acceptable method for accurately assessing the time spent on administrative activities.

RMS covers the entire sampled period, such as a quarter, but does not include weeks when schools are not in session. The sampling universe must include all employees whose salaries are to be allocated. According to OMB Circular A-87, “The entire time period involved must be covered by the sample; and the results must be statistically valid and applied to the period being sampled.” The circular also indicates that time reports be completed at least monthly. RMS meets these requirements. OMB Circular A-87 does provide that a less than fully compliant sample can be used if the cognizant agency can demonstrate that the proposed system “will result in lower costs to Federal awards than a system that complies with the standards.”

3. Time Study 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. Documentation to be retained must support and include the following: the sample universe determination, sample selection, sample results, sampling forms, cost data for each school district, and summary sheets showing how each school district’s claim was compiled. All claims by the LEAs and schools are summarized and submitted to the State Agency for one payment. The individual sample sheets may or may not be kept locally. Sometimes individual sheets are maintained locally while summary records are maintained at a central location.

Note that if a portion of a sampled employee’s time is also billed as medical services, then the administrative time study results should be validated in part by comparing the time coded to direct medical services (Code 4) to the actual amount of hours billed directly. The results should be within a reasonable tolerance or else the time study may result in an effective double payment.

4. Training for Staffing Time Study

All staff in the sample universe should be trained before the sampling begins. Training should cover all aspects of the sampling process. Staff should be clear on how to complete the form, how to choose activities, the difference between health related and other activities, and where to obtain technical assistance if there are questions. Professional staff must be clear on how to determine when and if their professional knowledge was required to do a function/activity. Further, to assure consistent application, a schedule of training on sampling and on the approved activity codes to be used by the staff who are sampled should be applied. This schedule should show the training required of the sample takers, staff being sampled, and frequency of training. The frequency of training should take into account turnover at the local level.

5. Monitoring Process

In order to ensure that the time study is statistically valid (for example, at the 95 percent confidence level), the State Medicaid Agency must monitor the compliance of the LEAs to the requirements of the sampling methodology. A description should be included of the monitoring of the sample results. This description should include information on the frequency of reviews at the local level, staff performing the reviews, and the review protocol.

C. Offset of Revenues

The costs which need to be allocated must be offset by certain revenues in order to reduce the total amount of costs in which the Federal government will participate. To the extent the funding sources have paid or would pay for the costs at issue, Federal Medicaid funding is not available and the costs must be removed from total costs (See OMB Circular A-87, Attachment A, Part C., Item 4.a.). The following include some of the revenue offset categories which must be applied in developing the net costs:

- All Federal funds, along with maintenance of effort and other State/local matching funds required by the Federal grant.
- All State expenditures which have been previously matched by the Federal government (includes Medicaid funds for medical assistance (e.g., fee-for-service funds).
- State funds, specifically targeted or earmarked for the delivery of program services (such as medical assistance), must be used for the purposes for which they are targeted or earmarked and cannot be used to match other expenditures; for example, the costs of administrative activities. These funds must be offset in developing net costs.
- Insurance and other fees collected from non-governmental sources must be offset against claims for Medicaid funds.
- A program may not claim any Federal match for administrative activities if its total cost has already been paid by the revenue sources above. A government program may not be reimbursed in excess of its actual costs, i.e., make a profit.

D. Cost Allocation

Requirements for the development, documentation, submission, negotiation, and approval of public assistance cost allocation plans are set forth in Subpart E of 45 CFR Part 95 and ASMB C-10. All administrative costs (direct and indirect) are normally charged to Federal awards by implementing the public assistance cost allocation plan (CAP). OMB Circular A-87, Cost

Principles for State, Local and Indian Tribal Governments - Attachment D - extends these requirements to all Federal agencies whose programs - including Medicaid - are administered by a State public assistance agency. OMB Circular A-87 policy is that State public assistance agencies will develop, document and implement, and the Federal government will review, negotiate, and approve, public assistance CAPs .

