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P1 National Security Classified Information [(a)(1) of the PRA]
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29 AUGUST 2000

MEMORANDUM TO CHRIS JENNINGS

FROM JANICE ENRIGHT

RE DRAFT GUIDELINES FOR MEDICAID'S ADMINISTRATIVE OUTREACH CLAIMING PROGRAM

Chris, in anticipation of Thursday's meeting, we had a meeting today with the American Association of School Administrators, the National School Board Association, and Deloitte Consulting, to discuss the comments and reaction to the draft guidelines which were circulated several weeks ago to the associations, including the Council of the Great City Schools.

As a result of the review and the comments of all parties, a revised version of the draft claiming guide is being produced. I would gladly have it delivered to you prior to the meeting if you think it conducive to a more productive meeting on Thursday. Please let me know.

Attached is a list of goals which were agreed upon for the Thursday (31 August) meeting. I transmit them to you for your review with the sincere hope that they will help you to meet your goal of having a productive, substantive, constructive meeting.

In addition, I attach a memorandum from Sara Rosenbaum, dated July 28, 2000, which describes her response to the draft guidelines referred to above.

Sent by fax to 202-456-5557

FAX DATE: 8/29/00
TO: Julia Doan for Chris Jennings
FAX #: 6-5557
FROM: ICKES OR ENRIGHT
202-887-6726
PAGES: 5

GOALS FOR 8/31/00 MEETING

1. Get the Administrative Claiming program going within a specific, short-term deadline:
   - Claims are being deferred indefinitely;
   - State plans are not being approved.

2. Guarantee protection and access to service for Medicaid-eligible and Medicaid-eligible disabled children, as current law requires.

3. Agree to a set of simple guidelines, like the current working draft, which:
   - Was reviewed favorably by all of the education groups represented here;
   - Was reviewed favorably by independent expert, Sara Rosenbaum;
   - Is responsive to GAO concerns about integrity and responsibility;
   - Most importantly, requires that HCFA approve all claiming programs (a primary GAO concern).

Memorandum

To: Nick Penning

Fr: Sara Rosenbaum

Re: Review of second draft of the administrative claiming guide

Date: July 28, 2000

I have had a chance to review the second draft of the administrative claiming guide.

In general

In my view this version is a significant improvement over the prior version, although a couple of significant issues remain. This version is reasonably clear and for the most part limits its reach to administrative claiming matters only. (As you may recall, the prior version of the Guide not only was confusing but more importantly, failed to limit its discussion to administrative activities. As a result, the first version appeared to incorrectly classify certain classes of covered medical assistance services as completely non-reimbursable, simply because they are not administrative services. If a service meets the definition of "medical assistance" under §1905(d) and is furnished to an eligible and enrolled child by a qualified participating provider, it is reimbursable, regardless of whether it qualifies for reimbursement under administrative claiming principles as well (some services can have a dual nature, as this version of the guide points out).

Specific Comments

Prior approval of "school-based administrative claiming programs." The major change in current policy that the guide appears to make is the imposition of a pre-approval requirement for "school-based"

administrative expenditures). According to HCHA, prior approval is not explicitly required by the statute or regulations, but the agency appears to want to institute such a policy.

I consider this alteration to fall within the changes in federal administrative practices that the agency can institute without going through a rulemaking; your staff or counsel may differ. However, I do feel that the circumstances under which prior approval will be required are ambiguous in certain respects, and the agency's policy needs clarification before it can be put into place. I elaborate on this issue below, along with offering further comments.

Ambiguity in the reach of the guide: This version does a better job of clarifying that it is not intended for application to medical assistance services. However, in at least two places the document appears to state that HCFA can in fact deny FFP for activities that constitute permissible medical assistance services under the statute. Any inference that this Guide has any application to issues of payment for medical assistance services, particularly in the area of medical case management, should be removed.

1. *The prior approval policy*: To whom does it apply? The document (p. 11) talks about prior approval for "new programs". Are all existing programs to be considered "new programs"? Are new programs limited to programs instituted for the first time only after the effective date of the change? How about an existing program that is expanded?

2. *"School-based:"* What is a "school based" program for purposes of prior approval? Is the program considered school based when the administrative functions are carried out by employees of the school district or specific schools? What if a school contracts with the local health department or a health center (or even an independent health professional) to deploy nurses and other health professionals in the school to carry out administrative activities along with the provision of medical care? Does the fact that they work in a school mean that their activities are "school-based" for purposes of pre-clearance?

