Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	Garry Mauro to Melanne Verveer re: phone number and address (partial) (1 page)	07/30/1999	P6/b(6)
002a. fax	Garry Mauro to Melanne Verveer re: phone number and address (partial) (1 page)	07/30/1999	P6/b(6)
002b. fax	Bruce to Melanne Verveer re: phone number and address (partial) (1 page)	08/02/1999	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20465

FOLDER TITLE:
Medicaid and School Based Clinics [Folder 1]

2012-0463-S
rc784

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

MELANNE VERVEER

[redacted]

Chris –

Can you please call me re: this.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	Garry Mauro to Melanne Verveer re: phone number and address (partial) (1 page)	07/30/1999	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20465

FOLDER TITLE:
Medicaid and School Based Clinics [Folder 1]

2012-0463-S
rc784

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

Garry P. Mauro
P6/(b)(6)

[001]

FACSIMILE TRANSACTION SHEET

TO	Date
Melanne Verveer Chief of Staff to Hillary Rodham Clinton	07/30/99
Company The Whitehouse	**From:** Garry P. Mauro
Fax Number Called: 202-456-6244	**Total Number of Pages (Including Cover Sheet): 7**
RE:	

Instructions:

PLEASE DELIVER TO MS. VERVEER

Ms. Verveer,

As we discussed, enclosed is a summary of the issues regarding the public school Medicaid reimbursement. It is also my understanding that school districts in the State of New York are getting an estimated $200 million per year in Medicaid reimbursement claims.

If you have any additional questions, please call me at P6/(b)(6)

Sincerely,

Garry Mauro

If any problems or questions arise, please contact this office immediately at 512/ 328-8877.

Person sending report: Frances	

ISSUE ALERT:
PUBLIC SCHOOL MEDICAID REIMBURSEMENT

- In a letter dated May 21, 1999, addressed to all State Medicaid Directors (letter attached), the Health Care Financing Administration (HCFA) announced its intention to review and possibly revise its current guidelines governing the requirements for filing Medicaid Administrative Claims (MAC) reimbursement claims.

  While states clearly play a role in the administration of the MAC program, it is absolutely imperative that local public school service providers be given an adequate and meaningful opportunity to develop and provide input so as to ensure that any program changes finally adopted do not undermine their ability to remain in full compliance with all reporting guidelines. In the case of Texas, and many other states, end service providers are local school districts. To date, school districts nationwide have not been given the opportunity to directly participate in this process.

BACKGROUND

- MAC is a federal program designed to reimburse states for performing federally mandated outreach programs for primary and secondary public school students at-risk due to physical or emotional disabilities. It is administered at the federal level by HCFA, which coordinates the reimbursement function through each state's designated Medicaid Director.

- States have the flexibility to delegate to local units of government the responsibility for performing various outreach activities. In Texas, local public schools are assigned this responsibility (this model of relying on school districts to provide these mandated services is common to most states participating in the MAC program). Texas has a total primary and secondary school age population of approximately 3.7 million students. ***If all Texas schools participated in the MAC program, their collective federal reimbursement for providing these mandated services has the potential to generate an estimated $80 to $100 million annually. This is an important source of revenue for Texas school districts. But it is equally important to note that if all reimbursable claims were paid nationwide, the total cost would amount to approximately $2 billion per year (realistically, the actual annual cost would be far less). Hardly enough to bankrupt the federal government.***

- The La Porte MAC Consortium is an umbrella organization of over 300 Texas school districts that provide outreach services eligible for reimbursement under the MAC program to more than 1.3 million Texas children. Most are from low-income families without health insurance or access to private health care providers. La Porte Independent School District serves as the fiscal agent for the consortium and coordinates both the filing of quarterly claims and the distribution of claims paid to the member school districts.

- HCFA's current reporting requirements for purposes of filing MAC claims are very detailed and complex. Both HCFA and the Texas Medicaid Director have approved the methodology utilized by the La Porte Consortium to prepare each claim submitted. Since the program's inception in Texas, the consortium has filed claims totaling $19.2 million. ***All have been approved and paid.***

ACTION REQUESTED

- At this very moment the Administration and members of Congress are exploring ways to broaden and expand health care screenings for senior citizens. It would be a sad irony if an arm of the Department of Health and Human Services implemented unreasonable reporting guidelines that would curtail, if not eliminate, a program for identifying medically at-risk, low-income school age children. ***Suspend or delay the accelerated, and unnecessary, issuance of HCFA's guidelines until the public schools have had the opportunity to provide direct input into the process. The system has worked to this point as Congress and the Administration intended. The guidelines under internal consideration may impose an onerous administrative burden on public school districts that, as a practicable matter, will make their continued participation in the program uneconomical. That result will harm tens of millions of children throughout this country.***

May 21, 1999

Dear State Medicaid Director:

This letter addresses reimbursement for school-based health services under Medicaid. School-based services play an important role in assuring that Medicaid-eligible adolescents and children receive needed health care. In particular, Medicaid is the payer of first resort for medical services provided to children with disabilities pursuant to the Individuals with Disabilities Education Act (IDEA). Although HCFA strongly supports the provision of school-based health services, it is important that these services meet applicable Federal Medicaid requirements. This letter clarifies HCFA policy in three areas: (1) use of a bundled rate to pay for medical services provided to Medicaid-eligible children in schools; (2) State claiming for school health-related transportation services for children with Individual Education Plans (IEPs) under the IDEA; and (3) State claiming for school health-related administrative activities.

Bundled Rates for School-Based Services

We and key Congressional Committees have identified a concern related to the "bundling" of school-based health services. We believe you share our interest in maintaining the fiscal integrity of the Medicaid program and, because of the risks discussed below, we are changing our policy in this regard.

A number of States have been paying for school-based services using a "bundled rate" methodology. This permits schools to minimize paperwork by billing for a package of medical services, rather than for each individual service provided to each child. A bundled payment rate exists when a State pays a single rate for one or more of a group of different services furnished to an eligible individual during a fixed period of time. The payment is the same regardless of the number of services furnished or the specific costs, or otherwise available rates, of those services. The bundle may include two or more components usually provided by different providers, each with their own unique provider qualifications, even if the components fall within the same 1905(a) service category. For example, bundling exists when two or more component services are provided under the rehabilitative services benefit even if all of the school-based services are identified in the State plan as being contained within that one 1905(a) service category.

Our concerns are related to the fact that bundled rates for school-based providers are not related to a specific type of procedure and are generally not available to all qualified providers in the community who might wish to be similarly reimbursed. Furthermore, schools do not maintain the types of medical documentation that establish the reasonableness or accuracy of a rate. Because of these factors, HCFA has concluded that these bundled rate methodologies do not produce sufficient documentation of accurate and reasonable payments, and may result in higher payments than would be reasonable on a fee-for-service basis for each individual service and thus do not meet the statutory intent of the law. Section 1902(a)(30)(A) of the Social Security Act requires that States have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care. We believe that a bundled rate for school-based services is inconsistent with economy, since the rate is not designed to accurately reflect true costs or reasonable fee-for-service rates, and with efficiency, since it requires substantially more Federal oversight resources to establish the accuracy and reasonableness of State expenditures. There is therefore no reliable basis for determining that the rate is related to the actual cost to the State and other public entities, absent documentation of the individual services provided.

Effective immediately, HCFA will no longer recognize bundled school-based health services rates as acceptable for purposes of claiming Federal financial participation (FFP). States that are currently paying bundled rates for school-based health services pursuant to an approved State plan amendment must develop and prospectively implement an alternative reimbursement methodology. We will be convening a meeting with a group from the States and the Department of Education to discuss options that are available. Also, States will be given time to work with the HCFA regional offices which will assist in the development and implementation of a non-bundled reimbursement methodology.

HCFA would like to work with states to implement a strategy so that States can come into compliance prospectively. At this time, no retroactive disallowances of FFP are planned nor are prospective deferrals. However, we expect states to work to come into compliance with this policy expeditiously. We recognize that some may require authorization or action by the State Legislature to implement a new reimbursement methodology. In the event that States do not come into compliance within a reasonable time, HCFA will consider taking a compliance action, including deferrals and retrospective disallowances to the date of this letter.

HCFA will not approve any additional amendments to State plans that seek to reimburse for school-based health services using

bundled rate. States with pending bundling plan amendments may either withdraw those amendments or revise them to conform to the requirements described in this letter. If the State wishes to retain the effective date of the amendment, HCFA will assist the State to develop an approvable amendment. An approvable amendment must include requirements for maintaining documentation of the individual services provided to support claims for FFP. It should be noted that the IEP is not sufficient for purposes of documenting services provided since it identifies only those services that a child should receive, and not those services that the child actually receives.

Transportation

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. The 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.

It is our understanding that an IEP should include only specialized services that a child would not otherwise receive in the course of attending school. Therefore, HCFA would like to clarify that 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 Office of Management and Budget 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.

Effective July 1, 1999, FFP will only be available for Medicaid school-based transportation cost as administrative activities in accordance with the policies described above. Similarly, FFP for IEP related transportation services will only be available for services provided on or after July 1, 1999 as specified in this letter. HCFA's regional offices will provide technical assistance to States to assist them in properly claiming FFP for school-related transportation.