In accordance with the Federal regulations indicated above 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 administrative claims in the Medicaid program. In this regard, the public assistance CAP must provide, in accordance with the approved interagency agreements, for reimbursement of the administrative activities performed in the school setting and for which claims will be made by the LEAs, school districts, and schools to the State Medicaid Agency. The public assistance CAP must make explicit reference to the methodologies, claiming mechanisms, interagency agreements, and other relevant issues that will be used by the LEAs, school districts, and schools 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. Therefore, the referenced elements must be reviewed and approved by HCFA before implementation of the school-based administrative claiming program and before the claiming of FFP.

See also Principle 12 in Section IV. of the Guide, "Review and Approval of Programs and Codes by HCFA."

Furthermore, the school-based administrative claiming program must be supported by a system which has the capability to isolate the costs which are directly related to the support of the Medicaid program from all other costs incurred by the school and which will ultimately be claimed by the State Medicaid Agency as administration. Such costs must comply with the cost allocation principles described in OMB Circular A-87 which requires that costs be "necessary and reasonable" and "allocable" to the Medicaid program. Claims for the school's or LEA's indirect costs are only allowable when the entity has an approved indirect cost rate issued by the cognizant agency and costs are claimed in accordance with the rate.

E. Administrative Claiming Implementation Plan

As discussed in the preceding section, the public assistance CAP amendments must be reviewed and approved by the DCA and HCFA. To ensure the successful implementation of a State Medicaid program to pay for Medicaid-related administrative claiming activities in schools, and to support and expedite the public assistance CAP and underlying claims mechanism approval process, we strongly suggest that the State Medicaid Agency submit an "administrative claiming implementation plan" (the "implementation plan") which provides a comprehensive description of

the mechanism and process for claiming administrative costs under Medicaid. To the extent the implementation plan provides underlying support and documentation referenced in the public assistance CAP amendments, it must be acceptable to HCFA before FFP will be available.

The following elements should be included in the implementation plan:

- **Interagency Agreements.** The State Medicaid Agency must have an interagency agreement with the State Department of Education or separate agreements with participating school districts for Title XIX (Medicaid) or in accordance with OMB Circular A-87, Attachment A. These interagency agreements should list or reference the allowable administrative activities for which school districts will be reimbursed and certify that all claims will be in accordance with A-87, the State Medicaid Plan and all Federally approved public assistance CAPs. As appropriate, the interagency agreement would describe or reference the treatment of indirect costs. The requirements for interagency agreements are also discussed in Section III of this Guide.
- **Description of Current Administrative Activities Paid by Medicaid.** Other State and local agencies (e.g., State and local health departments and mental health authorities) may be performing and receiving Federal reimbursement for the same services which are being considered for reimbursement in the school setting. Similarly, Medicaid managed care plans may be providing the same services to school aged children. Federal regulations prohibit duplicate payments for the same service. Therefore, the State should provide a description of the current administrative activities of these other entities. This would include a description of the relationship of these activities to Medicaid in the schools. A chart or matrix could be used to show the activities for which each agency currently receives Federal reimbursement and how this will change when schools are reimbursed for performing administrative activities.
- **Treatment of Indirect Costs.** In its submission of the administrative claiming implementation plan, the State Medicaid Agency must indicate whether indirect costs will be claimed. NOTE, indirect costs can only be claimed if there is an indirect cost rate approved by the cognizant agency responsible for approving such rates. With respect to school-based administrative costs, the cognizant agency is the Federal Department of Education or its delegate. Where indirect costs are allowed, the LEA, school district, or school must certify that costs claimed as direct costs do not duplicate those costs reimbursed through application of the indirect cost rate.
- **Sampling /Time Study Plan.** As discussed in greater detail in Section V.B., the time study methodology used to sample costs must be approved and statistically valid. The time study must include a description of job classifications to be sampled, job classifications considered eligible and ineligible for reimbursement and a listing of allowable activities performed by employees considered eligible for reimbursement. This plan should also address how your Agency will assure that results from the sampling

methods will be in the 95 percent confidence level.

