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Vaccines

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50 U.S. Law

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In this chapter, we review liability for vaccine injuries under the common law; the rationale, development, and implementation of the national Vaccine Injury Compensation Program (VICP); and the program's current status. The first part of the chapter covers the development of the law in the United States up to 1986, the year of the passage of the National Childhood Vaccine Injury Act. The next two sections cover the administration of the VICP and the reported decisions relating to liability for the production and administration of vaccines after 1986, respectively.

VACCINE LIABILITY BEFORE 1986

U.S. courts have addressed two major legal issues related to vaccination. First, are participants in the vaccination program, such as vaccine producers and administering medical personnel, liable for the adverse reactions of vaccinees to the vaccination? The answer to this question has generally been no, unless the vaccine is defective or the personnel have failed to follow accepted medical procedures or to advise the vaccinee of the risks. Occasionally, the answer has been yes, even when the vaccine and the procedures were completely proper. Second, can the government compel vaccination? The answer is yes.

Manufacturers and administering medical personnel need not fear liability under U.S. law as the rules are usually stated, provided that two conditions are met: first, that the vaccine is properly made and administered in accordance with accepted medical procedures and, second, that the recipient has been warned of the risks associated with vaccination.

The risk of liability created by these two qualifications is important. If, for instance, a batch of vaccine is defective and causes disease in recipients because the disease-causing agent has not been sufficiently inactivated or because of contaminants, the manufacturer may be liable, whether or not the defect in the vaccine can be shown to be the manufacturer's fault. This happened with an early batch of Salk-killed poliovirus vaccine, and there were numerous and substantial recoveries by persons who acquired polio from the vaccine.* Or if a

physician administers a vaccine when it is contraindicated—for instance, he or she administers Sabin oral poliovirus vaccine to a child known to be immunodeficient or administers a second dose of diphtheria-tetanus-pertussis (DTP) vaccine after a child has reacted strongly to the first—then the physician may be liable, if the adverse consequence risked by violating the indication occurs. Furthermore, if a physician administers a vaccine without warning the patient of the risks, the physician may be liable if the risks occur.

Court decisions that have imposed liability even if the vaccine was properly made and administered may be divided into three categories: the *Reyes* decision, the swine flu litigation against the government, and the 1980s decisions.

The cases discussed here are reported decisions in the appellate courts. An important aspect of the problem for the pharmaceutical houses was the number of cases filed. There is no systematic reporting of either pending or decided cases in the U.S. lower courts. *Reyes v. Wyeth Laboratories*, decided in 1974, held a producer of Sabin oral polio vaccine liable to a child who contracted polio after being administered the vaccine.* The facts on which the court based its opinion were that the manufacturer had sold the vaccine to the Texas Department of Public Health, accompanied by Food and Drug Administration (FDA) required package inserts containing a warning. The Texas Department of Public Health had then sent the vaccine on to the county health department without taking steps to ensure that the warning would actually be given to the vaccine recipients. The county public health nurse who administered the vaccine to the child had not warned the parents that there is a minute risk that a recipient or contact can contract the disease.

The general rule is that the manufacturer of prescription medicines, including vaccines, has no duty to directly warn the user of the product of risks. In contrast, the maker of an over-the-counter product sold directly to consumers does have a duty, on package labeling, to provide such warnings. These established rules would seem to have dictated a decision for the defendant phar-

**Gottsdanker v. Cutter Laboratories*, 182 Cal. App. 2d 602, 6 Cal. Repr. 320 (Dist. Ct. App. 1960).

**Reyes v. Wyeth Laboratories*, 498 F.2d 1264 (5th Cir. 1974). *Reyes* was followed in *Gitens v. Lederle*, 556 F.2d 1341 (5th Cir. 1977).

determined that Lederle's design of DTP was negligent, the verdict should be affirmed.

The increased risk of liability in the courts for those who manufacture and administer vaccines, which became apparent in U.S. law after 1970, was but a footnote to the general movement in the law of many states toward greater liability for suppliers of goods and services to consumers. This general trend has had noted effects on the medical professions in numerous areas, many of which have been affected more dramatically than the area of vaccination. The reaction of the courts in the previously cited cases may have been related to the fact that the very success of vaccines has changed the way they are perceived by the public. Vaccines are no longer perceived as a miracle preventive measure against frightening disease but as a routine nuisance procedure to prevent disease that hardly anyone—including most young physicians—has actually experienced. It becomes all too easy to demand that a preventive measure against a disease that exists mostly as a historical memory not appear to injure any recipient.^{*} Ironically, this attitude can retard the development of new vaccines against additional and currently threatening diseases. The material addressed here should remind medical experts and public health officials in charge of vaccination efforts that an effective vaccination program, no matter how justified medically and in relation to cost-benefit ratio, requires for its sustained success that its purposes and methods be well understood not only by medical personnel but by society in general. Lack of information, prejudice, and distrust in the larger community can operate to undermine perfectly rational and laudable public health objectives by leading to harmful legislation or ill-informed decisions by judges and juries. Patience and care in explaining what is being done and the reasons for it, no matter how tedious the process, can contribute importantly to the effectiveness of a vaccination program. The difficulties presented by the liability issues should not obscure the important fact that U.S. courts have in fact been very supportive of vaccination programs. That support reflects the judges' understanding of the importance of vaccination and their trust in public health professionals to carry out vaccination programs in a responsible and reasonable manner.

The Power to Compel Vaccination

U.S. courts have been deferential to public health judgments that mandatory vaccination is required. The leading case is *Jacobson v. Massachusetts*.[†] That case involved a Massachusetts statute that empowered local boards of health to require vaccination of the inhabitants "... if, in its opinion, it is necessary for the public health or safety." The statute demanded a penalty of \$5.00

from anyone who failed to comply. The Board of Health of the city of Cambridge, Massachusetts, determined that all residents of Cambridge should be vaccinated against smallpox. Jacobson refused and was fined. Apparently, Jacobson had previously experienced adverse reactions to the vaccine. Jacobson appealed to the Supreme Court, challenging the constitutionality of the statute on the ground that a requirement that he submit to vaccination was an unreasonable infringement of his personal liberty. The Court unanimously rejected this argument.

Jacobson offered to prove in the lower courts that some medical opinion attaches "... little or no value to vaccination as a means of preventing the spread of smallpox," and that some physicians believe "... that vaccination causes other diseases of the body" (197 U.S. 30). The Court was content to rely on general belief, without hearing evidence. "What everybody knows the court must know, and therefore the state court judicially knew, as this court knows, that an opposite theory accords with the common belief and is maintained by high medical authority. We must assume that, when the statute in question was passed, the legislature of Massachusetts was not unaware of these opposing theories, and was compelled, of necessity, to choose between them. It was not compelled to commit a matter involving the public health and safety to the final decision of a court or jury" (197 U.S. 30).

In closing, the Court observed that "We are not prepared to hold that a minority, residing or remaining in any city or town where smallpox is prevalent, and enjoying the general protection afforded by an organized local government, may thus defy the will of its constituted authorities, acting in good faith for all, under the legislative sanction of the states. If such be the privilege of a minority then a like privilege would belong to each individual of the community, and the spectacle would be presented of the welfare and safety of an entire population being subordinated to the notions of a single individual who chooses to remain a part of that population" (197 U.S. 37-38).

Decisions of contemporary courts continue to be supportive of mandatory vaccination requirements. In *Maricopa County Health Department v. Harmon*,^{*} the health department sought an injunction that excluded unimmunized children from school. The health department had issued an emergency rule barring unimmunized children from attending school because of an outbreak of measles in the county. The purpose of the injunction was to enforce the health department rule. The trial court granted the injunction, and the appellate court affirmed. The families resisting exclusion from school argued that the health department had no authority to exclude children unless there had been a confirmed case of measles in the particular school. The court answered, "Appellants cite no authority for the proposition that there is no compelling state interest in taking limited and temporary steps to combat a reasonably perceived risk of the spread of measles absent a serologically confirmed

^{*}Whether existing vaccines do in fact injure any recipient is a difficult question to answer, because the relative rarity of the phenomenon makes it difficult to study. The issues related to establishing actual causal connection are discussed in *Ellenberg S and Chen R*. The complicated task of monitoring vaccine safety. *Public Health Rep* 112:10-20, 1997.

[†]*Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

^{*}*Maricopa County Health Department v. Harmon*, 156 Ariz. 161, *50 P2d 1364 (Ariz. App. 1987).

case, and our research has revealed none" (750 P.2d 1369).*

Contemporary vaccination laws are not as sweeping as the law involved in *Jacobson*. All states require vaccination of children before their entry to school.[†] However, the recommended age of administration for these vaccines is during the first 2 years of life, and the vaccines are in fact administered to a high percentage of children at the recommended age. The laws may persuade reluctant parents that because vaccination will be required eventually, they might as well agree to vaccination at the recommended time. There are no requirements for adult vaccination in the United States.[‡]

The laws that require vaccination before school entry are congruent with the program operated by the Public Health Service under the provisions of the Public Health Service Act, 42 U.S.C. § 262. If a state or local government participates in a federally funded immunization program it must, among other things, have a "... plan to assure that children begin and complete their

*Whereas courts have upheld the right of individual states to mandate immunization, some states have voluntarily granted individuals exemptions from this requirement based on religious or personal beliefs. Although the court in *Brown v. Stone*, 378 So. 2d 218 (Mississippi, 1979), struck a religious exemption from the state statute on the grounds that it violated the equal protection clause of the Fourteenth Amendment, most courts have recognized the right of the state to allow religious exemptions. Instead, the courts have focused on the scope of the exemption. For example, in *Sherer v. Northport-East Northport Union Free School District*, 672 F. Supp. 81 (E.D.N.Y. 1987), the court held that limiting the religious exemption to "bona fide members of a recognized religious organization" whose doctrines oppose vaccinations violated the establishment clause and free exercise clause of the First Amendment. The court held that a deeply held religious belief in opposition to vaccination, regardless of whether the individual was part of an established religion, should satisfy the exemption. Other litigants have challenged the constitutionality of allowing religious exemptions and not philosophical exemptions. The courts have ruled that the First Amendment does not apply to philosophical exemptions and that there is no Constitutional right to such an exemption. As with religious exemptions, the courts have given the states the discretion to grant philosophical exemptions if they so choose. To date, less than one third of states allow philosophical exemptions. Other instances challenging mandatory vaccination include *Rutland v. Axelrod*, 562 N.Y.S. 2d 605 (1990), in which a New York trial court upheld health department regulations that required, among other things, that hospital employees and medical staff have current rubella immunizations. The lawsuit was filed by a staff doctor who argued that the vaccination requirement was a violation of the Fourth Amendment protection against unreasonable searches and seizures.

†Some states do not require all of the standard pediatric vaccines for school entry. Six states (Idaho, Maine, New York, Oregon, Pennsylvania, and Texas) do not require pertussis vaccine. Requirements for daycare attendees for pertussis vaccine are in place in all states, and there is no exception to the law. Additionally, six others (Alaska, Arkansas, Iowa, South Carolina, Vermont, and West Virginia) do not require mumps vaccination. (United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Immunization Program, State Immunization Requirements 1996-1997 (October 1997)). There is no indication that these vaccines are not widely administered to children even in those states that do not require them for school entry.