Administrative Claiming for School-Based Services

HCFA is currently reviewing practices related to State claiming for school-based administrative activities. A guide is expected to be published this Summer which clarifies the requirements for claims for Medicaid expenditures for administrative activities performed in schools.

HCFA regional and central office staff will provide every assistance to States in their efforts to conform to these policies.

Sincerely,

/s/

Sally K. Richardson
Director

cc

All HCFA Regional Administrators
All HCFA Associate Regional Administrators for Medicaid and State Operations
Lee Partridge - American Public Human Services Association
Joy Wilson - National Council of State Legislatures
Matt Salo - National Governors' Association

3374107

La Porte MAC Consortium

Districts that have either a contract or a letter of intent as of May 10, 1999

588 Educational Co-op
Academy ISD
Adrian ISD
Alief Montessori Community School
Allen ISD
Alvarado ISD
Alvin ISD
Amarillo ISD
American Institute for Learning Charter School
Anderson County Special Ed. Co-op
Angleton ISD
Aransas Pass ISD
Archer City ISD
Arlington ISD
Austin County Education Co-op
Austwell-Tivoli ISD
Avery ISD
Azle ISD
Bandera ISD
Bangs ISD
Barbers Hill ISD
Bartlett ISD
Bastrop ISD
Bastrop Special Education Co-op
Beaumont ISD
Beeville ISD
Bell County Special Ed. Co-op
Belton ISD
Big Four Co-op for Special Ed.
Big Thicket Co-op
Birdville ISD
Blanket ISD
Blooming Grove ISD
Boerne ISD
Bosque County Education Co-op
Brazosport ISD
Bronte ISD
Brookesmith ISD
Brownsville ISD
Brownwood ISD
Bryan ISD
Bushland ISD
Calallen ISD
Carrollton-Farmers Branch ISD
Castleberry ISD
Cedar Hill ISD
Center ISD
Center Point ISD
Central Heights ISD
Channelview ISD
Chilton ISD
Chireno ISD
Chisum ISD
Christoval ISD
City View ISD
Clarksville ISD
Clifton ISD
Cluster Seven Co-op for Special Ed.
Coldspring-Oakhurst CISD
College Station ISD
Collinsville ISD
Como-Pickton CISD
Connally ISD
Conroe ISD
Coolidge ISD
Coppell ISD
Copperas Cove ISD
Corpus Christi ISD
Crane ISD
Crowley ISD
Culberson County-Allamoor
Danbury ISD
Dawson ISD
De Soto ISD
Deer Park ISD
DeKalb ISD
Del Valle ISD
Detroit ISD
Dew ISD
Dripping Springs ISD
Eagle Mountain-Saginaw ISD
Early ISD
East Central ISD
East Chambers ISD
Eden CISD
Edgewood ISD
Electra ISD
Elgin ISD
Elkhart ISD
Emma L. Harrison Charter School
Ennis ISD
Etoile ISD
Evadale ISD
Everman ISD
Fairfield ISD
Falls City ISD
Falls Education Co-op
Flour Bluff ISD
Fort Davis ISD
Fort Stockton ISD
Frankston ISD
Fredericksburg ISD

La Porte MAC Consortium

Districts that have either a contract or a letter of intent as of May 10, 1999

Freestone-Navarro Bi County Co-op
Friendswood ISD
Garrison ISD
Glen Rose ISD
Goliad ISD
Goliad Special Education Co-op
Goose Creek CISD
Graham ISD
Grape Creek ISD
Grapevine-Colleyville ISD
Grayson Co. Co-op for Special Ed.
Greater Gulf Coast Special Ed. Co-op
Gregory-Portland ISD
Groesbeck ISD
Gunter ISD
Hallsville ISD
Hamshire-Fannett ISD
Hardin-Jefferson ISD
Harlandale ISD
Harleton ISD
Harlingen CISD
Harrison County Special Ed. Co-op
Hartley ISD
Hawkins ISD
High Island ISD
Highland Park ISD
Hitchcock ISD
Holland ISD
Holliday ISD
Hooks ISD
Houston Cant Academy Charter School
Howe ISD
Hubbard ISD
Hudson ISD
Huffman ISD
Hunt ISD
Huntsville ISD
Hurst-Euless-Bedford ISD
Ingleside ISD
Iowa Park Consolidated ISD
IRRA Inc.
Irving ISD
Jefferson ISD
Joaquin ISD
Judson ISD
Karnes City ISD
Kaufman ISD
Keller ISD
Kendleton ISD
Kenedy ISD
Kennedale ISD
Kerens ISD
Kerrville ISD
Killeen ISD
Kingsville ISD
Kountze ISD
La Marque ISD
La Porte ISD
La Vega ISD
La Vernia ISD
Lake Travis ISD
Lamar CISD
Lamar Co. Special Education Co-op
Lampasas ISD
Lancaster ISD
Laredo ISD
Leander ISD
Limestone County Co-op
Longview ISD
Lufkin ISD
Lumberton ISD
Magnolia ISD
Mansfield ISD
Marathon ISD
Marble Falls ISD
Marfa ISD
Marion ISD
Martin ISD
Marshall ISD
Martinsville ISD
May ISD
Megargel ISD
Mexia ISD
Midway ISD
Mildred ISD
Miles ISD
Mount Vernon ISD
Nacogdoches Co. Co-op for Spec. Ed.
Nacogdoches ISD
Nederland ISD
Needville ISD
New Boston ISD
Newcastle ISD
North Lamar ISD
Odem-Edroy ISD
Olfen ISD
Olney ISD
Paint Rock ISD
Palestine ISD
Panther Creek CISD
Paris ISD
Pasadena ISD
Pearland ISD
Pflugerville ISD
Pittsburg ISD

La Porte MAC Consortium

Districts that have either a contract or a letter of intent as of May 10, 1999

Plano ISD
Point Isabel ISD
Port Aransas ISD
Port Arthur ISD
Pottsboro ISD
Prairiland ISD
Presidio ISD
Quitman ISD
Red River County Co-op
Refugio ISD
Richardson ISD
Riesel ISD
Robert Lee ISD
Robstown ISD
Rosebud-Lot ISD
Round Rock ISD
Royal ISD
Runge ISD
Sabine Pass ISD
San Benito CISD
San Felipe Del Rio ISD
San Patricio Special Education Co-op
San Vicente ISD
Santa Fe ISD
Seymour ISD
Shepherd ISD
Sinton ISD
Slocum ISD
Small Schools Co-op
Smithville ISD
Southside ISD
Southwest ISD
Spring Branch ISD
Stafford MSD
Taft ISD
Talco-Bogata CISD
Teague ISD
Tenaha ISD
Texas Academy of Excellence
Texas City ISD
Throckmorton ISD
Tom Bean ISD
Tomball ISD
Troy ISD
United ISD
Van Alstyne ISD
Vega ISD
Veribest ISD
Waco ISD
Walcott ISD
Wall ISD
Waskom ISD
Water Valley ISD
Weatherford ISD
West Hardin County CISD
West Wichita County Special Ed. Co-op
Western Bowie County Co-op
Westphalia
Westwood ISD
White Settlement ISD
Whitesboro ISD
Whitewright ISD
Wichita Falls ISD
Wildorado ISD
Willis ISD
Windthorst ISD
Woden ISD
Woodsboro ISD
Woodson ISD
Wortham ISD
Zapata County ISD

To Deborah

Some Q's and A's from Administrator's Testimony on School-based Health Services
June 17, 1999

Q: Why is HCFA concerned about the way the Federal government is paying through Medicaid for health care services in the schools?

A: We are concerned about the payment for Medicaid services in school-based settings for several reasons. First, schools have not been traditional Medicaid providers or providers of medical services. Federal Medicaid requirements are complex and the implementation of Medicaid varies by State. Many schools are not as familiar with these requirements, and they are not accustomed to operating in the "medical services world." For example, most schools have needed to establish medical billing systems. It can be challenging and administratively complex for schools to obtain reimbursement.

Second, because schools are public entities, the potential exists for States to set generous Medicaid payment rates. These Medicaid payments could replace State education dollars previously spent on these services with new Federal funds through Medicaid. Since these are new Federal dollars, States can afford to provide consultants with a percentage of the new funds.

Third, States that pay using bundled rates do not maintain documentation of individual services. Without proper documentation of services, there is no reliable basis for determining the reasonableness of the rate or its accuracy. In addition, there is no means of ensuring that a particular service was provided to a child.

We, therefore, believe that careful monitoring and documentation are essential to ensure accurate reimbursement.

Q: What will happen to Medicaid payment for school-based services in those States now that HCFA has prohibited bundling?

A: The regional offices of HCFA will work closely with the States with approved plan amendments to help them develop acceptable reimbursement methodologies. Federal funding for school-based services will continue to be available to those States while the work of developing an alternative methodology is taking place. Should a State fail to show good faith in its efforts to revise its payment methodology, HCFA may pursue disallowances through the compliance process.