Further, to assure consistent application, the plan must also include a schedule of training on sampling and on the approved activity codes to be used by the staff who are sampled. This schedule should show the training required of the sample takers, staff being sampled, and frequency of training. In some States, training to both sample takers and those sampled is done quarterly (before each sample is conducted) to assure consistency. This is needed because of turnover on the local level.

- **Monitoring Process.** Include a description of your monitoring of the sample results. This description should include information on the frequency of reviews at the local level, staff performing the reviews, and the review protocol that will be followed.
- **Review of Implementation Plan By HCFA.** The implementation plan should be submitted to HCFA prior to submittal of the public assistance CAP amendment to DCA.
- **Certified Public Expenditures.** If the administrative payments for school-based services will be made utilizing certified public expenditures (CPE) to satisfy the State match, include in the implementation plan a description of the process used to document that there are sufficient State funds available to match Title XIX funds. A description of the process should be provided that will be used to verify/certify that local education agencies have unrestricted State funds available to earn the Federal participation claimed (i.e., that funds are not already being used to match Federal funds of other Federal programs or otherwise reimbursed by other Federal grants).

F. Timely Filing Requirements

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 which 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.

The implementing regulations for timely filing requirement are at 45 CFR Part 95 Subpart A and provide specific guidelines for determining when an expenditure is said to have been made so as to trigger the two-year filing period (46 Fed. Reg. 3529 January 15, 1981). A State's expenditure for Medicaid services is considered to have been made "in the quarter in which any State agency made a payment to a service provider."

Federal regulations at 45 CFR 95.13 (d) state: "We consider a State agency's expenditure for administration or training ... to have been made in the quarter payment was made by a State agency to a private agency or individual;..."

Further, 45 CFR 95.4 states: "State agency for purposes of expenditures for 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;”

G. State Law Requirements

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, cost must meet the following criteria . . . be authorized or not prohibited under State or local laws and regulations.” Thus, FFP for school-based services and administrative outreach claims is not available if the State is not in compliance with its own statutes. 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, preferably from the State Attorney General.

H. Contingency Fees

Many school districts or local education authorities have chosen to use the services of consultants. The OMB Circular A-87 states in item 33.a, of Attachment B, “Selected Items of Costs,” that:

Cost of professional and consultant services rendered by persons or organizations that are members of a particular profession or possess a special skill, whether or not officers or employees of the governmental unit, are allowable, subject to section 14 when reasonable in relation to the services rendered **and when not contingent upon recovery of the costs from the Federal Government** (added emphasis).

Thus, if payments to consultants by schools are contingent upon payment by Medicaid, the consultant fees are not an allowable cost of services rendered and as such, may not be used in determining the payment rate of school-based services. Further, as discussed in Office of Inspector General (OIG) Chief Counsel Advisory Opinion Number 98-4, contractual arrangements with consultants based on percentage billing arrangements may increase the risk of upcoding and similar abusive billing practices. Although this is not a per se application, the opinion suggests the need for caution in using such arrangements to avoid prohibited payments under the anti-kick back statute, Section 1128(b) of the Act.

Note also that OMB Circular A-87 states in item C.1., of Attachment A, “General Principles for Determining Allowable Costs,” that to be allowable, costs must be authorized or not prohibited under State or local laws or regulations.

I. Provider Agreements

There must be a provider agreement between the State and the actual provider of services

(Sections 1902(a)(4), 1902(a)(27), 1902(a)(57) and 1902(58) of the Social Security Act (SSA) implemented at 42 CFR 431.107).

J. Third Party Liability (TPL)/Medicaid as payor of last resort/Free Care

The Medicaid program is generally the “payor of last resort.” This refers to the principle that Medicaid must pay for services and the costs of activities only after other programs or third parties (such as private insurance) have paid for such services or costs of activities. This principle is based in Medicaid statute under two provisions, third party liability (TPL) and those relating to the consideration of individual’s income and resources in determining Medicaid eligibility. The TPL provisions require the State Medicaid Agency to take all reasonable measures to ascertain the legal liability of all potential third parties for paying for care and services covered under the State’s Medicaid plan. Furthermore, the State is required to seek such payment by the third parties before making payment under Medicaid and also to seek such payment as a recovery after making payment under the Medicaid program. Additionally, Medicaid statute is explicit in requiring the State Medicaid Agency to consider income and resources in determining an individual’s eligibility.