‡Vaccinations are required for entry into the military, but the United States no longer mandates any immunization for U.S. citizens who travel abroad. Although there are no federal mandates for adult vaccination, the Occupational Safety and Health Administration regulations require employers to make vaccination available to employees potentially exposed to bloodborne pathogens (e.g., healthcare workers must be offered hepatitis B immunization). An example of a nongovernment-related requirement is immunization for college entry.

immunizations on schedule . . ." and a "... plan to systematically immunize susceptible children at school entry through vigorous enforcement of school immunization laws" (42 C.F.R. § 51b.204).

And in the *Matter of Christine M.*,^{*} the court held that it was child neglect for an otherwise responsible and satisfactory parent to refuse to permit his or her 2-year-old child to be vaccinated for measles during a measles outbreak in New York City. However, the court, pointing out that vaccination would be required when the child entered school in any case and that the measles outbreak had ended by the time of the decision, refrained from ordering immediate vaccination.

NATIONAL CHILDHOOD VACCINE INJURY ACT

The National Childhood Vaccine Injury Act (NCVIA), was enacted in 1986.¹ Pleas to enact a federal statute date from *Reyer v. Wyeth*.[†]

The most dramatic development in the period after the *Reyer v. Wyeth* decision and its progeny was the withdrawal of a number of pharmaceutical houses from the activity of producing vaccines.[‡]

Vaccines were a stable, even declining, product market, with low profit margins even before concerns about product liability arose. For instance, the DTP vaccine was once sold for \$0.10 a dose. With roughly 3 million children born each year in the United States during the early 1980s, even if all children received the recommended five doses, the total annual gross revenue generated by the vaccine at that price would be \$1,500,000. If only a few of those children recovered \$1,000,000, a not unreasonable amount for a young child suffering a lifetime of mental impairment, then the cost of the tort recovery would exceed not the profit, but the total revenue from the product. Considering that gross sales of DTP (not profit) were about \$3 million in 1980 for all manufacturers, it is easy to understand withdrawal from the market in the face of increasing numbers of lawsuits with judgments that sometimes resulted in awards of millions of dollars. The difficulty of the cases was further compounded by the fact that under many state tort laws for children, the statute of limitations does not run out until some prescribed time period after they become adults. Thus, a case could be filed based on a vaccination given years before, with records lost and memories faded.

If the only problem presented by this liability was

*157 Misc. 2d 4, 595 N.Y.S. 2d 606 (Family Court, Kings County 1992).

†At the time of the swine flu program in 1976, the industry asked Congress to pass a statute dealing with the problem for all vaccines, but Congress passed a statute dealing only with the swine flu vaccine. The preamble to the statute stated that it was necessary "... in order to be prepared to meet the potential emergency ... until Congress develops a permanent approach for handling claims arising under programs of the Public Health Service act." That "permanent approach" did not appear for another decade.

‡Information about these developments is presented in *Insulin: Medicine, Vaccine Supply and Innovation*, Washington, DC, National Academy Press, 1985.

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Comments on any of these?

Forward Header

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Dear Federal Panelist:

Thank you for agreeing to participate in ASTHO's annual meeting in Savannah, Georgia. Based on the feedback from the planning teleconference, which only a few of you were able to join, we wanted to provide you some additional information to help you prepare for the Morning With our Federal Colleagues at the ASTHO Annual Meeting next Thursday at 9:00 a.m. Panelists should plan to speak for 10-15 minutes using the guidance in the next

paragraph, but the emphasis this year is to have more time for interactive questions. There will be a break after all presentations are complete and then the panel will resume for an interactive dialogue with participants. ASTHO staff have drafted some questions grouped into categories in paragraph 2. These are ideas of some questions that could come from the audience and/or the moderator. We are aiming for an informative, upbeat, collegial session, and we do not intend to put our guests on the spot.

Since the themes of the meeting are all infrastructure-related (performance measures, workforce development, and information technology), we think there is a lot of opportunity for panelists to highlight the various partnerships and initiatives between federal agencies to explore, define, and assure a more stable public health infrastructure-a high priority for ASTHO. Some examples we hope you all can address include the Investment Analysis Guide; the data sharing agreement between HRSA, CDC, and HCFA; and the workforce development and training collaborations between CDC and HRSA (e.g., Management Academy, etc.). Additional issues we believe our members would be interested in hearing about include:

General:

- * How is your agency building flexibility into its programs to be able to tailor them to individual state situations?
- * How can your agencies work with the states to strengthen the public and environmental health workforce?
- * How are your agencies working together to address the threat of chemical and biological terrorism?
- * What are each of your agencies doing to address racial and ethnic disparities in health? How do we assure coordination with state efforts?
- * What strategies are your agencies using to address behavioral change as it relates to the three major risk factors for disease, disability, and death: nutrition, physical inactivity, and tobacco use.

Managed Care:

- * What is the response of the agencies to the recent HHS Inspector General report finding that collaborations between public health and managed care to address population health issues has "barely begun"?
- * What is the latest on the HRSA - CDC managed care purchasing specifications project?
- * Have the environmental health agencies had any success in engaging managed care agencies to address environmental health issues?

Children's Health:

- * Are there any early trends being identified regarding barriers to

- SENT BY: DMS/HRSA OFC , 5-27-99 , 9:37AM , 3014432605- 92024565557.# 9
- * What are state's options to maximize availability of TANF dollars for CHIP and Medicaid outreach and enrollment? What are the prospects for funding extensions? ✓
 - * What are HCFA's planned strategies to report back to states on CHIP/Medicaid enrollment? ✓
 - * What are the early indications regarding provider capacity to meet increased CHIP demand? How are HRSA and HCFA working with the states to prioritize areas most in need of increased capacity? Wendy
 - * What can public health agencies do to assist with CHIP evaluation efforts? ?
 - * What are HRSA and CDC doing to support the "National Action Agenda" to improve state and local data capacity? ?
 - * What can we do together to address the deficiencies identified in the recent GAO report on childhood lead poisoning screening? Doc. 3

Environmental Health:

- * How will ATSDR's cooperative agreements with the states be affected if Superfund is not reauthorized?
- * How are EPA, ATSDR, CDC and others working together to ensure that the current child health initiative is not duplicative or leaves gaps?

Genetics

- * How is your agency preparing for the genetics advances that are coming out of the Human Genome Project and the impact they will have on public health policy and practice?
- * What partnerships do you think are necessary (for your agency? for state health departments?) to optimally use genetic advances to improve health?
- * How do we ensure that states have the capacity to integrate genetics knowledge across categorical programs?

We recognize that you will not be able to address all of these issues in your allotted presentation time (up to 15 minutes), but hope they provide you some direction in shaping your remarks and preparing you for the Q&A. Any additional questions can be directed to Jackie Bryan, Deputy Director for Policy and Programs (best reached by leaving message at Hyatt Regency in Savannah on Monday--912-238-1234) We look forward to seeing you in Savannah.

Sincerely,

Jim Stratton, Moderator

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Health Care Financing Administration

MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING GUIDE

DRAFT

SEPTEMBER 1999

MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING GUIDE

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MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING GUIDE

I. INTRODUCTION

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.

The purpose of this Medicaid School-Based Administrative Claiming Guide (referred to here as the Guide) is to provide information for schools, State Medicaid Agencies, HCFA staff, and other interested parties on the requirements associated with the claiming of Federal funds under the Medicaid program for the costs of administrative activities performed in the school setting and associated with School-Based Health Services Programs. (For purposes of the Guide, a “School-Based Health Services Program” refers to any type of Medicaid-covered health services provided in a school-based setting.) The Guide is not intended to provide new policy; rather, it is intended to consolidate and clarify existing policy.

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. Each State has 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. 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. Although this guidance document is intended to be comprehensive, in light of the complexity of the issue, it cannot completely reflect all relevant authorities in a particular instance. At this time, there are no plans for regular updates to the Guide to reflect new developments; therefore, HCFA will respond to questions as they arise. HCFA envisions this Guide to 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, in order to avoid potential issues, States= programs for Medicaid administrative claiming for school-based activities must 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.

The development of a school-based Medicaid administrative claiming program involves complex factors and issues related to Medicaid and Education programs, and must account for the interrelationship and coordination of these components in the context of Federal, State, and local concerns. This Guide will list 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." The Guide includes a description of the Departmental Appeals Board (DAB) cases which have relevance to understanding the program and references HCFA policy issuances, such as the Medicaid and School Health: A Technical Assistance Guide, issued in 1997. The Guide is meant to supplement the 1997 technical assistance guide and to be a definitive source of guidance on administrative claiming. The Appendix to the Guide contains citations from source materials on the topics of sampling and backcasting.

This Guide sets forth some procedures to identify costs incurred by a school or school district that are allowable and may be claimed as Medicaid administrative costs. Such procedures must identify school-based activities that could be undertaken as administrative functions by the Medicaid Agency, must determine which of those activities can be attributed to Medicaid-eligible individuals and covered Medicaid services, and must distinguish allowable and unallowable costs for FFP. The Guide discusses a time study mechanism which can be a fundamental part of such procedures and provides examples of time study activity codes.

All activities that the individual performs must be captured in the time study activities for administrative claiming; therefore, the activity codes must include codes for recognizing both allowable and unallowable costs under Medicaid. Since collection of information on the activities of all staff might be a massive undertaking in large school districts, the use of statistically valid samples and sampling methods are permitted. The Guide also discusses identification of costs eligible for enhanced federal matching rates, and cost allocation plans that are required to be approved before an administrative claiming program can operate. Finally, the Guide discusses operational issues such as required interagency agreements, documentation, and the use of consultants.

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: §1903(a)(7) of the Social Security Act (the Act)
- Federal matching rate for administration: §1903(a)(7) of the Act
- Timely filing: §1132 of the Act, Title 45 of the Code of Federal Regulations (CFR) Subpart A §95.1 ff
- Skilled Professional Medical Personnel (SPMP): §1903(a)(2)(A) of the Act, 42 CFR 432.50
- Family Planning: §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
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

45 CFR

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

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). Every entity that is generating administrative claims needs to have an interagency agreement, but not their parent agency. For example, schools and/or school districts need an interagency agreement with the State Medicaid Agency, but not necessarily with the State Department of Education. Each individual school does not need an agreement if their employees are all part of the school district or county, as long as the school district/county itself has an agreement with the Medicaid Agency. These agreements should list the allowable administrative activities for which school districts will be reimbursed and state that all claims will be in accordance with OMB Circular A-87, the State Medicaid Plan and all Federally approved 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 LEAs or schools that receive payments for administrative activities under Medicaid are acting as an agent or contractor for the State Medicaid Agency. While an LEA or school is not required to have a Medicaid provider agreement, in order to perform allowable administrative activities, there must be a formal intergovernmental/interagency agreement approved by HCFA between the LEAs or schools and the Medicaid Agency. The agreement must include:

- ! the mutual objectives and responsibilities of all parties to the agreement;
- ! the activities or services each party offers and in what circumstances;

- ! the specific activity codes (by reference or inclusion) approved by HCFA for which administrative costs will be claimed;
- ! the specific description and methodology (by reference or inclusion) approved by HCFA which will be used to build 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 STUDY ACTIVITY CODES

A. General

In carrying out the full range of their job responsibilities, 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 time study is the primary mechanism which provides the basis for identifying and categorizing the 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.