With respect to North Carolina, the State has already notified HCFA that it plans to submit a new methodology for approval by the end of June. It also indicated that it has sufficient documentation to justify the FFP paid for school based services for past periods as fee-for service claims.

Q: Why did HCFA move now to prohibit use of these rates in schools?

A: A number of consultants have been encouraging States to implement bundled rate methodologies. In light of our concerns about the reasonableness of the rates, HCFA decided to act expeditiously to prevent additional States from investing time and effort into implementing a problematic system of reimbursement.

Q: What are HCFA's concerns with bundling of school-based services?

A: States that pay using bundled rates do not maintain documentation of individual services sufficient to establish the reasonableness or accuracy of the rates. Most rely on the Individualized Education Plans (IEPs) which describe in broad terms the services which a child should receive, but do not document the services that a child actually receives. HCFA believes that these bundled rates may therefore result in higher payments than would be reasonable on a fee-for-service basis.

Q: Please provide a chronology of events on school-based health services. When did you identify this as a problem and what actions have you taken to address it?

A: August 1997: In response to the emerging interest and involvement by schools and State Medicaid agencies in establishing systems for paying for medical services and associated administrative expenses for Medicaid-eligible children under IDEA, HCFA published a technical assistance guide on Medicaid and School Health in August 1997. This Guide provides the Federal policies and guidelines related to Medicaid coverage and reimbursement of school-based health services and describes many of the issues involved in establishing a system for receiving Medicaid payment.

Early 1998: Florida applied for a State Plan Amendment to reimburse on a "bundled rate" methodology. They informed us that consultants were assisting them and were working with other States. HCFA identified three areas of concern: 1) Administrative claiming; 2) Use of the "bundled rate methodology" for reimbursing SBHS and; 3) Payment for transportation of Medicaid-eligible IDEA children to-and-from school who do **not** require specialized transportation.

November 1998: Briefed Hill staff twice on the three areas we had identified as concerns. They requested that we send a State Medicaid Director letter prohibiting "bundling."

January 1999: Senate Finance Committee staff asked Department of Education and HCFA to discuss why "bundling" was important to States.

April 1999: HCFA organized a site visit to two Philadelphia area schools for Hill staff and OMB..

May 21, 1999 HCFA issued a State Medicaid Directors' letter prohibiting use of the

bundling rate methodology to pay for Medicaid covered SBHSs and prohibiting Medicaid payment for transportation to-and-from schools for IDEA children who do **not** require specialized transportation. In the Summer, we plan to publish a guide that clarifies the requirements for Medicaid expenditures for administrative activities performed in schools.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

395-7840

MAY 21 1999

Dear State Medicaid Director:

This letter addresses reimbursement for school-based health services under Medicaid. School-based services play an important role in assuring that Medicaid-eligible adolescents and children receive needed health care. In particular, Medicaid is the payer of first resort for medical services provided to children with disabilities pursuant to the Individuals with Disabilities Education Act (IDEA). Although HCFA strongly supports the provision of school-based health services, it is important that these services meet applicable Federal Medicaid requirements. This letter clarifies HCFA policy in three areas: (1) use of a bundled rate to pay for medical services provided to Medicaid-eligible children in schools; (2) State claiming for school health-related transportation services for children with Individual Education Plans (IEPs) under the IDEA; and (3) State claiming for school health-related administrative activities.

Bundled Rates for School-Based Services

We and key Congressional Committees have identified a concern related to the "bundling" of school-based health services. We believe you share our interest in maintaining the fiscal integrity of the Medicaid program and, because of the risks discussed below, we are changing our policy in this regard.

A number of States have been paying for school-based services using a "bundled rate" methodology. This permits schools to minimize paperwork by billing for a package of medical services, rather than for each individual service provided to each child. A bundled payment rate exists when a State pays a single rate for one or more of a group of different services furnished to an eligible individual during a fixed period of time. The payment is the same regardless of the number of services furnished or the specific costs, or otherwise available rates, of those services. The bundle may include two or more components usually provided by different providers, each with their own unique provider qualifications, even if the components fall within the same 1905(a) service category. For example, bundling exists when two or more component services are provided under the rehabilitative services benefit even if all of the school-based services are identified in the State plan as being contained within that one 1905(a) service category.

Our concerns are related to the fact that bundled rates for school-based providers are not related to a specific type of procedure and are generally not available to all qualified providers in the community who might wish to be similarly reimbursed. Furthermore, schools do not maintain the types of medical documentation that establish the reasonableness or accuracy of a rate. Because of these factors, HCFA has concluded that these bundled rate methodologies do not produce sufficient documentation of accurate and reasonable payments, and may result in higher payments than would be reasonable on a fee-for-service basis for each individual service and thus do not meet the statutory intent of the law. Section 1902(a)(30)(A) of the Social Security Act requires that States have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care. We believe that a bundled rate for school-based services is inconsistent with economy, since the rate is not designed to accurately reflect true costs or reasonable fee-for-service rates, and with efficiency, since it requires substantially more Federal oversight resources to establish the accuracy and reasonableness of State expenditures. There is therefore no reliable basis for determining that the rate is related to the actual cost to the State and other public entities, absent documentation of the individual services provided.

Effective immediately, HCFA will no longer recognize bundled school-based health services rates as acceptable for purposes of claiming Federal financial participation (FFP). States that are currently paying bundled rates for school-based health services pursuant to an approved State plan amendment must develop and prospectively implement an alternative reimbursement methodology. We will be convening a meeting with a group from the States and the Department of Education to discuss options that are available. Also, States will be given time to work with the HCFA regional offices which will assist in the development and implementation of a non-bundled reimbursement methodology.

HCFA would like to work with states to implement a stratgey so that States can come into compliance prospectively. At this time, no retroactive disallowances of FFP are planned nor are prospective defferals. However, we expect states to work to come into compliance with this policy expeditiously. We recognize that some may require authorization or action by the State Legislature to implement a new reimbursement methodology. In the event that States do not come into compliance within a reasonable time, HCFA will consider taking a compliance action, including defferals and retrospective disallowances to the date of this letter.

HCFA will not approve any additional amendments to State plans that seek to reimburse for school-based health services using a bundled rate. States with pending bundling plan amendments may either withdraw those amendments or revise them to conform to the requirements described in this letter. If the State wishes to retain the effective date of the amendment, HCFA will assist the State to develop an approvable amendment. An approvable amendment must include requirements for maintaining documentation of the individual services provided to support claims for FFP. It should be noted that the IEP is not sufficient for purposes of documenting services provided since it identifies only those services that a child should receive, and not those services that the child actually receives.

Transportation

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. The 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.

It is our understanding that an IEP should include only specialized services that a child would not otherwise receive in the course of attending school. Therefore, HCFA would like to clarify that 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 Office of Management and Budget 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.

Effective July 1, 1999, FFP will only be available for Medicaid school-based transportation cost as administrative activities in accordance with the policies described above. Similarly, FFP for IEP related transportation services will only be available for services provided on or after July 1, 1999 as specified in this letter. HCFA's regional offices will provide technical assistance to States to assist them in properly claiming FFP for school-related transportation.

Administrative Claiming for School-Based Services

HCFA is currently reviewing practices related to State claiming for school-based administrative activities. A guide is expected to be published this Summer which clarifies the requirements for claims for Medicaid expenditures for administrative activities performed in schools.

HCFA regional and central office staff will provide every assistance to States in their efforts to conform to these policies.

Sincerely,

Sally K. Richardson

Sally K. Richardson
Director

cc:

All HCFA Regional Administrators
All HCFA Associate Regional Administrators
For Medicaid and State Operations
Lee Partridge - American Public Human Services Association
Joy Wilson - National Council of State Legislatures
Matt Salo - National Governors' Association

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear State Medicaid Director:

This letter addresses reimbursement for school-based health services under Medicaid. School-based services play an important role in assuring that Medicaid-eligible adolescents and children receive needed health care. In particular, Medicaid is the payer of first resort for medical services provided to children with disabilities pursuant to the Individuals with Disabilities Education Act (IDEA). Although HCFA strongly supports the provision of school-based health services, it is important that these services meet applicable Federal Medicaid requirements. This letter clarifies HCFA policy in three areas: (1) use of a bundled rate to pay for medical services provided to Medicaid-eligible children in schools; (2) State claiming for school health-related transportation services for children with Individual Education Plans (IEPs) under the IDEA; and (3) State claiming for school health-related administrative activities.

Bundled Rates for School-Based Services

We and key Congressional Committees have identified a concern related to the "bundling" of school-based health services. We believe you share our interest in maintaining the fiscal integrity of the Medicaid program and, because of the risks discussed below, we are changing our policy in this regard.

A number of States have been paying for school-based services using a "bundled rate" methodology. This permits schools to minimize paperwork by billing for a package of medical services, rather than for each individual service provided to each child. A bundled payment rate exists when a State pays a single rate for one or more of a group of different services furnished to an eligible individual during a fixed period of time. The payment is the same regardless of the number of services furnished or the specific costs, or otherwise available rates, of those services. The bundle may include two or more components usually provided by different providers, each with their own unique provider qualifications, even if the components fall within the same 1905(a) service category. For example, bundling exists when two or more component services are provided under the rehabilitative services benefit even if all of the school-based services are identified in the State plan as being contained within that one 1905(a) service category.