3. *Non-applicability to medical assistance services:* The meaning of the second sentence in the Conclusion section (p. 13): I do not know what is meant by the sentence that reads "It is important to note that to minimize the possibility of confusion, this Guide does not, except where there are potential issues of overlap or duplication, address requirements related to LEAs' provision of direct medical services." If a service can be reimbursed as a direct medical service and is billed as such by the LEA (or its contractor), then nothing in this guide has

any relevance as far as I can tell, since the guide by definition does not deal with medical assistance services. This sentence should be omitted; I see no reason to even imply that the materials in this guide have any relevance to the question of how , when, and for what a school health program can be paid for its medical care services.

The Guide should begin with a disclaimer (following the first sentence in the introduction) that the guide does not address medical care matters and that services that can be billed as medical services are governed by completely different rules and methods that are not discussed here.

In this regard, the materials on page 7 (non-reimbursable activities) should either be revised or eliminated. The paragraph that begins with the word "additionally" describes much of what constitutes targeted case management under §1905(a)(19). Case management assistance to obtain medical, educational, social and other services is a type of medical assistance benefit to which all EPSDT children are entitled. Because the purpose of EPSDT is preventive, the service does not have to be *medically* necessary in the sense that it is necessary to treat an illness or injury before there can be coverage. The very fact that case management is necessary to promote healthy growth and development and achieve the preventive goals of EPSDT is sufficient to permit the service to be claimed as a medical assistance service. A school nurse or other health worker could be paid to furnish targeted case management to children whose needs include services that are furnished through other health, educational, social and other programs.

The ambiguity on page 7 regarding the term "non-reimbursable" activities is heightened by the sentence in the conclusion regarding the applicability of the guide to "overlapping" matters. These two sections, in combination, seem to imply that the agency reserves the right, however elliptical, to deny FFP *either* as a medical or administrative expenditure, for the services and activities described on page 7 in the sentence in question. They may not be administrative services, but they certainly are medical assistance in my view.

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June 30, 2000

Timothy M. Westmoreland
Director, Center for Medicaid and State Operations
Health Care Financing Administration
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Westmoreland:

On behalf of the partners, directors and staff in the Deloitte Consulting school-based health care billing practice, and the nearly 2,000 school districts that we serve as clients, we are pleased to provide you with the attached comments regarding the draft Medicaid School-Based Administrative Claiming Guide that was distributed for comment in February 2000.

Many of our clients have already submitted their comments to the several national associations that were identified to compile, synthesize and forward comments to HCFA. As you know, we have worked closely with our school district clients, and with the national associations as well, to assist them in articulating their points of view and concerns. While we did not previously provide written comments on behalf of Deloitte Consulting, preferring to assist our clients in their efforts to do so, it was recently suggested by staff of the Senate Finance Committee that it would be appropriate for Deloitte to submit comments. Since we have been advised that the comment period has not been formally closed and the national associations have not yet been provided with feedback regarding their submissions, we would like to take this opportunity to convey our thoughts and suggestions regarding the draft guidelines.

Attached to this letter you will find a rather detailed analysis of the draft guidelines. We are aware that that one consistent criticism of the draft is its tone and prescriptive negativism. Therefore, we would like to make some suggestions with regards to how a draft claiming guide can be more instructive, positive and useful to the constituency for which it is intended, the schools. In this vein we would like to suggest that the guidance provided to the states and the schools convey the following public policy principles:

1. Medicaid is a vital and prevalent funding source to reimburse schools for their role in assisting the states' with the proper and efficient administration of their State Medicaid Plans.
2. Schools are effective and efficient at identifying "at risk" children who are in need of or can benefit from health care and educational interventions.
3. Medicaid is a federal program that is financed and administered in partnership with the states and accordingly recognizes the flexibility and discretion states require to effectively and efficiently administer the Medicaid program.
4. Schools are an important constituency whose interests and points of view as stakeholders should be incorporated in any claiming guidance provided to the states.
5. Regardless of purpose, Individuals with Disabilities Education Act (IDEA) related activities performed by schools do result in children obtaining access to needed health care and therefore are in support of the State Medicaid Plan and should be reimbursed.
6. States that have requested review of Medicaid Administrative Claiming programs should be approved by HCFA for reimbursement under existing rules, on an interim basis, until the claiming guidance is finalized.