It is essential to develop the elements of the time study, the activity codes, with recognition and consideration of the actual functions and responsibilities that are 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, which were developed in accordance with these principles; these may be used by States, school districts, and schools as the basis for time studies which would be used to claim administrative costs under the Medicaid program.

B. Operational Principles/Issues

In this context, HCFA considers a principle to be a statement of policy applicable to the administrative claiming aspects of the Medicaid program.

1. Proper and Efficient Administration

In order 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). This basic statutory requirement is found at §1903(a)(7) of the Act and is implemented in Medicaid regulations at 42 CFR 430.1 and 431.15.

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

Under these provisions, costs must be reasonable and necessary for the operation of the governmental unit for the performance of the Federal award. This principle has further been upheld by decisions of the Departmental Appeals Board (DAB). The DAB has established and reinforced the principle that it is the Federal Department of Health and Human Services (that is, HCFA) which determines whether or not the costs for particular activities meet the necessary and reasonableness tests and are related to the proper and efficient operation of the Medicaid State plan.

Although these requirements are applicable for determining the allowability of claims under the Medicaid program, similar principles are applicable for other Federal government programs. Please note that Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services must be offered to a child whether or not it is covered in the State Medicaid plan.

The principle of proper and efficient administration must be applied in developing the time study activity codes. For example, outreach activities would be in support of the Medicaid program if the outreach is in regard to explaining Medicaid requirements. In comparison, outreach with respect to explaining the requirements of Education program requirements would not be in support of the Medicaid program.

2. Claiming for Allowable Activities Only

Medicaid does not pay for administrative expenditures related to, or in support of, non-Medicaid services or for services which are not reimbursed under Medicaid. For example, in assisting a Medicaid eligible child to obtain medical services (which are included in the child’s Individualized Education Plan (IEP)), if the provider furnishing the service is not participating in the State’s Medicaid program, FFP would not be available for such services or for assisting the child in accessing such services. These activities would 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 should not be considered as Medicaid administration. This type of activity is subject to the free care principle, discussed in Section V.,K.

3. Capture 100 Percent of Time

The time study that must be constructed must reflect/measure all, that is, 100 percent of the time and activities performed by employees who participated in the administrative claiming time studies for each program; this is a comprehensive, all-inclusive list of activities performed by the staff who are time studied for that program.

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 work together to determine which of the activities in each program are allowable Medicaid administrative activities. Once these master lists of activities by program are completed, they are distributed to the local jurisdictions.

HCFA and the States determine which activities are allowable Medicaid administrative activities in accordance with the following instructions 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 that a requirement to document costs monthly doesn't mean that time studies are required monthly.

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.

In order to meet the requirement of having 100 percent of the time study participants 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 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 in a way which not only captures 100 percent of the activities performed by the time study participants, as indicated by Principle 3., but which also carefully balances and presents 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, helps to ensure that all the activities are accounted for, and furthermore 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 the 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/Activities

In determining allowable administrative costs under Medicaid, a basic principle is that duplicate payments are **not** allowable. That is, 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.

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

- ! An activity that has already (actually) been, or will be, paid for as medical assistance (or other program services rate) should not be paid again as Medicaid administration.
- ! An activity that has already (actually) been, or will be, paid for as Medicaid administration (or other program administration) should not be paid again as Medicaid administration.
- ! An activity that is included as part of a managed care rate. The activity is best performed by the managed care organization (MCO), not the school.
- ! An activity that is the basic responsibility of another governmental component; for example, the preparation of EPSDT pamphlets may be best (and may already be) performed by the Medicaid Agency. Therefore, it may not be appropriate for the schools to prepare and be reimbursed for developing EPSDT pamphlets. School districts/schools should coordinate and consult with the State Medicaid Agency to determine the appropriate activities related to EPSDT.

Payments for claims for administrative activities and medical assistance services must not duplicate administrative activities and services which are paid for under a capitation rate. This is especially significant in counties that have county-wide Medicaid managed care programs. To ensure that such duplication does not occur, particularly with the expansion of county-wide Medicaid managed care programs, the State may incorporate non-duplication language into existing and future Medicaid managed care agreements. 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. 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; furthermore, there are typically different funding sources and mechanisms related to the 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 must 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 certain Education services or outreach for Education programs. The time study codes must be able to distinguish between each of these activities. Therefore, as indicated in subsection C. below, in this example, 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 Education services under Code 3.

As indicated in Principle 5. above, 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 that 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 as defined below.

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 services, and be necessary for the “proper and efficient administration of the State plan.”

Some examples of administrative case management services specifically 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 and whether or not they are necessary for the administration of the State plan. More specific examples of these types of activities as performed in a school-based setting may be found in the approved 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).

7. Discount (Medicaid Percentage/Rate)/Non-Discount

Since many school-based medical activities are provided to both Medicaid and non-Medicaid students, the costs applicable to these activities must be allocated to both groups. This allocation is known as “discounting” and involves the reduction of the total costs applicable to a specific activity by the percentage of non-Medicaid students in a particular school or school district. The discount rate should be developed on the same basis as 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. The discount rate and the claim **must** be developed on the same basis.

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 be determined to be either: (1) **Unallowable** - the activity is unallowable as administration under the Medicaid

program, (2) **Non discountable** - the activity is solely attributable to the Medicaid program and as such is not subject to discounting, (3) **Discountable** - the activity is allowable as administration under the Medicaid program, but is discounted by the Medicaid percentage 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 discount 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 becomes 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 discountable time codes to determine the costs applicable to Medicaid administrative activities. Please 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.

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

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 the discounting exercise is to determine the reduction necessary to account for the fact that a specific activity is provided to both Medicaid and non-Medicaid students. The following example establishes how much of the costs related to the activity should be claimed to Medicaid. The amount of Federal reimbursement is then determined based on the resulting amount.

EXAMPLE OF DISCOUNTING

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 (Discounted Code/50 Percent Federal Financial Participation)

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

Gross Claimable Amount	\$1,500
Discount Rate	X .20
	\$300
FFP Rate	.50
Net Claimable Amount	\$150

8. 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: §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 have professional education and training in the field of medical care or appropriate medical practice.
- (III). The SPMP are in positions that have duties and responsibilities that require those professional medical knowledge and skills.

- (IV). A State documented employer-employee relationship exists between the Medicaid Agency and the 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 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. Note, State qualification requirements for SPMPs can differ (be more stringent than) from the qualification requirements for participating as a Medicaid provider; this may be the case in the school setting. 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 different (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 that are applied to determine whether school staff qualify as SPMPs. 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. The next step is to determine whether an individual meets the SPMP criteria for “professional education and training.” This can be demonstrated by checking to see if 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 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. The DAB has ruled in numerous cases that 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 what activity was completed, who provided the activity, the date, length of time, purpose. 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.

While the codes listed in this Guide are not all inclusive, 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 administering 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. below, “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 below, “Direct Medical Services.”

A family planning health education outreach program or campaign may be allowable as a Medicaid administrative cost, if it is targeted specifically at family planning Medicaid services covered in the State and offered to Medicaid eligible individuals. If such a program is structured as a stand-alone program dealing only with Medicaid family planning services covered in the State for Medicaid eligibles, then it would be allowable. However, if such a program is structured to be included as part of a broader general health education program, the Medicaid-only portion is allowable if the cost of the Medicaid-only portion is adequately documented and the Medicaid percentage is discounted to account for the fact that such programs target broader populations of potential eligibles and potential non-eligibles. The burden is on the State to document the Medicaid portion of any imbedded program and HCFA would normally approve any reasonable method for documenting this.

Also, if the State has any managed care systems in place, the State is responsible for ensuring that the activities provided through this program do not duplicate the requirements on managed care providers to do such activities and which are already paid for through the capitation rates.

9. Provider Participation in the Medicaid Program

Any local education administration (LEA) or school which receives payments for administrative activities under Medicaid is acting as an agent or contractor for the State Medicaid Agency. While an LEA or school is not required to have a Medicaid provider agreement in order to perform allowable administrative activities, there must be a formal intergovernmental/interagency agreement between the LEAs or schools and the Medicaid Agency which must specify:

- ! the mutual objectives and responsibilities of all parties to the agreement;
- ! the activities or services each party offers and in what circumstances;
- ! 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.

However, with respect to certain administrative activities, the availability of Federal matching is determined by whether the administrative activities support medical services which 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 furnishing the medical services must be a participating provider in the Medicaid program with a provider agreement and a Medicaid provider identification number

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. If the provider is not participating in the Medicaid program (that is, there is no provider agreement), 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.

10. 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.

Please note there are various education-related statutes that obligate schools to furnish or make payment for services provided in the school setting for which Medicaid payment is not available. However, there is an exception set forth in Section 1903(c) of the Social Security Act. This exception references only Parts B and H 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 a local education agency (LEA), in order to determine whether a child is a child with a disability, and to determine the educational needs of the child. A reevaluation 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

11. Review and Approval of Programs/Codes by HCFA

Federal regulations (42 CFR 433.34) require that under the Medicaid State plan, the single or appropriate State agency has an approved cost allocation plan (CAP) on file with the Federal Department of Health and Human Services (DHHS) that meets certain regulatory requirements (Subpart E of 45 CFR part 95). The OMB Circular A-87 contains additional CAP requirements applicable to governmental units that receive Federal grants. OMB Circular A-87 (item 1 in the Definition section of Section B, Attachment A) indicates:

“Approval or authorization of the awarding or cognizant Federal agency” means documentation evidencing consent **prior to** incurring a specific cost. If such costs are specifically identified in a Federal award document, approval of the document constitutes approval of the costs. If the costs are covered by a State/local-wide cost allocation plan or an indirect cost proposal, approval of the plan constitutes the approval. (Emphasis added).

Furthermore, there are certain items that must be in the CAP which a State Medicaid Agency must submit to HCFA **before** providing reimbursement to school districts for administrative claiming, if it chooses to use schools to provide such services. These items are discussed in

Section V., Claiming Issues of this Guide. Depending on the nature of the time study methodology, a State's CAP may have to be amended. States should consult with the HCFA Regional Office and the Division of Cost Allocation (DCA) in DHHS.

C. Activities/Codes (Descriptions/Discussions and Examples)

1. Introduction

When staff spend time on 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 who spend time performing Medicaid functions must be conducted. The purpose of the time study is to identify the time and costs spent on Medicaid administrative activities that are allowable and reimbursable under the Medicaid program.

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 Medicaid discount status of the Code. This listing of activity codes should be modified when activities listed here 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 Percentage

- | | |
|----|--|
| ND | Refers to an activity which is 100 percent allowable as administration |
|----|--|

under the Medicaid program.

- D Refers to an activity which is allowable as administration under the Medicaid program, but which is Discounted, generally, by the percentage of Medicaid eligible students to total students.

Reallocated Activities

- R Refers to an activity which is reallocated across other codes based on the percentage of time spent on allowable/unallowable administrative activities.

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

- CODE 1.a. Non-Medicaid Outreach - U
- CODE 1.b. Medicaid Outreach - ND/50 Percent FFP
- CODE 2.a. Facilitating Application for Non-Medicaid Programs - U
- CODE 2.b. Facilitating Medicaid Eligibility Determination-ND/ 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 - D/50 Percent FFP
- CODE 6.a. Non-Medicaid Translation - U
- CODE 6.b. Translation Related to Medicaid Services - D/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 - D/50 Percent FFP
- CODE 8.a. Non-Medicaid Training - U
- CODE 8.b. Medicaid Specific Training - D/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 - D/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 - ND/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.
- ! 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.,K.)
- ! 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 - ND/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 individual 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 client 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.