Our concerns are related to the fact that bundled rates for school-based providers are not related to a specific type of procedure and are generally not available to all qualified providers in the community who might wish to be similarly reimbursed. Furthermore, schools do not maintain the types of medical documentation that establish the reasonableness or accuracy of a rate. Because of these factors, HCFA has concluded that these bundled rate methodologies do not produce sufficient documentation of accurate and reasonable payments, and may result in higher payments

than would be reasonable on a fee-for-service basis for each individual service and thus do not meet the statutory intent of the law. Section 1902(a)(30)(A) of the Social Security Act requires that States have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care. We believe that a bundled rate for school-based services is inconsistent with economy, since the rate is not designed to accurately reflect true costs or reasonable fee-for-service rates, and with efficiency, since it requires substantially more Federal oversight resources to establish the accuracy and reasonableness of State expenditures. There is therefore no reliable basis for determining that the rate is related to the actual cost to the State and other public entities, absent documentation of the individual services provided.

Effective immediately, HCFA will no longer recognize bundled school-based health services rates as acceptable for purposes of claiming Federal financial participation (FFP). States that are currently paying bundled rates for school-based health services pursuant to an approved State plan amendment must develop and prospectively implement an alternative reimbursement methodology. We will be convening a meeting with a group from the States and the Department of Education to discuss options that are available. Also, States will be given time to work with the HCFA regional offices which will assist in the development and implementation of a non-bundled reimbursement methodology.

No retroactive disallowances of FFP will be taken, nor will there be prospective deferrals or disallowances for those States with approved school-based services bundling plan amendments; however, we expect states to work to come into compliance with this policy expeditiously. We recognize that some may require authorization or action by the State Legislature to implement a new reimbursement methodology or to appropriate additional Medicaid or education funds, should a funding shortfall for either program be anticipated.

HCFA will not approve any additional amendments to State plans that seek to reimburse for school-based health services using a bundled rate. States with pending bundling plan amendments may either withdraw those amendments or revise them to conform to the requirements described in this letter. If the State wishes to retain the effective date of the amendment, HCFA will assist the State to develop an approvable amendment. An approvable amendment must include requirements for maintaining documentation of the individual services provided to support claims for FFP. It should be noted that the IEP is not sufficient for purposes of documenting services provided since it identifies only those services that a child should receive, and not those services that the child actually receives.

Transportation

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. The 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.

We have been informed by the Department of Education, which has responsibility for

development of IEPs under the IDEA, that an IEP should include only specialized services that a child would not otherwise receive in the course of attending school. Therefore, HCFA would like to clarify that 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 Office of Management and Budget 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.

Effective July 1, 1999, FFP will only be available for Medicaid school-based transportation cost as administrative activities in accordance with the policies described above. Similarly, FFP for IEP related transportation services will only be available for services provided on or after July 1, 1999 as specified in this letter. HCFA's regional offices will provide technical assistance to States to assist them in properly claiming FFP for school-related transportation.

Administrative Claiming for School-Based Services

HCFA is currently reviewing practices related to State claiming for school-based administrative activities. A guide is expected to be published this Summer which clarifies the requirements for claims for Medicaid expenditures for administrative activities performed in schools.

HCFA regional and central office staff will provide every assistance to States in their efforts to conform to these policies.

Sincerely,

Sally K. Richardson
Director

cc:

All HCFA Regional Administrators
All HCFA Associate Regional Administrators
For Medicaid and State Operations
Lee Partridge - American Public Human Services Association
Joy Wilson - National Council of State Legislatures
Matt Salo - National Governors' Association

OIRA

Olmstead?

SCHOOL BASED SERVICES

Ed got it at the same time as groups; finance cmt in April

VK: fees
transportation
bundling
} sure?

AL: trying to claim & HCFA announced new guidance coming, but they don't have it

EPSDT argument - admin claiming
starting point

refer to Ed act NO CLAIM
refer to health act CLAIM

IEP — all claimable b/c they can identify it

consultant fees → guide not new policy

if it is new policy is the comment period sufficient?

meet w/ Sarah?

starting point IEP →
Ed law → not our problem / Ed

HCFA approving claims

AL school based amendment denied on draft

admin draft in one week

Schedule assignment for response

HCFA HILL mtgs — bundling

end of March early April

Senate House briefing — last Friday this Friday

Meeting w/ Ed O?

Advocacy groups health families?

disabled advocacy groups?

wait until period is closed?

WH - Goals
Ed/HCFA/OMB - briefing
groups - feedback

week or so

Finance Cmt staff → legislation?

Jonathan

HCFA

MEDICARE ! MEDICAID
Health Care Financing Administration

MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING GUIDE

DRAFT

SEPTEMBER 1999

MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING GUIDE

TABLE OF CONTENTS

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 the1997 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:

42 CFR	Description
430.1	Scope of subchapter C - Proper and efficient administration
430.12	Submittal of State plans and plan amendments
430.30(b)	Grants procedures - Program estimates (HCFA-37)
430.30(c)	Grants procedures - Expenditure reports (HCFA-64)
430.32	Program reviews
430.33	Audits - OIG audits including cost efficiency
430.40	Deferral of claims for FFP
430.42	Disallowance of claims for FFP
431.15	Methods of Administration
431.53	Assurance of transportation
431.107	Required provider agreements
432.50	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 be not be claimable because they would not be considered in support of the operation of the Medicaid State plan (even if the services are included in the State's Medicaid program).

In addition, Medicaid does not pay for health care services that are rendered free of charge to the general population. Consequently, any administrative activity which supports the referral, coordination, planning of screens or services that are provided free to the general population 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 the 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.

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

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 then 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 preformed 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 ΣSection 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.

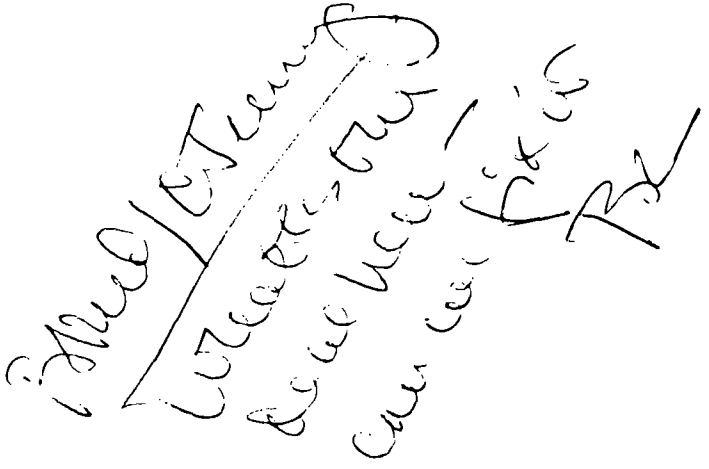
If a child requires transportation in a vehicle adapted to serve the needs of the disabled, including a specially adapted school bus, that transportation may be billed to Medicaid if the need for that specialized transportation is identified in the IEP. In addition, if a child resides in an area that 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.

Congress of the United States
House of Representatives
Washington, DC 20515

OFFICIAL BUSINESS



M.C.

5-3-00

Cop. rcd
Reed
Jennings
Reg Affs
Podesta

5-3-00

Congress of the United States

House of Representatives

Washington, DC 20515–4325

May 2, 2000

The Honorable William Jefferson Clinton
President of the United States
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. President:

For the past month, I have been contacted by a number of school administrators and educators in my district who are concerned that the draft Medicaid School-Based Administrative Claiming (MAC) Guide that was issued in February 2000 by the Health Care Financing Administration (HCFA) will jeopardize the future of this critical program. Texas' MAC program has been operating successfully for the past three years pursuant to formal written approval by HCFA.

Whether by accident or design, the draft guide appears to both substantially limit reimbursements and place new administrative burdens on participating school districts. If HCFA does opt to go forward with the guide in its current form, I respectfully request that Texas MAC program be "grandfathered." Texas' MAC program deserves special consideration in that it is only one of two states which have a HCFA-approved reimbursement program.

In its introduction, the guide asserts that its purpose is to provide a framework for administration of the MAC program; not to change existing policy. Unfortunately, the guide, in its current form, does appear to change policy. Should this draft guide be implemented, a reduction of 40% of funds is projected for Texas' MAC program. Specifically, with respect to reimbursements, the proposed draft guide appears to redesignate several activities that are currently reimbursable as unallowable. Further, the proposed guide seems to reimburse administrative outreach only when students are referred to Medicaid-enrolled providers. Currently, they are reimbursed for the activity, regardless of whether or not the student is referred to a Medicaid-enrolled provider.

In addition to the changes in reimbursement, the guide appears to place new administrative burdens on the schools. The draft guide promulgates a new time study sampling methodology, random moment sampling (RMS), that would be more administratively taxing than the current sampling model. The guide also appears to make reimbursement for Skilled Professional Medical Personnel (SPMP) activities more onerous than current practices. As a result, the ability to obtain reimbursement for skilled professionals would likely be significantly limited.