An exception or qualification to this principle, contained at Section 1903(c) of the Act, relates to medical services contained in a child’s Individualized Education Plan (IEP). If such services are contained in a child’s IEP, the child is eligible for Medicaid, and the services are covered by the Medicaid program, then Medicaid may pay for such services. Another qualification is contained at Section 1902(a)(11) of the Act, under which Medicaid can pay for the allowable care and services that may be reimbursed under title V of the Act (Maternal and Child Health Services block grant) before title V.

Therefore, except for special circumstances, the State Medicaid Agency is the payor of last resort for the costs of services and activities that are also payable under other programs or by third parties. Furthermore, Medicaid does not pay for the health services or administration costs related to those services that are provided free of charge to non-Medicaid eligible students. In applying the free care principle to determine whether medical services are provided free of charge and, thus, there is no payment liability to Medicaid, a determination must be made whether both Medicaid and non-Medicaid beneficiaries are charged for the service.

The free care principle is relevant to the construction of time study activity codes and reporting under such codes by time study participants as relates to activities that are subject to payment by other programs. Thus, for example, if certain activities or services are specifically provided for under a special program, the cost of such administrative activities related to such programs would not be allowable as administrative costs in Medicaid. For example, State laws may require immunizations be provided to all school children, regardless of whether the child is Medicaid eligible or the child’s income status. In such a case the administrative activities related to assisting the child to obtain such immunizations in the school would not be reimbursable as a Medicaid administrative cost. Therefore, such an activity would be reported under Code 9.a., not 9.b.,

below.

K. Transportation as Administration

HCFA's policy concerning Medicaid payment for transporting Medicaid-eligible IDEA children to and from schools is described in the Medicaid and School Health Technical Assistance Guide, issued in 1997. That Guide indicates that transportation to and from school may be claimed as a Medicaid service when the child receives a medical service in school on a particular day and when transportation is specifically listed in the IEP as a required service. As a Medicaid administrative activity, Codes 5.a. and 5.b. cover the time spent in assisting or actually transporting a child to a service, but does not cover the actual cost of the transportation (bus fare, taxi fare, etc.).

An IEP should include only specialized services that a child would not otherwise receive in the course of attending school. Therefore, a child with special education needs under IDEA who rides the regular school bus to school with the other non-disabled children in his/her neighborhood should not have transportation listed in his IEP and the cost of that bus ride should not be billed to Medicaid.

If a child requires transportation in a vehicle adapted to serve the needs of the disabled, including a specially adapted school bus, that transportation may be billed to Medicaid if the need for that specialized transportation is identified in the IEP. In addition, if a child resides in an area that does not have school bus transportation (such as those areas in close proximity to a school) but has a medical need for transportation that is noted in the IEP, that transportation may also be billed to Medicaid. As always, transportation from the school to a provider in the community also may be billed to Medicaid. These policies apply whether the State is claiming FFP for transportation under Medicaid as medical assistance or administration.

When a State claims FFP under the Medicaid program for transportation services as medical assistance under an approved reimbursement rate, the requirements for documentation of each service must be maintained for purposes of an audit trail. This usually takes the form of a trip log maintained by the provider of the specialized transportation service. The methodology used to establish the transportation rate should also be described in the State plan.

When FFP for the costs of transportation services is claimed as administration, the requirements of the OMB Circular A-87 for determining allowable costs, as well as any other applicable requirements for claiming administration under Medicaid, must be met. This includes the development of a cost allocation methodology to ensure that Medicaid only pays for that portion of the specialized mode of transportation allocable to Medicaid beneficiaries.