- ! Providing health/mental health services contained in an IEP.
- ! Assessment and evaluation as part of the development of an IEP.
- ! Conducting 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. (This type of activity is subject to the free care principle, discussed in Section V.,K.)
- ! 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 - D/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. Please 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 - D/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
- D/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 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 - D/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. Please 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 - D/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. Please 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 when staff are performing activities for the administration of the local education agency. Include related paperwork, clerical activities, or staff travel required to perform these activities. Please note that certain administrative activities, such as payroll, maintaining inventories, developing budgets, etc., may be conducted by a large number of school personnel, many of whom would not be included in a time study, and if they were their time would be related to unallowable activities. Therefore, using the method of allocation outlined in this Guide, no costs are allocated to these personnel.

Below are typical examples of administration, 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.

- ! Processing payroll/personnel-related documents.
- ! Maintaining inventories and ordering supplies.
- ! Developing budgets and maintaining records.
- ! 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 activities of a similar nature as listed above.

V. CLAIMING ISSUES

This section of the Guide discusses issues related to the actual submittal of a claim for administrative activities. States may realize after reading this Guide that some of what they are or have been claiming as administrative costs is unallowable or may need to be reclassified. In those cases HCFA will work with the State(s) to develop acceptable administrative claiming procedures.

A. Documentation

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 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.

In addition to the above requirements pertaining to documentation, there are numerous Departmental Appeal Board (DAB) decisions which involve the issue of documentation requirements. Some of those decisions are summarized as follows:

- DAB Decision 1468 concerned the documenting of salaries and wages including personnel activity reports;
- DAB Decision 1384 stated that accounting records shall be supported by source documentation such as canceled checks, paid bills, payrolls, contract and subgrant award documents;
- DAB Decision 1355 involved foster care payments and administrative costs and the documentation required;
- DAB Decision 1304 maintained that case management services based on time studies was an acceptable form of documentation for a given period;
- DAB Decision 1134 said that the use of statistical sampling procedures by the State was not (by itself) a sound basis for a disallowance by HCFA, and the case was remanded back to HCFA to determine whether the State was in compliance with documentation requirements in general;
- DAB Decision 1009 indicated that certain costs were not verified as being incurred in the particular Federal program and 45 CFR Part 74 was cited;
- DAB Decision 899 involved undocumented personnel costs; and
- DAB Decision 861 concerned inadequate documentation for labor costs.

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 (time studies) may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort. 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 funding sources 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 cost pool.

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.

Costs claimed 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. 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.. 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.” In at least one State, costs were less when the RMS methodology was used than when an alternative sample methodology was used.

3. Time Study Documentation

As with all administrative costs that are related to time study activities, the State must document the costs it wants to claim for reimbursement. Documentation to be retained for the sample must include the following: the sample universe determination, sample selection, sample results, sampling forms, cost pool data for each school district, and summary sheets showing how each school district=s claim was compiled. All claims 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. Backcasting

1. Discussion

"Backcasting" is a methodology under which a Medicaid Agency claims Federal matching funds for the costs of Medicaid related administrative activities performed by school districts for past periods supported on the basis of current period sampling. There is a substantial body of documentation about backcasting in various DAB Decisions. The Board, in suggesting that backcasting may be permissible under certain limited conditions, has stressed that in order for backcasting to be used, it is absolutely essential that the proponent of such a technique show that there are no material differences between the sample and the unsampled periods.

In DAB No. 1021 (February 1989) the Board summarized its position with the statement: "The Board=s position may therefore be stated as permitting sample results from one period to be used to support claims from other periods provided that it can be shown that there are no significant differences between the periods. The party asserting the use of data for unsampled periods has the burden of showing that circumstances relating to the sampled and unsampled periods are constant. HCFA is not prepared to state what degree of similarity in circumstances is necessary to support the retroactive application of sampling results; each case must be judged by its particular circumstances. The uncontested soundness of the data provided during the sample period is not sufficient in itself to justify expenditures made in earlier periods; the conditions surrounding the expenditures must approach those in the sampled period."

In DAB No. 1483 (1994) Board states: "The Board has long held that, while sampling in its purest form envisions samples from the same period in question, common sense would dictate that samples from another period may be used if it can be established that no substantial change has occurred so as to invalidate the procedure. See Ohio Dept. of Human Services, DAB No. 900 (1987). The Board has also held that the party asserting the use of data for unsampled periods has the burden of showing that circumstances relating to the sampled and unsampled periods are such that the data can be used for the unsampled period. See Missouri Dept. of Social Services, DAB No. 1021 (1989)."

The following sections are taken from DAB 1606, December 18, 1996. The topic at issue was Medicaid systems costs for the State of California, but the same time/cost allocation principles are applicable.

It is a fundamental principle that a State has the initial burden to document its costs and to show that its claim for reimbursement is proper, especially showing that its claim qualifies for an enhanced funding rate and meets any special conditions for that rate. See California Dept. Of Health Services, DAB No. 1539, at 7-8 (1995); New York Dept. Of Social Services, DAB No. 204 (1981) (page 7).

California also asked us to find that it was unreasonable for HCFA to disallow all the enhanced funding California claimed "when a time study conducted in the present can easily be applied to the retroactive period of the disallowance...." In asserting this equitable argument California claimed that the current functions of the PRG units are substantially similar to the functions performed in the disallowance period.... California requested that we remand this matter back to HCFA to work with California to refine a methodology to develop a matching rate for prospective use. California asserted that the methodology could be adapted so that it could be applied retroactively to the period of the disallowance, a practice referred to as backcasting, based on California=s premise that there were no significant differences in the activities performed by the EDS staff to be surveyed

in the present period and those activities performed in the retroactive period....

There are several flaws in California=s argument. First, California=s argument asks us to overlook its failures to allocate its PRG contract costs in accord with applicable regulations and guidelines and to meet its burden of documentation. There is no basis for doing so especially since California has been in similar circumstances before....(pages 8-9)

California did not show that the circumstances under which the Board previously suggested that "backcasting" might be permissible exist here. One of the conditions for using such results is where the sample period is contiguous in time to the claim period. See Missouri Dept. of Social Services, DAB No. 1021 (1989); California Dept. Of Health Services, DAB No. 666 (1985). In this instance, California seeks to apply the results of a proposed time study methodology to be performed in the near future to a non-contiguous time period (July 1, 1991 through June 30, 1992). Moreover, the Board has stated that backcasting would be appropriate only if it can be established that circumstances in the sampled period are not substantially different from those in the retroactive claim period. Id. HCFA asserted that the fact that California proposed to adapt its prospective methodology to account for organizational changes indicates that there are differences between the two time periods. While California asserted that the changes were not substantial, the record shows that whole units have been moved out of the PRG and into other organizational components since the time period in question. State Brief at 19; State Ex. C. California nevertheless argued that the configuration of the PRG invoice which was the basis for the 1991-92 claim in question here could be easily "replicated," "simulated," or "reconstructed," as the same units performing the same functions exist today in the EDS. State Brief at 19; State Reply at 11; and Tr. at 32 and 37. (page 10)

2. Summary

In order for "backcasting" to take place the following factors and conditions must be met:

- 1) A statistically valid time study for the sampled period;
- 2) An unsampled period (the target of the backcasting technique) that is immediately adjacent to the sampled period, i.e., contiguous time periods; and
- 3) The "backcasting" methodology must show that the circumstances relating to the sampled and unsampled periods are constant. For example:

- The organizational structure in the unsampled period must be substantially the same as in the sampled period so as not to invalidate the procedure. This may be documented by verifiable parallel organization charts for the sampled period and the full duration of the unsampled prior period.
- The position descriptions, duties, and activities of the personnel in the sampled period and the unsampled period must be substantially the same. This may be documented by position descriptions or other documents describing the activities of personnel during the sample period and the prior unsampled period.
- All circumstances, including the Medicaid discount percentage, relating to the sampled and unsampled periods are essentially constant, i.e., the sample period must be shown to be representative for the unsampled period. Documentation to support this representation should be submitted. If the unsampled period is subject to seasonal or other periodic fluctuations within its duration, the sample period must be in sufficient scope/duration to reflect these same fluctuations.

D. Offset of Revenues

The cost pool, which is the base for allocation, must be offset by certain revenues in order to reduce the total amount of costs in which the Federal government will participate. The following include some of the revenue offset categories which must be applied in developing the net cost pool:

- ! All Federal funds, along with maintenance of effort and other State/local matching funds required by the Federal grant
- ! All State General Fund monies which have been previously matched by the Federal government (includes Medicaid funds for medical assistance (e.g., fee-for-service funds).
- ! State General funds specifically targeted or earmarked to the delivery of services may not be used to draw down Federal match for administrative activities; these funds must be offset.
- ! Insurance and other fees collected from non-governmental sources must be offset.
- ! A program may not draw down 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.

E. 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. All administrative costs (direct and indirect) are normally charged to Federal awards by implementing the public assistance cost allocation plan. 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 cost allocation plans. The provisions of Attachment D summarize the provisions of Subpart E.

For Medicaid, a cost allocation plan must be filed with and approved by the Division of Cost Allocation (DCA) within DHHS before FFP is available for administrative claims.

The State Agency should send to HCFA an outline of its proposed reimbursement plan and allowable reimbursable cost centers before submitting claims. The plan and cost centers must be related to the authorized activities delegated to the schools. The plan will need to describe the carve out of general and administrative costs included in the indirect cost rate claimed for reimbursement by the school district under its educational cost allocation plan (filed and approved by the U.S. Department of Education) and those costs that are identifiable in the provision of direct medical services. This will assure that costs are not duplicated in the claiming of administrative costs. The plan should describe any restrictions that may be placed on the school districts such as caps on cost categories or class ceilings, if applicable. This plan should also include a description of costs which are considered unallowable.

The plan 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 agency. Cost allocation plans distinguish between direct and indirect costs, and must abide by the cost allocation principles described in OMB Circular A-87 which requires that costs be "necessary and reasonable" and "allocable" to the Medicaid program.

States often negotiate contracts with local school districts, or the State's DOE for the provision of Medicaid administrative services prior to submitting a formal plan to HCFA. However, administrative claims reimbursement is subject only to the terms negotiated in the final approved submission by the State Medicaid Agency.

F. Administrative Claiming Implementation Plan

To ensure the successful implementation of a State Medicaid program to pay for Medicaid-related administrative claiming activities in schools, the Medicaid Agency must formally submit an "implementation plan" which provides a comprehensive description of the mechanism and process for claiming administrative costs under Medicaid. The plan must be reviewed and approved by HCFA before FFP will be available.

The following elements are required in an implementation plan for administrative claiming:

- ! **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 agreements should list the allowable administrative activities for which school districts will be reimbursed and state that all claims will be in accordance with A-87, the State Medicaid Plan and all Federally approved cost allocation plans. The requirements for interagency agreements are discussed more fully 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.