In summary, I have many concerns about what this draft guide will mean for Texas' MAC program. Texas currently receives $14 per student reimbursement rate for outreach efforts, one of the lowest reimbursement rates in the country. Because the Texas MAC program is in full compliance with existing HCFA guidelines and is, by any objective measure, an unqualified success, I believe that Texas should be grandfathered under the guide. This provision could be narrowly-tailored to only apply to those states with approval letters. In light of the new policies promulgated in the HCFA guide, such action is both necessary and proper. Thank you for your prompt attention in this serious matter.

With kindest personal regards,

Sincerely,

Kenneth E. Bentsen, Jr.
Member of Congress

KEB:rc

March 20, 2000

The Honorable William J. Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear President Clinton:

The undersigned organizations, representing parents, educators, school administrators, school health professionals, school board members, and other education advocates wish to express our strong dissatisfaction with the recently released *Medicaid School-Based Administrative Claiming Guide*. Providing health services in the school setting is the easiest and most effective way to reach the majority of our nation's children. Unfortunately, the practice of serving children through schools is fundamentally challenged by HCFA's draft guidance.

Medicaid reimbursement is currently available for a wide range of administrative health service costs and screenings. The practice of screening students in schools provides us with the greatest chance of identifying those in need of special health services. Medicaid reimbursements also help to pay for the expensive health care costs sometimes associated with educating students with disabilities. The recent *Cedar Rapids* decision requires that school districts provide health care services to disabled students to facilitate their participation in the classroom setting. If the HCFA guidelines are accepted, and Medicaid administrative reimbursement for school-based health services is significantly reduced, a large financial burden would be placed on local school districts. Without help from Medicaid, districts will be forced to either raid the budgets of other critical education programs or cut services.

The Health Care Financing Administration's *Claiming Guide* is misguided in two critical areas. First, the guide fails to ensure that schools will continue to be reimbursed for services covered by Medicaid. Your work on the CHIP program clearly illustrates your desire to deliver health care services to as many children as possible. The HCFA guidelines, as currently drafted, are a step in the opposite direction. Second, the *Claiming Guide* offers a list of what schools should NOT do rather than providing a comprehensive guide to making claims through Medicaid. Any attempts at Medicaid reform must take a positive approach that make it easier for school districts to participate and easier for students to receive necessary services. It is also important that HCFA incorporate the education community in future discussions of new guidelines so we can ensure that the guidance accurately reflects the needs of schools.

The *Claiming Guide* is evidently a reaction to a report by the General Accounting Office. The GAO reported to the Senate Finance Committee that the number of school reimbursement claims is up dramatically, and HCFA subsequently began looking into

reasons for the increase. The true reason for the rapid increase in claims is quite simple: the number of school districts participating in the program has shot up over the last few years as more and more schools became aware of the program. We went from a handful of districts applying for reimbursement a few years ago to over 10,000 districts applying today. The rise in costs is a reflection of the increase in Medicaid claims; it should not be questioned, it should be applauded.

GAO is also about to report some cases where school districts have pushed the limits of Medicaid reimbursement for administering the services. If they look GAO will also find that some states are taking an inordinate percentage of funds generated by school-based services off the top as a sort of tribute for passing through the Medicaid system. In New Jersey, for example, the governor takes a large percentage of Medicaid reimbursement funds and uses it for expenses unrelated to child health care or education. Our organizations in no way support any bad accounting practices or governors seizing funds meant for children's services. Clearly that practice must be stopped, but at the same time, we must not cut off school-based health services in the process.

A successful Medicaid guide ought to make it as easy as possible for legitimate Medicaid claims to be efficiently processed and reimbursed. We hope that you will encourage HCFA to rethink their approach and issue a new, more positive set of guidance.

Sincerely,

American Association of School Administrators
American Counseling Association
American Federation of Teachers
Association of Educational Service Agencies
Council for Exceptional Children
Council of the Great City Schools
National Association of School Psychologists
National Association of Secondary School Principals
National Association of Social Workers
National Education Association
National Parent Teacher Association
National Rural Education Association
National School Board Association
New York State Education Department
School Social Work Association of America

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002a. fax	Garry Mauro to Melanne Verveer re: phone number and address (partial) (1 page)	07/30/1999	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20465

FOLDER TITLE:
Medicaid and School Based Clinics [Folder 1]

2012-0463-S
rc784

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

Garry P. Mauro
P6/(b)(6)

[0020]

FACSIMILE TRANSACTION SHEET

TO	Date
Melanne Verveer Chief of Staff to Hillary Rodham Clinton	07/30/99
Company The Whitehouse	**From:** Garry P. Mauro
Fax Number Called: 202-456-6244	**Total Number of Pages (Including Cover Sheet): 7**
RE:	

Instructions:

PLEASE DELIVER TO MS. VERVEER

Ms. Verveer,

As we discussed, enclosed is a summary of the issues regarding the public school Medicaid reimbursement. It is also my understanding that school districts in the State of New York are getting an estimated $200 million per year in Medicaid reimbursement claims.

If you have any additional questions, please call me at P6/(b)(6)

Sincerely,

Garry Mauro

If any problems or questions arise, please contact this office immediately at 512/ 328-8877.

Person sending report: Frances	

ISSUE ALERT:
PUBLIC SCHOOL MEDICAID REIMBURSEMENT

- In a letter dated May 21, 1999, addressed to all State Medicaid Directors (letter attached), the Health Care Financing Administration (HCFA) announced its intention to review and possibly revise its current guidelines governing the requirements for filing Medicaid Administrative Claims (MAC) reimbursement claims.

  While states clearly play a role in the administration of the MAC program, it is absolutely imperative that local public school service providers be given an adequate and meaningful opportunity to develop and provide input so as to ensure that any program changes finally adopted do not undermine their ability to remain in full compliance with all reporting guidelines. In the case of Texas, and many other states, end service providers are local school districts. To date, school districts nationwide have not been given the opportunity to directly participate in this process.

BACKGROUND

- MAC is a federal program designed to reimburse states for performing federally mandated outreach programs for primary and secondary public school students at-risk due to physical or emotional disabilities. It is administered at the federal level by HCFA, which coordinates the reimbursement function through each state's designated Medicaid Director.

- States have the flexibility to delegate to local units of government the responsibility for performing various outreach activities. In Texas, local public schools are assigned this responsibility (this model of relying on school districts to provide these mandated services is common to most states participating in the MAC program). Texas has a total primary and secondary school age population of approximately 3.7 million students. ***If all Texas schools participated in the MAC program, their collective federal reimbursement for providing these mandated services has the potential to generate an estimated $80 to $100 million annually. This is an important source of revenue for Texas school districts. But it is equally important to note that if all reimbursable claims were paid nationwide, the total cost would amount to approximately $2 billion per year (realistically, the actual annual cost would be far less). Hardly enough to bankrupt the federal government.***

- The La Porte MAC Consortium is an umbrella organization of over 300 Texas school districts that provide outreach services eligible for reimbursement under the MAC program to more than 1.3 million Texas children. Most are from low-income families without health insurance or access to private health care providers. La Porte Independent School District serves as the fiscal agent for the consortium and coordinates both the filing of quarterly claims and the distribution of claims paid to the member school districts.

- HCFA's current reporting requirements for purposes of filing MAC claims are very detailed and complex. Both HCFA and the Texas Medicaid Director have approved the methodology utilized by the La Porte Consortium to prepare each claim submitted. Since the program's inception in Texas, the consortium has filed claims totaling $19.2 million. ***All have been approved and paid.***

ACTION REQUESTED

- At this very moment the Administration and members of Congress are exploring ways to broaden and expand health care screenings for senior citizens. It would be a sad irony if an arm of the Department of Health and Human Services implemented unreasonable reporting guidelines that would curtail, if not eliminate, a program for identifying medically at-risk, low-income school age children. ***Suspend or delay the accelerated, and unnecessary, issuance of HCFA's guidelines until the public schools have had the opportunity to provide direct input into the process. The system has worked to this point as Congress and the Administration intended. The guidelines under internal consideration may impose an onerous administrative burden on public school districts that, as a practicable matter, will make their continued participation in the program uneconomical. That result will harm tens of millions of children throughout this country.***

May 21, 1999

Dear State Medicaid Director:

This letter addresses reimbursement for school-based health services under Medicaid. School-based services play an important role in assuring that Medicaid-eligible adolescents and children receive needed health care. In particular, Medicaid is the payer of first resort for medical services provided to children with disabilities pursuant to the Individuals with Disabilities Education Act (IDEA). Although HCFA strongly supports the provision of school-based health services, it is important that these services meet applicable Federal Medicaid requirements. This letter clarifies HCFA policy in three areas: (1) use of a bundled rate to pay for medical services provided to Medicaid-eligible children in schools; (2) State claiming for school health-related transportation services for children with Individual Education Plans (IEPs) under the IDEA; and (3) State claiming for school health-related administrative activities.