- ! **Administrative Cost Reimbursement Plan and Reimbursable Cost Centers.** The State Agency should send an outline of its proposed reimbursement plan and allowable reimbursable cost centers. The plan and cost centers must be related to the authorized activities delegated to the schools. The plan will need to describe the carve out of general and administrative costs included in the indirect cost rate claimed for reimbursement by the school district under its educational cost allocation plan (filed and approved by the U.S. Department of Education) and those costs that are identifiable in the provision of direct medical services. This will assure that costs are not duplicated in the claiming of administrative costs. The plan should describe any restrictions that may be placed on the school districts such as caps on cost categories or class ceilings, if applicable. This plan should also include a description of costs which are considered unallowable.

- ! **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 must be filed with and approved by HCFA before FFP is available for administrative claims.
- ! **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).

G. 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;"

EXAMPLE:

DAB Decision 1129- Demonstration project for a New York County - The administrative costs at issue were first incurred by a separate corporation set up to run a demonstration project. The county paid the contractor and then submitted the voucher to the State. The State paid the county and submitted the claim to HCFA more than two years after the county paid the contractor. The State argued that the clock should start two years from the time it paid the county, not when the county paid the contractor.

The DAB upheld the disallowance because it agreed that the regulation and the State Medicaid Manual provide that expenditures for administration are incurred in the quarter in which payment was made by a State agency to a private agency or individual (unlike expenditures for medical services which are made in the quarter in which any State agency made a payment to a service provider). The county is considered a "State agency" as far as the language of the timely claims filing regulation is concerned. A school is considered a local organization which incurs matchable expenses under 45 CFR 95.4.

H. 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.

I. 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, §1128(b) of the Act.

J. 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).

K. 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 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 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.

L. 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.

Sarah
Shuptrine
& Associates

9/16/99

Chris -

HCFA and ACF have worked on a joint letter re the paternity issue, but it's stuck in the approval process. It will help clarify that children are not to be denied due to lack of cooperation by an adult. Can you prode it along ?!

Thanks
Paul

620 Sims Avenue • P.O. Box 5345 • Columbia, SC 29250 • (803) 779-2607

S O U T H C A R O L I N A

Children's Hospital Collaborative

The Children's Hospital Of Greenville Hospital System • McLeod Children's Hospital
Children's Hospital Of Palmetto Richland Memorial Hospital • Children's Hospital Of Medical University Of South Carolina

To: Interested Parties

From: Charles P. Darby, MD, Medical University of South Carolina
Tom Hartley, RN, MS, McLeod Regional Medical Center
Helen Lynch, RN, Palmetto Richland Memorial Hospital
William F. Schmidt, MD, PhD, Greenville Hospital System

Re: *Status Report: South Carolina Medicaid Eligibility Study*

Date: September 13, 1999

The *South Carolina Medicaid Eligibility Study* was published in December 1998 and it included specific recommendations for removing eligibility barriers to child health coverage. The report contained eight state recommendations, two federal recommendations and four recommendations for children's hospitals.

The enclosed *Status Report: South Carolina Medicaid Eligibility Study* outlines actions taken to facilitate children's enrollment in Medicaid and to reduce inappropriate closures of children's cases. It also indicates where actions are pending. Limited additional copies of the Status Report and copies of the December 1998 report can be obtained by contacting Lynn Gregory at 803/779-2607.

The South Carolina Children's Hospital Collaborative is pleased to have sponsored this project and appreciates the support provided by The Duke Endowment for the data component of the project. The cooperation extended by the South Carolina Governor's Office, state agencies, county agencies and federal agencies is also greatly appreciated.

Attachment

S O U T H C A R O L I N A

Children's Hospital Collaborative

STATUS REPORT

South Carolina Medicaid Eligibility Study

The Children's Hospital
of Greenville Hospital
System

* * *

McLeod Children's
Hospital

* * *

Children's Hospital of
Medical University of
South Carolina

* * *

Children's Hospital of
Palmetto Richland
Memorial Hospital

August 1999

STATUS REPORT

South Carolina Medicaid Eligibility Study

**Prepared for
South Carolina Children's Hospital Collaborative**

The Children's Hospital of Greenville Hospital System
McLeod Children's Hospital
Children's Hospital of Medical University of South Carolina
Children's Hospital of Palmetto Richland Memorial Hospital

**By
Sarah Shuptrine and Associates
620 Sims Avenue
Columbia, SC 29205**

August 1999

SOUTH CAROLINA CHILDREN'S HOSPITAL COLLABORATIVE
--

The South Carolina Children's Hospital Collaborative (SCCHC) was established in 1994 to enable the children's hospitals to work individually and collectively with local and state governments to improve the health status of children. The member hospitals and their representatives on the SCCHC Steering Committee are:

The Children's Hospital of
Greenville Hospital System

William F. Schmidt, M.D.

McLeod Children's Hospital

Tom Hartley

Children's Hospital of
Medical University of South Carolina

Charles P. Darby, M.D.

Children's Hospital of
Palmetto Richland Memorial Hospital

Helen Lynch, Chairman

An Advisory Council was established to assist the South Carolina Children's Hospital Collaborative in the collection and development of information on relevant issues. The Advisory Council is composed of representatives of state agencies responsible for planning, financing and delivering services to children, private health providers and advocacy groups.

Since its inception, the South Carolina Children's Hospital Collaborative has been instrumental at the state and federal levels in identifying and promoting public policy actions needed to improve children's access to preventive and primary health care. Staffing for the South Carolina Children's Hospital Collaborative has been provided by Sarah Shuptrine and Associates.

ACKNOWLEDGMENTS

The South Carolina Children's Hospital Collaborative would like to express appreciation to the South Carolina Office of the Governor, the South Carolina Department of Health and Human Services, the South Carolina Department of Social Services, and the South Carolina Department of Education for the cooperation and assistance displayed during the preparation of this status report on the recommendations contained in the *South Carolina Medicaid Eligibility Study*.

Appreciation is also extended to the Health Care Financing Administration and the Administration for Children and Families for their cooperation in the ongoing examination of the federal issues outlined in the *South Carolina Medicaid Eligibility Study*.

The South Carolina Children's Hospital Collaborative would also like to recognize the contribution made by The Duke Endowment to the data analysis component of the *South Carolina Medicaid Eligibility Study*.

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STATUS REPORT

South Carolina Medicaid Eligibility Study

BACKGROUND

In August 1997, the South Carolina Partners for Healthy Children initiative was established with the goal of making Medicaid coverage available to an additional 75,000 uninsured children in South Carolina. Partners for Healthy Children is the state's first phase of the new federal State Children's Health Insurance Program (SCHIP). It is noteworthy that South Carolina had already committed to helping low-income working families obtain health coverage for their children prior to passage of SCHIP. The additional federal matching funds made available by SCHIP allowed the state to extend Medicaid beyond its original plan. The South Carolina Children's Hospital Collaborative was one of the public/private sector partners that supported this child health coverage initiative.

Partners for Healthy Children raised the Medicaid income eligibility level for children ages one through 18 to 150% of the federal poverty level. The initiative significantly addressed, but did not eliminate, a previous inequity whereby children in the same family were eligible at different age and income levels. Today, the remaining income eligibility difference across children's age groups in South Carolina is for infants to age one, where the eligibility level is higher. The table below displays the South Carolina Medicaid eligibility levels for children by age group for a family of three.

SOUTH CAROLINA POVERTY RELATED MEDICAID ELIGIBILITY LEVELS FOR CHILDREN, 1999		
Age Group	Percentage of 1999 Federal Poverty Level	Annual Income (Family of Three)
Birth to Age 1	185%	\$25,678
Ages 1 – 18	150%	\$20,820
Source: South Carolina Children's Hospital Collaborative, 1999.		

South Carolina's experience with previous health coverage expansions had underscored the need to take a studious approach to the removal of barriers that could thwart the intent of Partners for Healthy Children. To identify additional actions needed to assure that eligible children will become enrolled and will be more likely to maintain coverage, the South Carolina Children's Hospital Collaborative, in cooperation with the South Carolina Department of Health and Human Services (DHHS) and the South Carolina Department of Social Services (DSS), initiated an assessment of the Medicaid application and closure process. Financial support for the assessment, referred to as the South Carolina Medicaid Eligibility Study, was provided by the member hospitals of the South Carolina Children's Hospital Collaborative and The Duke Endowment. The assessment was initiated in January 1998.

The South Carolina Medicaid Eligibility Study was published in December 1998 and provides information on the study process, site visits and data analysis findings.¹ It noted actions taken by South Carolina before the study and actions taken to resolve issues identified during the study. The report also set forth recommendations for additional actions needed at the state and federal levels.

STATUS OF ACTION ON RECOMMENDATIONS

The South Carolina Medicaid eligibility process has periodically been independently examined with the goal of removing eligibility barriers that impede access to health care. The state is to be commended for its willingness to participate in examining its policies and systems in order to improve the Medicaid eligibility process and thereby make health coverage more accessible. Previous assessments have been sponsored by the state's hospitals and The Duke Endowment and have included pregnant women as well as children.

The site visits and eligibility data analysis conducted as part of the South Carolina Medicaid Eligibility Study were highly useful in identifying additional actions needed to improve access to health coverage for children in low-income families in South Carolina. The assessment identified eight state issues, two federal issues and four children's hospital issues.

On publication of the South Carolina Medicaid Eligibility Study, the South Carolina Children's Hospital Collaborative initiated follow-up activities designed to bring about actions to address the recommendations. The South Carolina Governor's Office, the South Carolina Department of Health and Human Services, the South Carolina Department of Social Services and the South Carolina Department of Education participated in addressing the recommendations. Additionally, meetings were held at the federal level to address the eligibility barriers that require federal attention. While there is still work to be done, the accomplishments of this collaborative effort are testimony to the results that can be achieved through a public/private sector eligibility initiative that is well informed and focused on helping eligible low-income children gain access to health coverage.

The identified issues, the recommendations and the status of implementation are summarized below. A full discussion of the issues, data analyses and recommended actions is contained in the South Carolina Medicaid Eligibility Study.

¹ Sarah C. Shuptrine, Genny G. McKenzie, South Carolina Medicaid Eligibility Study (Columbia, SC: South Carolina Children's Hospital Collaborative, December 1998). Also available at www.coveringkids.org/MedicaidEligStud.html on the Simplification page.

South Carolina Medicaid Eligibility Study Status of Recommendations

August 1999

STATE ISSUES

Issues	Recommendations	Status of Follow-Up Actions
1. Policies and procedures have not been implemented to assure that all efforts are made to avoid inappropriate closures of children's Medicaid cases.	a) DHHS and DSS should identify and implement actions to assure that all efforts are made to avoid inappropriate closures of children's Medicaid cases. Efforts should be directed toward reducing instances in which families must reapply for child health coverage when it is highly likely that the children would be eligible under a different Medicaid category.	<u>DHHS</u> In 3/99, a workgroup of both DSS and DHHS representatives was formed to address the issue of deemed infants' case closures after one year of eligibility. The workgroup recommends removal of the automated closure at one year. Instead, deemed infants will appear on a partial review list. Proposed procedures follow: Upon a receipt of a DSS 1716, DSS determines if there is an active Partners for Healthy Children (PHC) case in the household to which the infant can be added. If yes, the infant is added to the active case. If no, the infant is deemed. • When the deemed infant is four months old, an automated letter is sent advising that the child is eligible for one year and requesting the child's SSN. • At nine months, an application is sent to apply for coverage beyond the child's first year. • If an application is not received by DSS by the 11th month for those infants on the partial review listing, caseworker must attempt to contact. Case is closed if there is no response or a request for closure is received. • Unless DSS is specifically notified that the client does not want continued Medicaid for the child, the case is referred to DHEC for outreach after case closure. Monitoring of three (3) reports will provide information on effectiveness of both DSS and DHEC outreach efforts. 1) The existing partial review listing generated from CIS shows children turning one.