Bundled Rates for School-Based Services

We and key Congressional Committees have identified a concern related to the "bundling" of school-based health services. We believe you share our interest in maintaining the fiscal integrity of the Medicaid program and, because of the risks discussed below, we are changing our policy in this regard.

A number of States have been paying for school-based services using a "bundled rate" methodology. This permits schools to minimize paperwork by billing for a package of medical services, rather than for each individual service provided to each child. A bundled payment rate exists when a State pays a single rate for one or more of a group of different services furnished to an eligible individual during a fixed period of time. The payment is the same regardless of the number of services furnished or the specific costs, or otherwise available rates, of those services. The bundle may include two or more components usually provided by different providers, each with their own unique provider qualifications, even if the components fall within the same 1905(a) service category. For example, bundling exists when two or more component services are provided under the rehabilitative services benefit even if all of the school-based services are identified in the State plan as being contained within that one 1905(a) service category.

Our concerns are related to the fact that bundled rates for school-based providers are not related to a specific type of procedure and are generally not available to all qualified providers in the community who might wish to be similarly reimbursed. Furthermore, schools do not maintain the types of medical documentation that establish the reasonableness or accuracy of a rate. Because of these factors, HCFA has concluded that these bundled rate methodologies do not produce sufficient documentation of accurate and reasonable payments, and may result in higher payments than would be reasonable on a fee-for-service basis for each individual service and thus do not meet the statutory intent of the law. Section 1902(a)(30)(A) of the Social Security Act requires that States have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care. We believe that a bundled rate for school-based services is inconsistent with economy, since the rate is not designed to accurately reflect true costs or reasonable fee-for-service rates, and with efficiency, since it requires substantially more Federal oversight resources to establish the accuracy and reasonableness of State expenditures. There is therefore no reliable basis for determining that the rate is related to the actual cost to the State and other public entities, absent documentation of the individual services provided.

Effective immediately, HCFA will no longer recognize bundled school-based health services rates as acceptable for purposes of claiming Federal financial participation (FFP). States that are currently paying bundled rates for school-based health services pursuant to an approved State plan amendment must develop and prospectively implement an alternative reimbursement methodology. We will be convening a meeting with a group from the States and the Department of Education to discuss options that are available. Also, States will be given time to work with the HCFA regional offices which will assist in the development and implementation of a non-bundled reimbursement methodology.

HCFA would like to work with states to implement a strategy so that States can come into compliance prospectively. At this time, no retroactive disallowances of FFP are planned nor are prospective deferrals. However, we expect states to work to come into compliance with this policy expeditiously. We recognize that some may require authorization or action by the State Legislature to implement a new reimbursement methodology. In the event that States do not come into compliance within a reasonable time, HCFA will consider taking a compliance action, including deferrals and retrospective disallowances to the date of this letter.

HCFA will not approve any additional amendments to State plans that seek to reimburse for school-based health services using

a bundled rate. States with pending bundling plan amendments may either withdraw those amendments or revise them to conform to the requirements described in this letter. If the State wishes to retain the effective date of the amendment, HCFA will assist the State to develop an approvable amendment. An approvable amendment must include requirements for maintaining documentation of the individual services provided to support claims for FFP. It should be noted that the IEP is not sufficient for purposes of documenting services provided since it identifies only those services that a child should receive, and not those services that the child actually receives.

Transportation

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. The 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.

It is our understanding that an IEP should include only specialized services that a child would not otherwise receive in the course of attending school. Therefore, HCFA would like to clarify that 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 Office of Management and Budget 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.

Effective July 1, 1999, FFP will only be available for Medicaid school-based transportation cost as administrative activities in accordance with the policies described above. Similarly, FFP for IEP related transportation services will only be available for services provided on or after July 1, 1999 as specified in this letter. HCFA's regional offices will provide technical assistance to States to assist them in properly claiming FFP for school-related transportation.

Administrative Claiming for School-Based Services

HCFA is currently reviewing practices related to State claiming for school-based administrative activities. A guide is expected to be published this Summer which clarifies the requirements for claims for Medicaid expenditures for administrative activities performed in schools.

HCFA regional and central office staff will provide every assistance to States in their efforts to conform to these policies.

Sincerely,

/s/

Sally K. Richardson
Director

cc

All HCFA Regional Administrators
All HCFA Associate Regional Administrators for Medicaid and State Operations
Lee Partridge - American Public Human Services Association
Joy Wilson - National Council of State Legislatures
Matt Salo - National Governors' Association

La Porte MAC Consortium

Districts that have either a contract or a letter of intent as of May 10, 1999

588 Educational Co-op
Academy ISD
Adrian ISD
Alief Montessori Community School
Allen ISD
Alvarado ISD
Alvin ISD
Amarillo ISD
American Institute for Learning Charter School
Anderson County Special Ed. Co-op
Angleton ISD
Aransas Pass ISD
Archer City ISD
Arlington ISD
Austin County Education Co-op
Austwell-Tivoli ISD
Avery ISD
Azle ISD
Bandera ISD
Bangs ISD
Barbers Hill ISD
Bartlett ISD
Bastrop ISD
Bastrop Special Education Co-op
Beaumont ISD
Beeville ISD
Bell County Special Ed. Co-op
Belton ISD
Big Four Co-op for Special Ed.
Big Thicket Co-op
Birdville ISD
Blanket ISD
Blooming Grove ISD
Boerne ISD
Bosque County Education Co-op
Brazosport ISD
Bronte ISD
Brookesmith ISD
Brownsville ISD
Brownwood ISD
Bryan ISD
Bushland ISD
Calallen ISD
Carrollton-Farmers Branch ISD
Castleberry ISD
Cedar Hill ISD
Center ISD
Center Point ISD
Central Heights ISD
Channelview ISD
Chilton ISD
Chireno ISD
Chisum ISD
Christoval ISD
City View ISD
Clarksville ISD
Clifton ISD
Cluster Seven Co-op for Special Ed.
Coldspring-Oakhurst CISD
College Station ISD
Collinsville ISD
Como-Pickton CISD
Connally ISD
Conroe ISD
Coolidge ISD
Coppell ISD
Copperas Cove ISD
Corpus Christi ISD
Crane ISD
Crowley ISD
Culberson County-Allamoor
Danbury ISD
Dawson ISD
De Soto ISD
Deer Park ISD
DeKalb ISD
Del Valle ISD
Detroit ISD
Dew ISD
Dripping Springs ISD
Eagle Mountain-Saginaw ISD
Early ISD
East Central ISD
East Chambers ISD
Eden CISD
Edgewood ISD
Electra ISD
Elgin ISD
Elkhart ISD
Emma L. Harrison Charter School
Ennis ISD
Etoile ISD
Evadale ISD
Everman ISD
Fairfield ISD
Falls City ISD
Falls Education Co-op
Flour Bluff ISD
Fort Davis ISD
Fort Stockton ISD
Frankston ISD
Fredericksburg ISD

La Porte MAC Consortium

Districts that have either a contract or a letter of intent as of May 10, 1999

Freestone-Navarro Bi County Co-op
Friendswood ISD
Garrison ISD
Glen Rose ISD
Goliad ISD
Goliad Special Education Co-op
Goose Creek CISD
Graham ISD
Grape Creek ISD
Grapevine-Colleyville ISD
Grayson Co. Co-op for Special Ed.
Greater Gulf Coast Special Ed. Co-op
Gregory-Portland ISD
Groesbeck ISD
Gunter ISD
Hallsville ISD
Hamshire-Fannett ISD
Hardin-Jefferson ISD
Harlandale ISD
Harleton ISD
Harlingen CISD
Harrison County Special Ed. Co-op
Hartley ISD
Hawkins ISD
High Island ISD
Highland Park ISD
Hitchcock ISD
Holland ISD
Holliday ISD
Hooks ISD
Houston Canl Academy Charter School
Howe ISD
Hubbard ISD
Hudson ISD
Huffman ISD
Hunt ISD
Huntsville ISD
Hurst-Euless-Bedford ISD
Ingleside ISD
Iowa Park Consolidated ISD
IRRA Inc.
Irving ISD
Jefferson ISD
Joaquin ISD
Judson ISD
Karnes City ISD
Kaufman ISD
Keller ISD
Kendleton ISD
Kenedy ISD
Kennedale ISD
Kerens ISD
Kerrville ISD
Killeen ISD
Kingsville ISD
Kountze ISD
La Marque ISD
La Porte ISD
La Vega ISD
La Vernia ISD
Lake Travis ISD
Lamar CISD
Lamar Co. Special Education Co-op
Lampasas ISD
Lancaster ISD
Laredo ISD
Leander ISD
Limestone County Co-op
Longview ISD
Lufkin ISD
Lumberton ISD
Magnolia ISD
Mansfield ISD
Marathon ISD
Marble Falls ISD
Marfa ISD
Marion ISD
Martin ISD
Marshall ISD
Martinsville ISD
May ISD
Megargel ISD
Mexia ISD
Midway ISD
Mildred ISD
Miles ISD
Mount Vernon ISD
Nacogdoches Co. Co-op for Spec. Ed.
Nacogdoches ISD
Nederland ISD
Needville ISD
New Boston ISD
Newcastle ISD
North Lamar ISD
Odem-Edroy ISD
Olfen ISD
Olney ISD
Paint Rock ISD
Palestine ISD
Panther Creek CISD
Paris ISD
Pasadena ISD
Pearland ISD
Pflugerville ISD
Pittsburg ISD

La Porte MAC Consortium

Districts that have either a contract or a letter of intent as of May 10, 1999

Plano ISD
Point Isabel ISD
Port Aransas ISD
Port Arthur ISD
Pottsboro ISD
Prairiland ISD
Presidio ISD
Quitman ISD
Red River County Co-op
Refugio ISD
Richardson ISD
Riesel ISD
Robert Lee ISD
Robstown ISD
Rosebud-Lot ISD
Round Rock ISD
Royal ISD
Runge ISD
Sabine Pass ISD
San Benito CISD
San Felipe Del Rio ISD
San Patricio Special Education Co-op
San Vicente ISD
Santa Fe ISD
Seymour ISD
Shepherd ISD
Sinton ISD
Slocum ISD
Small Schools Co-op
Smithville ISD
Southside ISD
Southwest ISD
Spring Branch ISD
Stafford MSD
Taft ISD
Talco-Bogata CISD
Teague ISD
Tenaha ISD
Texas Academy of Excellence
Texas City ISD
Throckmorton ISD
Tom Bean ISD
Tomball ISD
Troy ISD
United ISD
Van Alstyne ISD
Vega ISD
Veribest ISD
Waco ISD
Walcott ISD
Wall ISD
Waskom ISD
Water Valley ISD
Weatherford ISD
West Hardin County CISD
West Wichita County Special Ed. Co-op
Western Bowie County Co-op
Westphalia
Westwood ISD
White Settlement ISD
Whitesboro ISD
Whitewright ISD
Wichita Falls ISD
Wildorado ISD
Willis ISD
Windthorst ISD
Woden ISD
Woodsboro ISD
Woodson ISD
Wortham ISD
Zapata County ISD

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002b. fax	Bruce to Melanne Verveer re: phone number and address (partial) (1 page)	08/02/1999	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20465

FOLDER TITLE:
Medicaid and School Based Clinics [Folder 1]

2012-0463-S
rc784

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

Chris

CESAR CHAVEZ PUBLIC CHARTER HIGH SCHOOL FOR PUBLIC POLICY

FACSIMILE TRANSMITTAL SHEET

TO: Melanne Verveer	FROM: Bruce N. Allen
FAX NUMBER: 456-6244	DATE: 8/2/99
COMPANY: Office of the 1st Lady	TOTAL # OF PAGES INCLUDING COVER: 1
PHONE NUMBER: 395-3000	
RE: Health Care	

NOTES/COMMENTS:

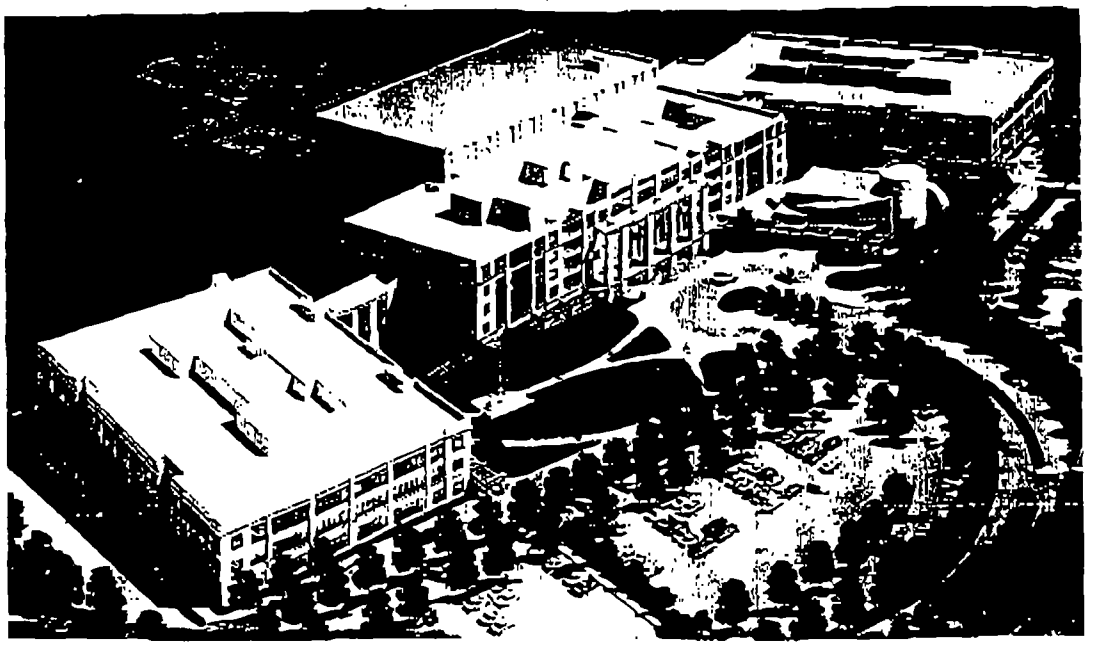
The Sunday NYT says VA Hospitals are under-utilized. There is a shortage of affordable healthcare in our country. Why not match the excess supply with the excess demand?

P6/(b)(6)

[6026]

CESAR CHAVEZ PUBLIC CHARTER HS • 401 M STREET, SW • WASHINGTON, DC 20024
PHONE: 202-488-1951 • FAX: 202-488-1953

HEALTH CARE FINANCING ADMINISTRATION
NATIONAL HEADQUARTERS
7500 Security Boulevard
Baltimore, MD 21244-1850



FACSIMILE TRANSMISSION REQUEST

ADDRESSEE:(Name, Organization, Address)
Deborah Adler

Phone: (202) 456-5560

FROM: Lori P. Maatta
OFFICE OF THE ADMINISTRATOR
C5-26-11-Location
C5-16-03-Mail Stop
Phone: (410) 786-3151 /Fax (410) 786-8060

TOTAL PAGES:	ADDRESSEE'S FAX MACHINE NUMBER	DATE:
Cover + 5	(202) 456-5557	8/29/00

REMARKS:

Deborah -
Significant issues identified by HCFA - Internal Document ONLY. First 4 items are most significant
Please call me at (410) 786-3151 to discuss prior to Call. - Thanks
Lori

IF FAX MACHINE RETRANSMISSION IS NECESSARY PLEASE CALL:

Lori Maatta **AT:** (410) 786-3151
(Name) **(Phone)**

MEDICAID SCHOOL BASED ADMINISTRATIVE CLAIMING GUIDE

SIGNIFICANT PROGRAMMATIC ISSUES

Free care rule. This issue is the extent to which the Medicaid "Free Care" principle precludes payment for medical services and administrative costs under the Medicaid program. Under the Medicaid "Free Care" principle, related to the Medicaid as "payor of last resort" provision, the costs of services and activities which are generally available to the public without charge, and for which no other sources for reimbursement are pursued, are not reimbursable under the Medicaid program. For example, even though the Medicaid program would otherwise reimburse for physicals provided to children in schools as an "EPSDT" service, if such services were provided free of charge to all school children and no payment was pursued from any other payment sources; payment would be precluded under Medicaid under the free care provision. The Department of Education (ED) believes that the Free Care principle should not apply with respect to such and other services.

The exceptions to the Free Care and payor of last resort principles are specified in Medicaid statute:

> §1902(a)(11)(B) of the Act which provides for Medicaid to pay for Medicaid coverable services provided by a Title V grantee in the State
>
> §1903(c) of the Act which allows Medicaid to pay for coverable Medicaid services for children included in an Individualized Education Program (IEP) or Individualized Family Support Plan (IFSP) under the Individuals with Disabilities in Education Act (IDEA).

In these two situations, rather than being payor of last resort, Medicaid would pay before the State Title V agency and education agencies in the specified circumstances. It must be clarified that these statutory exceptions to the payor of last resort principle do not make HCFA the payor of first resort for these services (and related administrative costs). Instead, under these statutory exceptions Medicaid would pay before the referenced IDEA Department of Education. Medicaid third party liability (TPL) provisions for pursuing all sources of liability, such as "pay and chase" for the costs of these services, are still required by statute (§1902(a)(25)(E)) and recovery is sought if there is a liable third party (i.e., private insurer).

"Section 504" Services. This issue is whether Medicaid funding is available for "section 504" services (referring to services provided to children under section 504 of the Rehabilitation Act of 1973). HCFA's position is that, under the principle that the Medicaid program is the "payor of last resort," ED programs would pay before the Medicaid program with respect to section 504 services provided to Medicaid eligibles. The Medicaid statute (§1903(c)) provides for a specific exception to this principle with respect to services included in IEP provided under the IDEA. With respect to this explicit exception to the payor of last resort principle, the Medicaid program would pay before the IDEA programs for Medicaid covered services for Medicaid eligible children that are included in an IEP. Although §504 services are similar to those provided to

children with IEPs/IFSPs under IDEA and §504 calls for the development of an individualized service plan (ISP), they are normally provided to children who are less disabled and do not qualify under IDEA. Therefore, the §1903(c) exception does not pertain to section 504 services. ED would like HCFA to reconsider the differing treatment for IEP services and section 504 services. ED has in the past expressed interest in the possibility in having a meeting between their Civil Rights staff and HHS General Counsel on this issue (they have not to date requested this meeting). ED will follow up with their Civil Rights staff on this issue to determine whether it would be appropriate to set up such a meeting.