Issues	Recommendations	Status of Follow-Up Actions
	b) DHHS and DSS should remove the computer command that closes infant cases at age one and should require caseworkers to make every effort to determine whether the infant can be transferred to another Medicaid category.	2) A listing of closed cases at 12 months will be generated and sent to DHEC. 3) DHHS produces a report which shows children who regain Medicaid eligibility within a year of closure. Comparing Report 1 to Report 2 will show the results of DSS outreach prior to closure. Comparison of Report 2 to Report 3 will show results of DHEC outreach efforts. The joint workgroup may meet at a later date to determine how successful outreach efforts have been based on the data from these three (3) reports. The forms necessary to accomplish the above procedures have been designed and forwarded to DSS for review. It has been confirmed that CIS can accommodate the necessary changes. <u>DSS</u> A committee composed of staff from DHHS and DSS is currently working on actions to avoid inappropriate closures and continue eligibility of children's cases. We have reinforced caseworker referrals to other Medicaid categories, especially to Partners for Healthy Children. Estimated date of completion is December 1, 1999. <u>DHHS</u> Refer to 1a. <u>DSS</u> The above joint committee is developing and proposing system changes to remove computer commands that perform automatic closures of children's cases at age one. Caseworkers are required by policy to make every effort to determine whether the infant can be transferred to other Medicaid categories. We are reinforcing this policy in our training efforts. Estimated completion date is October 1, 1999.

Issues	Recommendations	Status of Follow-Up Actions
	c) DHHS should incorporate an automated system to search all possible eligibility categories for child health coverage in the development of the new Medicaid computer system. d) DHHS and DSS should work with families and community organizations to develop more effective strategies to prevent the closure of children's Medicaid cases due to an inability to obtain a response from families. This effort should include improving both the message and the presentation of Medicaid closure notices so as to reduce the chance that families will not respond because they do not understand what is required to continue Medicaid for their children.	<u>DHHS</u> With MEDS implementation, there will be an automated system to search all possible eligibility categories for children's coverage. <u>DSS</u> DHHS is giving this recommendation appropriate consideration in developing the new Medicaid computer system. Efforts are being studied to determine if the system will have the capability to search for all possible children's health coverage categories before a case closure is effected. The MEDS project is estimated to be completed by January 2002. <u>DHHS</u> Refer to 1a. <u>DSS</u> The joint committee is developing strategies to work with families and community organizations to prevent closure of cases due to an inability to obtain a response from families. The newly expanded outreach efforts by DHEC nurses provide an opportunity to expand efforts. The committee is also developing improved letters and communications to families to ensure all efforts have been made to contact parents who do not follow-up or provide necessary information to make an eligibility determination. Estimated completion date is October 1, 1999. Additionally, FI case managers have begun to include the confirmation of continued Medicaid coverage in their 60/90 day assessments visits for family units losing FI eligibility due to the expiration of the time limits.
2. Section 1931 Medicaid coverage for poor families had not been implemented in South	a) South Carolina should move expeditiously to implement Section 1931 so that poor families are informed of this new opportunity to obtain family Medicaid coverage without having to be on welfare.	<u>DHHS</u> Low Income Family Coverage, Medicaid category 59, was implemented in South Carolina effective September 1998.

Issues	Recommendations	Status of Follow-Up Actions
Carolina at the time of the site visits.	b) Aggressive efforts should be undertaken to inform community organizations that work with welfare families and other low income families about family Medicaid coverage through Section 1931.	<u>DSS</u> Section 1931 Medicaid coverage was implemented effective September 1, 1998. <u>DHHS</u> As specified in the DHEC contract, DHEC does outreach for all Medicaid coverage groups. <u>DSS</u> Community organizations that work with welfare families and other low-income families are being informed about Family Medicaid coverage through Section 1931 by county staff in their speaking engagements and community networking efforts. Additionally, the state office FI Community Coordinator has included the discussion and dissemination of Medicaid pamphlets to community groups. We are currently exploring the possibility of a Medicaid web site in conjunction with the agency's web site to include information about Medicaid categories and eligibility. Projected completion date is December 31, 1999.
3. There is no procedure in place to assure that Medicaid applications are taken on children and families denied by the Family Independence welfare program.	a) DSS should take and process an application for child Medicaid coverage while the family's application for Family Independence is being processed. Such action will assure that children are provided Medicaid coverage at the earliest possible time and that they are enrolled in a program that has the most liberal eligibility criteria so as to reduce the chances of coverage disruption due to category changes. b) To assure that opportunities for health coverage are not missed, DSS should design and implement an automatic Section 1931 Medicaid referral process for	<u>DHHS</u> A referral process is in place in each county. Appropriate referrals to Medicaid are monitored during county technical assistance visits. <u>DSS</u> This recommendation was previously studied and because of conflicting and complex procedures regarding dual applications, it was decided the caseworkers would give Partners for Healthy Children applications to FI applicants. Further study is being done on procedures to accommodate this recommendation. Projected completion by October 1, 1999. <u>DHHS</u> Family Independence case managers currently include the confirmation of continued Medicaid coverage in their 60/90

Issues	Recommendations	Status of Follow-Up Actions
	families denied by Family Independence. Family Independence denial notices should advise families that, although they were denied welfare benefits, their applications have been referred to Medicaid for an eligibility determination, and notices should give a number to obtain information on their Medicaid applications.	day assessment visits for family units losing FI eligibility due to the expiration of the time limits. A joint committee is developing policy and procedures for a Section 1931 Medicaid referral process for families denied for Family Independence (FI). FI and Medicaid denial notices are being examined to ensure client understanding and readability. Also, referrals between the two programs are being examined to enhance clients' success in applying for services. Estimated completion date is December 1, 1999. <u>DSS</u> The joint committee is developing policy and procedures for a Section 1931 Medicaid referral process for families denied by FI. FI and Medicaid closure denial notices are being examined to ensure client understanding and readability. Also, referrals between the two programs are being examined to enhance clients' success in applying for services. Estimated completion date is December 1, 1999.
4. Although DHHS and DSS have enacted policies to make the eligibility process less burdensome for families, some local eligibility workers routinely ask all applicants to provide birth and citizenship verification even though it is no longer required.	a) DHHS and DSS should clarify state policy allowing self declaration of a child's age. DSS should communicate to county eligibility offices that information should be obtained from Vital Statistics when age verification is deemed necessary for children born in South Carolina.	<u>DHHS</u> For medical assistance only applicants, age verification is required only when the declaration is questionable. Conformance with policies and procedures is routinely monitored. <u>DSS</u> Our current policy regarding self declaration of child's age has been reinforced with county eligibility staff. We re-emphasize that for medical assistance only applicants, age verification is required only when the declaration is questionable (Section 2.06.01A). Conformance with agency policies and procedures is being routinely monitored. In the FI Program, birth certificates are used to establish that the caretaker relative meets the specified relative requirement. Use of vital statistics as a verification source is still being used when appropriate.

Issues	Recommendations	Status of Follow-Up Actions
	b) DSS should communicate to county eligibility offices that only the signature on the application is required to attest to citizenship.	<u>DHHS</u> All application forms routinely used in the eligibility determination of children allow self declaration of citizenship status. Policy has been clarified in the new Medicaid Eligibility Manual. DSS has communicated this clarification to county offices in regional training and during program specialists' county visits. <u>DSS</u> Currently, policy regarding signatures for citizenship verification has been clarified and re-emphasized with county staff (all application forms routinely used in the eligibility determination of children allow self declaration of citizenship status).
5. Although considerable public awareness and enrollment efforts have been implemented at the state level, county DSS offices have not been engaged in community based outreach initiatives.	a) DHHS should establish a broad based work group to develop a plan for proactive community outreach initiatives to identify and enroll children for health coverage. State and local DSS offices, children's hospitals, community organizations, advocacy groups, and employers should be included in the membership of the work group.	<u>DHHS</u> The South Carolina Health Alliance has applied for and received a <i>Covering Kids</i> grant from The Robert Wood Johnson Foundation. Included in the grant proposal was the establishment of a broad based work group to develop outreach initiatives to identify and enroll children for health coverage. Membership of the group would include, but not be limited to, DSS, DHHS, DHEC, other state agencies interested in children's health, children's hospitals, advocacy groups, businesses, and community organizations. <u>DSS</u> DSS is ready to participate as a member of such a broad based work group to develop a plan for proactive community outreach initiatives to identify and enroll children within the confines of our resources. Status: A <i>Covering Kids</i> application was filed on January 15, 1999, by the South Carolina Hospital and Research Foundation.

Issues	Recommendations	Status of Follow-Up Actions
	b) DHHS and DSS should implement the plan for outreach initiatives using available Medicaid, CHIP and TANF funding.	<u>DHHS</u> Sensitivity and other training sessions will be held for DSS employees under the <i>Covering Kids</i> grant as well. <u>DSS</u> DSS is in favor of implementing a plan for outreach initiatives if funds from the Medicaid, CHIP and TANF programs can be made available for outreach efforts.
6. Staffing issues require attention to determine if actions are needed to improve opportunities for children to obtain and retain Medicaid coverage.	DHHS and DSS should accelerate their work to address staffing issues that could impede access to child Medicaid coverage and Section 1931 coverage.	<u>DHHS</u> A staffing study has been completed by DSS. Issues raised as a result are being assessed. Section 1931 was implemented with existing staff. Implementation was completed 9/1/98. <u>DSS</u> Currently, Section 1931 coverage is being implemented with existing manpower. However, an effort is underway to refine staffing issues and needs between DSS and DHHS. These issues should be addressed by October 1, 1999. Meanwhile, every effort is being made to ensure access is not impeded due to staffing issues.
7. South Carolina has not utilized the presumptive eligibility option.	South Carolina should consider a pilot test of presumptive eligibility to determine if it will provide expanded opportunities for children to be enrolled in Medicaid and to determine the extent to which such children are formally approved for continued coverage.	<u>DHHS</u> After consideration, DHHS has chosen not to implement the presumptive eligibility option at this time. <u>DSS</u> DSS is willing to address this option if DHHS agrees to a pilot test.

Issues	Recommendations	Status of Follow-Up Actions
8. Clarification is needed to determine the appropriate timing and use of information available through the federal IEVS wage match system.	DHHS and DSS should jointly review state and federal IEVS requirements with the goal of minimizing or eliminating the system and, if necessary, apply to the federal government for waivers.	<u>DHHS</u> In preparation for MEDS implementation, DHHS wrote to HCFA on August 14, 1998, requesting exclusion of certain data matches. It is DHHS' intent that the worker have access to the excluded information but not be required to follow up within the prescribed 45 day time frame. Proposed exclusions include: • Continue current exclusions • Applicants • Denied and closed cases • Children under age 19 (will continue to be targeted on the BENDEX and IRS matches) • SSI recipients • Transitional Medicaid, FI-MAO, TANF Low Income Families (will continue to be targeted on the BENDEX and IRS matches) • Pregnant women eligible for the Optional Coverage for Women and Infants category, and IV-E Foster Care • AFDC related categories – BEER only • Exclude matched records from follow up if the income on the eligibility file is the same as that reported through the match or if the income differs, but the new income would not exceed the income limit for the program. • Exclude repetitive information if information has already been reported. DHHS has not yet received a response from HCFA. A second letter with some revisions to the proposed exclusion list was sent on July 27, 1999. <u>DSS</u> DHHS has written to the HCFA to explore the feasibility of modifying the IEVS process to minimize the burden to the Medicaid workers. HCFA has not responded to the letter. Staff from DHHS is following up on this request to HCFA. Note: TANF regulations mandate the use of IEVS. Refusal to comply will result in a reduction of program funding.

FEDERAL ISSUES

Issue	Recommendations	Status of Follow-Up Actions
9. Access to child Medicaid coverage is impeded by the federal requirement that, as a condition of Medicaid eligibility, custodial parents or other legally responsible adults must cooperate in establishing paternity and in obtaining medical support and payments from any third party.	a) Federal action is needed to ensure that paternity establishment requirements and procedures do not impede access to child health coverage. Families applying for child health coverage should receive information on the reasons to establish paternity, but the pursuit of paternity establishment should not be connected to the child's Medicaid case. b) Federal clarification is needed regarding the removal of the adult from the budget unit in a child health coverage application in order to avoid the paternity establishment requirements. If this action is allowed, it should not result in a reduction of the income eligibility level for children.	In February 1999, the SCCHC held meetings with White House/Administration officials, members of Congress, congressional staff and representatives of national advocacy organizations to discuss the paternity issue. Numerous follow-up discussions have taken place. HCFA had issued a fact sheet on Medicaid/CHIP and Child Support Enforcement as a result of the findings of the SCCHC site visits. (See Attachment A). Discussions continue at the federal level to determine further action that can be taken to assure that children are not denied Medicaid coverage due to the lack of cooperation on the part of an adult, as stipulated by federal statute. Senator Ernest Hollings, Congressman James Clyburn and Congressman John Spratt sent a letter to HCFA to request that HCFA use "whatever flexibility it may have within the law to clarify to the states that no questions pertaining to paternity establishment or medical support are necessary for the establishment of child health coverage only." The South Carolina DHHS has removed a statement on the Partners for Healthy Children application that had implied that cooperation was required for child only Medicaid cases. Status: Federal clarification has been issued in the form of a HCFA fact sheet. (See Attachment A)
10. Due to federal Department of Agriculture rules on sharing of client information, DHHS has been unable to effectively coordinate	DHHS should work with the school lunch program in South Carolina to utilize a school lunch program application check box to notify families about child health coverage and to assist them in obtaining information about enrolling their children.	South Carolina Secretary of Education Inez Tenenbaum provided a letter to the SCCHC and wrote to DHHS to express the Department of Education's willingness to develop a method to coordinate eligibility services for families who want to apply for both the school lunch program and child Medicaid coverage. DHHS Director Sam Griswold responded, indicating his willingness to work on

Issue	Recommendations	Status of Follow-Up Actions
with the school lunch program statewide in order to link children eligible for school lunch to Medicaid coverage.		establishing greater coordination. A meeting was held with Superintendent Tenenbaum, Dr. Griswold, DSS Director Elizabeth Patterson and Sarah Shuptrine to initiate the development of strategies to achieve greater coordination with the goal of maximizing opportunities to enroll low-income, uninsured children in Medicaid. A work group has been established to develop methods to achieve effective collaboration. Additionally, in August 1999, US Secretary of Education Richard Riley issued a letter to all state education superintendents to urge their active participation in initiatives to enroll eligible children in child health coverage programs. (See Attachment B)

CHILDREN'S HOSPITAL ISSUES

Issue	Recommendations	Status of Follow-Up Action
11. Medicaid Referral Practices	Each children's hospital should determine if additional actions are needed to assure that on-site Medicaid eligibility services are sufficient to maximize opportunities to enroll children.	The Children's Hospital of Greenville Hospital System: It has been determined that on-site Medicaid eligibility services are sufficient. Greenville Hospital System has added staff to accompany caregivers on The Children's Hospital Mobile Clinic (which travels to underserved areas in the Greenville community 3-4 times per week) to enhance opportunities to enroll more children. McLeod Children's Hospital: The utilization of on-site Medicaid eligibility services is sufficient to maximize opportunities to enroll children at McLeod Children's Hospital. Currently, however, there are problems with the on-site eligibility workers' productivity. They are enrolling an average of 30 individuals per month, while many children are being admitted and discharged without enrollment occurring. Hospital staff have been helping the families complete the mail-in form in the absence of eligibility worker assistance. The amount of staff is adequate for the volume of workload, if improved productivity and flexibility of the current DSS staff on-site can be achieved. The eligibility workers have been placed under closer supervision to facilitate improved productivity and McLeod will continue to monitor this adaptation of the current system closely for effectiveness. Children's Hospital of Medical University of South Carolina: Two eligibility workers are located in Room 148 of the Medical University of South Carolina Trauma/Access Area. For several patient care and logistical reasons, these staff workers are not located directly in the emergency room but are very conveniently located in a nearby site. Children's Hospital of Palmetto Richland Memorial Hospital: Palmetto Richland has determined that most children who have no payment source and are eligible for Medicaid are being enrolled once they are hospitalized, and thus there are no plans to place eligibility staff at the emergency room or the pediatric clinic. A social worker has now been assigned to the pediatric clinic and is taking applications.

Issue	Recommendations	Status of Follow-Up Action
12. Electronic Connections	State DSS should move expeditiously to install the computers for eligibility staff at McLeod Regional Medical Center.	The Children's Hospital of Greenville Hospital System: Not applicable since computer linkages are in place. McLeod Children's Hospital: The computer for the eligibility staff is installed at McLeod Children's Hospital and networked to the central DSS system. However, it has been nonoperational with some regularity. The repair work on this system can only be performed by the state contractor, so any down time is lengthened. Children's Hospital of Medical University of South Carolina: This recommendation was not applicable to Children's Hospital at Medical University of South Carolina at the time the study was completed. The computer issue identified as a problem during the site visit was the lack of computer connections to DSS due to not having sufficient ports, and this need was addressed by Medical University of South Carolina. However, Medical University of South Carolina now reports that there are ongoing issues that have developed with regard to the computer connections. Efforts are being made to resolve the issues between DSS and Medical University of South Carolina. Children's Hospital of Palmetto Richland Memorial Hospital: Not applicable since computer linkages are in place.
13. Outreach	a) At the state level, the South Carolina Children's Hospital Collaborative should work with DHHS and DSS to develop a plan for community outreach initiatives designed to identify and enroll children for health coverage. (See recommendations on outreach in State Issues section.) b) At the local level, the children's hospitals should continue partnerships with DSS county offices to encourage effective community outreach programs.	<i>A Covering Kids</i> application to address statewide outreach and enrollment was filed on January 15, 1999, by the South Carolina Hospital and Research Foundation and a grant was awarded on July 1, 1999. Helen Lynch, Chairman of the SCCHC and Vice President of the Children's Hospital and Women's Services at Palmetto Richland Memorial Hospital, is a member of the statewide <i>Covering Kids</i> coalition. The Children's Hospital of Greenville Hospital System: The Children's Hospital of Greenville Hospital System is partnering with DHHS to provide new services in northern Greenville County (Northwest Crescent Project) and in southern Greenville County (Golden Strip Project). These projects will increase access to medical care for children covered by Medicaid and also serve as new sites for Medicaid enrollment.

Issue	Recommendations	Status of Follow-Up Action
		McLeod Children's Hospital: The Florence County DSS office indicated to McLeod that they are unable to participate in many outreach activities at this time. McLeod Health has supported an eligibility worker in Lake City, SC for this purpose. This is one of the intake workers for which McLeod Regional Medical Center is paying half of the salary. McLeod Children's Hospital staff have also distributed outreach materials throughout the Florence area through churches and schools. The outreach materials have been made available at social functions, fairs, etc., and utilized McLeod's Licensed Medical Social Worker to address groups on the eligibility criteria and enrollment process, expanding community awareness. Children's Hospital of Palmetto Richland Memorial Hospital: No activities reported. Children's Hospital of Medical University of South Carolina: Children's Hospital of Medical University of South Carolina continues to support local outreach efforts through a longstanding working relationship with the Charleston County DSS and states that activities focused at school sites appear to offer good potential. The Charleston County DSS is the pilot organization for the <i>Covering Kids</i> program in Charleston County.
14. Training for Hospital Social Workers	All children's hospitals should arrange for routine training for social work staff to build their capacity to refer children for Medicaid eligibility.	The Children's Hospital of Greenville Hospital System: Training is being provided for social work staff and other caregivers who work with Medicaid eligible children (e.g., NICU nurse coordinators) to increase capacity to refer children for Medicaid eligibility. McLeod Children's Hospital: McLeod Children's Hospital and all McLeod Regional Medical Center Social Worker staff have been trained. In addition, nursing staff within the Children's Hospital have been trained on the current Medicaid eligibility criteria and enrollment process. They have been provided with instruction and have easy access to handouts and applications. They are further encouraged both to use the materials with patients on site and to take along to church and social groups where they feel the materials may be used within the community.

Issue	Recommendations	Status of Follow-Up Action
		Children's Hospital of Palmetto Richland Memorial Hospital: No response re status. Children's Hospital of Medical University of South Carolina: Medical University of South Carolina Social Workers are being oriented on eligibility requirements for both adult and pediatric patient populations.

Source: South Carolina Children's Hospital Collaborative, August 1999.

Acronyms:

SCCHC	South Carolina Children's Hospital Collaborative
DHHS	State Department of Health and Human Services
DSS	South Carolina Department of Social Services
HCFA	US Health Care Financing Administration (USDHHS)

APPENDIX A

**HCFA FACT SHEET ON MEDICAID/CHIP AND
CHILD SUPPORT ENFORCEMENT**

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

FACT SHEET

CHIP AND CHILD SUPPORT ENFORCEMENT (CSE)

The following summary outlines HCFA's Child Support Enforcement policy under Medicaid and CHIP. The substance of the fact sheet explains that under separate State CHIP programs, there are no federal requirements. Under Medicaid CHIP expansions, the usual Federal Medicaid rules apply. A central element of our policy is that even when a parent or legal guardian refuses to cooperate with the State, the child's eligibility is not affected.

MEDICAID CHIP-RELATED EXPANSION:

Cooperation with the State in Establishing Paternity and in Obtaining Medical Support and Payments. Cooperation is a condition of eligibility under Medicaid which applies to Medicaid CHIP expansions. Applicants/recipients, with the exception of poverty level pregnant women, must cooperate in order to be eligible for Medicaid, unless there is "good cause" for failure to cooperate. Cooperation is part of the assignment of rights provision of section 1912 of the Social Security Act governing the third party liability (TPL) process.