Individualized Education Program (IEP) Activities. This issue is whether the Medicaid program should pay for the administrative costs related to the development of the IEP. Although, under the §1903(c) exception to the payor of last resort principle, the Medicaid can provide funding for the provision of medical services contained in an IEP, the Medicaid program does not pay for the administrative costs associated with the development of an IEP and Individualized Family Service Plans (IFSPs). The development of the IEP/IFSP is an Education program requirement under IDEA; it is not an activity which is for the administration of a State's Medicaid State plan. ED believes that some of the administrative costs related to the development of the IEP, such as meetings to coordinate or review a student's needs for health-related services that are covered under Medicaid, should be payable under the Medicaid program.

Child Find. This issue is whether the costs of "Child Find" activities, should be payable under the Medicaid program. Medicaid funding is available for the proper and efficient administration of the Medicaid State plan; it is not available for the administrative costs of other programs, such as under the IDEA. A State is only eligible for funding under IDEA (§612(a)) if the State demonstrates to the Secretary of ED that it meets certain conditions, such as conducting Child Find activities, as defined in IDEA. Child Find (§612(a)(3) of IDEA) refers to the IDEA requirement for all children with disabilities (as defined in §602(a)(3) of IDEA) residing in the state and who are in need of special education and related services to be "identified, located, and evaluated and a practical method" to be "developed and implemented to determine which children with disabilities are currently receiving needed special education and related services." HCFA views the child find activities as required and relevant to IDEA; they are not generally allowable as Medicaid program administration. However, there are related activities, such as Medicaid outreach, which are claimable under Medicaid. ED believes that much of Child Find should be claimable under Medicaid. The issue is how to distinguish between "Child Find" activities performed by school personnel which are under the purview of IDEA and Medicaid administrative activities, such as Medicaid outreach, that are performed under the purview of the Medicaid program.

SECONDARY ISSUES

ED has also identified secondary issues:

Documentation. ED would like to discuss documentation issues further with HHS/HCFA and OMB, in terms of the differing requirements of ED and HCFA as they pertain to school-based

programs. ED's questions on this issue are with respect to OMB Circular A-87, which establishes a single set of requirements for all Federal programs. OMB references a "cognizant agency" as responsible for establishing certain parameters, such as indirect cost rates, and the associated types and level of documentation that grantees/recipients must maintain for Federal programs. ED noted that the schools are struggling with the documentation requirements in the Medicaid program, which differ from ED's requirements and which are perceived as significantly more burdensome than those of ED (although not necessarily conflicting). The Workgroup observed that ED's programs are capped whereas Medicaid is an open-ended program, which might account for much of the difference between the requirements. HCFA indicated that Medicaid administrative claims are submitted by the Medicaid agency to HCFA for these school based administrative costs, and as such, HCFA and the State are responsible for ensuring that such claims are allowable under Medicaid in accordance with Medicaid statute and regulations. In that regard, HCFA indicated its belief that there is not necessarily any conflict in Medicaid and A-87 requirements.

ED is concerned with the interplay of the statutory and regulatory provisions and would like to pursue with HCFA the possibility of additional flexibility in this area. Much of their concern is in the details; at the sub-regulatory level. ED indicated that time studies are an example of the differences between HCFA's and ED's documentation requirements. ED also noted that they do not believe this issue affects the Guide in many places and that any higher level discussions on the issue will not result in major changes to the Guide. HCFA asked ED what the cost allocation requirements are for Education programs. ED noted that they have issued guidance on indirect costs which they will share with HCFA.

Data Sharing. ED indicated that their concerns about data sharing largely pertain to the pertinent legal requirements, mainly in terms of confidentiality issues which may impose administrative barriers to States/schools in their school based programs.

OTHER ISSUES

Following identifies other issues identified either from the comments on the Draft Guide or by the Workgroup:

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. The Workgroup is in consensus that the Guide should clarify EPSDT services and provisions as they relate to the allowability and availability of FFP for the costs of associated Medicaid administrative activities. However, certain screening activities are considered by HCFA as being provided and available as free care to all children in the school setting. Although such screenings might otherwise be reimbursable under Medicaid as an EPSDT screen, because of the free care principle, they would not. Since these screens are not included in an IEP/IFSP, Medicaid would not reimburse for such screens under the §1903(c) exception to the payor of last resort principle. Under the EPSDT provisions, any medically necessary services discovered by the screening services must be provided by the Medicaid agency. Therefore, although as indicated, the screenings would not be reimbursable under Medicaid, because of the "discovered though a screen" provision, the Medicaid program would be required to pay for the services pursuant to the screen. The ED believes that the screen should also be reimbursed under the Medicaid program.

Skilled Professional Medical Personnel (SPMP). Many of the public commenters indicated that they believe the documentation requirements for enhanced rates are overly burdensome, and that the language in the Draft Guide discourages claiming at enhanced rates, particularly for SPMP activities. In addition, a number of commenters objected to the fact that the Draft Guide does not indicate which activity codes may be claimed at enhanced rates; or that there are no specific activity codes for SPMP activities. Although, at least theoretically SPMP activities may be performed in the school setting, because of ongoing questions and problems, at this time HCFA considers most such SPMP activities to be questionable. Accordingly, SPMP activities were not explicitly included in the activity codes contained in the draft Guide. Rather, the draft Guide described the requirements for availability of the enhanced SPMP rate, indicating the possibility for such claims.

Family Planning. Under Medicaid statute, the 90 percent enhanced FFP rate is available only for the "offering, arranging, and furnishing" of family planning services and related administrative activities. HCFA's longstanding policy under this provision is that FFP at the enhanced FFP rate is not available for the costs of the administrative activities related to family planning, unless the entity performing the activities are offering, arranging, and furnishing such services. That is, unless the entity actually offers and furnishes such services, enhanced FFP for the administrative activities related to the services (such as arranging for the services) would not be available. A number of comments argued that the statute should not be interpreted so as to limit the availability of the enhanced FFP rate to only those who provide all three listed activities (offering, arranging, and furnishing). These commenters believe the enhanced family planning rate should be available to those who, for example, offer and/or arrange for family planning services, but do not actually furnish them. However, schools may claim administrative activities related to covered Medicaid family planning services at the 50 percent administrative match.

Provider participation. In order for the costs of administrative activities related to medical services to be reimbursed, the coverable medical services must be performed by a Medicaid provider who bills for the services. Numerous commenters indicated that schools find it problematic to verify that a provider is participating in the Medicaid program. HCFA has previously discussed allowing schools to utilize a "proportional Medicaid provider rate." The provider participation rate would be analogous to the Medicaid percentage related to eligibility. This would relieve schools of the administrative burden of verifying Medicaid provider status, while still providing a valid method to confirm the percentage of participating providers serving the schools for claiming purposes. We would require an updating of the provider percentage on an appropriate frequency (e.g., quarterly). This HCFA proposal needs further discussion and/or approval.

Revenue Offsets. A number of comments were received indicating that further clarification regarding revenue offsets was needed. The consensus of the Workgroup is that the draft Guide is confusing on this issue and should be clarified. Revenue offsets are the revenues that must be offset from costs to be allocated in order to reduce the total amount of costs in which the Federal government will participate. To the extent the funding sources have paid or would pay for the costs at issue, Federal Medicaid funding is not available. In particular, the treatment of funding under IDEA under the revenue offset provisions will need to be further clarified.

Transportation. HCFA is planning to issue policy guidance which will further clarify the transportation policy contained in the May 21, 1999, letter to States on Medicaid school-based issues. If

this policy clarification is issued prior to finalization of the Guide, the new policy will need to be reflected in the Guide.

Transition Period. The Workgroup is in consensus regarding the issue of treatment and compliance of States' school based claiming programs with the provisions referenced in the Guide during the transition to implementation of the final Guide period. Specifically, since the Guide is intended to be a permanent document, transition policies will not be addressed directly in the Guide itself. Rather, the Workgroup agreed that transition policies should be addressed and disseminated in a cover letter transmitting the final Guide, or in a separate letter. Regardless of the specific vehicle for issuing transition policies, such policies will need to be developed in order to allow States to come into compliance with program requirements.

[INITIAL APPROACHES WERE TO WORK ON BRINGING EXISTING PROGRAMS INTO COMPLIANCE ON A PROSPECTIVE BASIS AND THEN WORKING WITH STATES TO DEAL WITH THE RETROACTIVE ISSUES. THIS ISSUE WOULD REQUIRE FURTHER INPUT FROM CMSO PRINCIPALS.]

TOTAL P.06