Denial or Termination of Medicaid Eligibility. Medicaid eligibility cannot be denied or terminated for a child due to the refusal of another person to: 1) assign to the State his/her rights or the rights of any individual eligible on whose behalf he/she has the legal authority to execute an assignment of rights, 2) cooperate in establishing paternity and in obtaining medical support and payments, and 3) cooperate in identifying and providing information to assist the State in pursuing any third party. Therefore, failure of a parent to cooperate will not affect the eligibility of the child.

Note: Because eligibility under Medicaid is no longer contingent upon receipt of AFDC, the size of a child's family is never reduced on the basis that a parent refused to cooperate in establishing paternity and pursuing support. The family size and need remain the same for Medicaid purposes, whether or not the parent cooperates.

Information on Non-custodial parent. States must identify and pursue TPL, including medical child support, whether or not an applicant actively cooperates. The State is responsible for seeking information about the non-custodial parent during the application process. This doesn't necessarily mean that this information must be collected in the "simplified application" itself as long as it is obtained in the "application process." The State can ask for this information at any time during the application process. The last step in the application process is the notification of the determination of eligibility.

Referrals to the State CSE agency. CSE agencies are required to petition courts for medical support from a non-custodial parent and to provide other services to all families with a non-custodial parent who receive Medicaid. For these agencies to provide the required services, they need to know who these individuals are that need these services. Therefore, the State Medicaid agency should coordinate with the CSE agency to ascertain what information is necessary and refer appropriate cases to them for services, unless the recipient already has satisfactory health insurance other than Medicaid or is receiving adequate medical support from the non-custodial parent. When working out the referral arrangements with the CSE agency, the State should develop procedures that do not pose a barrier to simplifying the Medicaid application and enrollment process.

The State is not required to notify the custodial parent in advance of the referral if the custodial parent cooperated by providing the information. However, if the custodial parent did not cooperate and the information was obtained elsewhere, the custodial parent must be provided the opportunity to show "good cause" for not providing the information and why there should not be a referral, taking into consideration the best interests of the individuals involved.

CHIP - SEPARATE STATE HEALTH INSURANCE PROGRAM REQUIREMENTS

Federal CHIP Requirements. Under a program governed only by title XXI, there are no federal requirements for cooperation and/or coordination with CSE. A State could, however, impose requirements of its own. In other words, if a State chooses to expand title XXI through Medicaid, all of the above Medicaid requirements will apply (because the newly covered children will be Medicaid beneficiaries) but, if the State chooses to implement CHIP through a separate State health insurance program, the State is not subject to Medicaid requirements and there are no independent federal CHIP requirements.



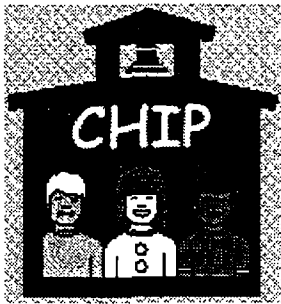
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Last Updated January 12, 1999

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

APPENDIX B

**US SECRETARY OF EDUCATION
LETTER TO SUPERINTENDENTS**



CALL TOLL-FREE
1-877-KIDS NOW



THE SECRETARY OF EDUCATION
WASHINGTON, D.C. 20202

Dear Superintendent:

A healthy child comes to school one step closer to academic success. More than six million children in our country are eligible for free and reduced-cost health insurance, yet still have no coverage. Children without health insurance suffer more from asthma, ear infections, vision problems - treatable conditions that dramatically interfere with classroom participation. And children without health insurance are absent more frequently than their peers. As we strive for high standards in every school and classroom, it is essential we help families ensure their children come to school ready to learn.

This is why I ask you to partner with the Department of Education in a national campaign to ***Insure Kids Now!*** and help connect families with affordable health insurance.

As you may know, in 1997 Congress allocated \$24 billion over five years for the Children's Health Insurance Program (CHIP) to provide health coverage to children ages 0-18. CHIP fills the gap for working parents who earn too much to qualify for Medicaid, but too little to provide their children with health insurance. Despite early efforts, *over six million children*, eligible either for Medicaid or CHIP, are still not enrolled.

As an educational leader, you are in a prime position to ask principals and parent organizations in your community to reach out and help enroll children in health insurance. As trusted sources of information for families, schools are essential to this outreach effort. In the attached packet, you will find:

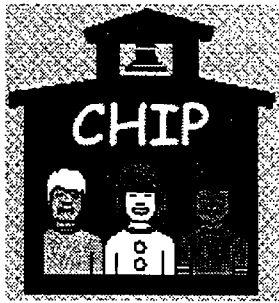
- A list of state contacts who can help enroll children in health insurance programs;
- Ideas on how schools can support the ***Insure Kids Now! Through Schools Campaign***; and
- A pledge form signaling your desire to participate in the ***Insure Kids Now! Through Schools Coalition***, so that we can recognize and better support your efforts.

I would appreciate your sharing this information with principals and other administrators in your district. I also hope that you will consider taking a leadership role in reaching out to your peers to help involve them in the national effort. If your schools have already been involved in enrolling children in health insurance, I'd like to share your best strategies with other educators around the country.

I appreciate your role in this effort, and want to support your involvement. If you have any further questions about the campaign, please contact 1-800-USA-LEARN or visit <http://www.ed.gov/chip>. I hope you will join the Department in the ***Insure Kids Now! Through Schools Coalition*** and help all of our school children come to school, each day, healthy and ready to learn.

Yours sincerely,

Richard W. Riley
Secretary of Education



**CALL TOLL-FREE
1-877-KIDS NOW**



Children's Health Insurance Program

Insuring Kids -- Ensuring a Healthy Chance to Learn

Insure Kids Now! Through Schools School and District Outreach and Enrollment Activities



Schools across the country are reaching out to help families enroll their children in free and low-cost health insurance so that all students come to school, each day, healthy and ready to learn. Here are some ways your school or district can help families and get involved in the *Insure Kids Now! Through Schools Campaign*:

SUPPORT ONGOING STATE ACTIVITIES!

- **Participate in your state's or county's current outreach activities.** Get in touch with the local contacts listed on the U. S. Department of Education web site at <http://www.ed.gov/chip> to find out how your state is reaching out to insure children now. Schools are excellent places to display posters or brochures and easy locations for families to pick up applications. The first step to getting children insured now is developing a relationship with your state or local agency that handles child health coverage eligibility.
- **Make certain all school staff members know about children's health insurance.** Principals, school nurses, school lunch staff, school social workers, guidance counselors, teachers, athletic directors, coaches and school aides come in direct contact with children and families every day. All school staff members should be briefed about children's health insurance programs, informed of current activities, and primed to share this information with families.

INTEGRATE HEALTH INSURANCE ENROLLMENT INTO SCHOOL ACTIVITIES!

- **Make enrollment part of the school registration process.** Add a question about whether a student has health insurance to school enrollment and emergency contact forms. Follow up with families who indicate a need for coverage by providing them with an application and a person to contact for more information and assistance.
- **Work with the School Lunch Program.** Children who are eligible for free and reduced-price school meals are usually eligible for free or low-cost health insurance programs. Work in conjunction with state and local eligibility agencies to provide information about health insurance with school lunch applications or when families are notified of their children's eligibility for free or reduced-price meals. Some districts include a check-off box on the school lunch application where parents grant school lunch staff permission to forward the family's name and address to the appropriate agency. The U.S. Department of Agriculture (USDA) has developed two prototype school meal applications that indicate exactly how schools can use the school lunch application as a means for health insurance enrollment. The forms are available at <http://www.fns.usda.gov/cnd/Lunch/Default.htm>.
- **Collaborate with school nurse and school-based health center staff.** School-based health facilities staff members play a critical role in providing students' health care. If your school or district has school nurses or school-based health centers, these are natural resources to connect with and to help provide families with information or assistance in enrolling their children.
- **Identify school or district-based staff who can help families with the application process.** Schools are trusted places for parents. Assigning a staff member or parent outreach worker the role of answering basic questions and referring families for more help will make a big difference for family members. Staff can also link with local outreach workers from community-based organizations to help them reach out to families.

TELL FAMILIES WHAT YOU KNOW ABOUT CHILDREN'S HEALTH INSURANCE!

- **Send informational materials home with your regular mailings.** Include brochures and applications in back-to-school packets that are sent home with families. Publish an article in your school newsletter or newspaper or feature information in school nurse publications. Sending these materials separately also focuses attention on them. Tell families they can call 1-877-KIDS-NOW toll-free to be connected with state health insurance workers and begin the enrollment process.
- **Feature information about children's health insurance when parents come to school.** Kindergarten registration, school transfer processes, Back to School nights, orientation for new students, sign-ups for extracurricular activities, report card pick-up days, PTA meetings, and parent-teacher conferences all offer opportunities to let families know about health coverage. Have promotional materials and applications on hand. Invite a representative from a local eligibility agency or organization involved in outreach to give a presentation on children's health coverage programs, answer questions, and provide assistance in completing applications.
- **Highlight children's health insurance programs at school events.** Whenever school time is devoted to health-related activities, a child health insurance outreach opportunity exists. Health fairs, school physicals, immunization drives, vision and hearing testing days provide ideal opportunities to let families know about health insurance and how to enroll. Other school events, such as sports and cultural events are also good times to make information available to families.
- **Create opportunities for parents to enroll their children at school.** Schedule periodic Child Health Insurance Enrollment Days. Contact the local eligibility agency that administers the child health coverage programs and arrange for eligibility workers to come to your school to help families enroll. Staff of community-based organizations or institutions, such as hospitals, health clinics, human service organizations or child advocacy groups are often also trained to provide application assistance and may be willing to assist. Be sure to tell families what to bring and ensure ready access to a photocopier for duplicating the necessary forms.

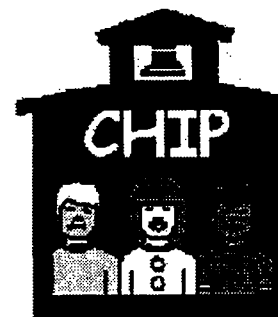
For more information about the campaign, call us at 1-800-USA-LEARN
or visit <http://www.ed.gov/chip>.

[[CHIP Home Page](#) | [About Chip](#) | [How You Can Help](#) | [Insure Kids Now! Through School](#) | [Successful School-Based Strategies](#) | [Contacts and Resources](#)]

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INSURE KIDS NOW! THROUGH SCHOOLS PLEDGE FORM

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YES! WE WANT TO JOIN THE *INSURE KIDS NOW!*

***THROUGH SCHOOLS* CAMPAIGN - A nationwide effort to connect families with free or reduced-price health insurance programs!**

Organization _____

Contact Person _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ E-mail _____

By signing this pledge, your organization becomes a member of the ***INSURE KIDS NOW! THROUGH SCHOOLS Coalition*** and commits to taking at least one step to help enroll children in health insurance. Please tell us what your organization plans to do to increase children's enrollment in health insurance.

- We will contact our State and/or regional CHIP/Medicaid outreach coordinator(s) for forms or assistance
- We will distribute information to families about children's health insurance programs
- We will help integrate health insurance enrollment into school activities (such as registration)
- We want to help get other organizations involved. Please contact us about how we can help.
- Other _____

Fax this pledge to 301-470-1244, or pledge online at www.ed.gov/chip, so we can recognize your outreach efforts on the Department of Education web site. For more information on the ***INSURE KIDS NOW! THROUGH SCHOOLS Campaign***, call 1-800-USA-LEARN or visit our web site.