An overarching principle that should be considered in preparing the claiming guide is that it should provide guidance consistent with the federal and state partnership that characterizes the Medicaid program. Since Medicaid is a jointly funded program, states are entitled to and require the flexibility to design and implement programs that best suit the unique circumstances and needs of each state. For example, the differences between large and small, rural and urban schools districts within states must be accounted for. When it comes to addressing the health needs of needy and disabled children, the flexibility of a state to tailor its approach is even more important. Just as federal education statutes establish certain mandates and requirements that schools throughout the country must meet, each state and its local education agencies have a high degree of flexibility in establishing standards and program requirements to assure children in their schools are provided an appropriate education.

With regards to Medicaid Administrative Claiming, a sound approach is one that establishes clear policy objectives regarding program and fiscal integrity, effectiveness and efficiency to which states are expected to adhere. Within those policy objectives, states should have the discretion to tailor their program to address the respective needs of their schools and Medicaid beneficiaries.

We recommend a process in which school districts of all sizes and locales, HCFA, Education Department, respective national education associations and representatives of the interested committees of the House and Senate and the White House are brought together to assure that the voices of all stakeholders are heard. Additionally, we would be pleased to assist in and participate in such a process. Some past attempts to assure a positive outcome have resulted in adversarial or confrontational misunderstandings. Accordingly, we would like to help HCFA work with the various stakeholders to develop a positive and consultative process that culminates in guidance to the states that is supportive of the needs of all stakeholders.

All of us at Deloitte Consulting and the school districts we represent welcome the opportunity to participate in this important process.

Respectfully submitted,

DELOITTE CONSULTING

DC/rj

Attachment
cc: American Association of School Administrators (AASA)
American Public Human Services Association (APHSA)
Council of the Great City Schools (CGCS)
Council of Chief State School Officers (CCSSO)
National Association of State Directors of Special Education (NASDSE)
National Schools Boards Association (NSBA)

Medicaid School-Based Administrative Claiming Guide
Comprehensive Issue Analysis

A. Without inclusion of Early Periodic Screening, Diagnosis and Treatment (EPSDT) administrative requirements, the scope of activities for which FFP is allowable is greatly reduced. Consequently, schools will be forced to divert even more state and local dollars from education uses to the provision of basic health care and related support activities.

Citation: HCFA Draft Guidelines, Page 2, Section II. BASIS/AUTHORITY; A. Statute/Regulations

References/Comments:
EPSDT provisions are not included in the references/authorities cited above as being applicable to claiming Medicaid reimbursement for the cost of school based administrative activities. Because of the broad range of services and activities provided for under the EPSDT program, much of the time and effort of school personnel related to administrative outreach is authorized under the EPSDT program. Additionally, given Health Care Financing Administration's (HCFA) historical emphasis on the value of the EPSDT program as referenced below, it can only be assumed that the omission of any reference to the EPSDT regulations was simply due to oversight.

The HCFA Technical Assistance Guide, dated August, 1997, states, on page 9, that *"children under the age of 21 are entitled to the mandatory Federal Medicaid benefit known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT)...The goal is to assure that children's health problems are diagnosed and treated as early as possible, before the problems become more complex and treatment more costly".*

Also in the HCFA Technical Assistance Guide - pages 10 & 11 *"The following are required EPSDT services (under Section 1905(r) of the Act):*

- *Screening Services*
- *Vision Services*
- *Dental Services*
- *Hearing Services*
- *Other necessary health care, diagnostic services and treatment services*
- *Provision of medically necessary interperiodic screening – The referral for interperiodic screening can be made by any health or developmental education personnel who comes in contact with the child, within or outside the health care system...Because of the proximity of schools to the target population, HCFA has always encouraged the participation in the Medicaid program as they can play a particularly useful role in providing EPSDT services. School based services can represent an effective tool which can be used to bring more Medicaid-eligible children into preventive and appropriate follow-up care.*

In addition, schools represent a wonderful opportunity for Medicaid outreach. That is because schools are by definition "in the business of serving children," they can be a catalyst for

encouraging otherwise eligible Medicaid children to obtain primary and preventative services, as well as other necessary treatment services."

B. It appears that the following guidelines prohibit states from utilizing a currently approved program management structure that is based primarily on a multi-district consortium model. The model is especially designed for school based programs to achieve several implementation and management efficiencies including; reducing the administrative burden on the State; assuring that all schools, regardless of size, have an equal opportunity to participate in and benefit from the administrative outreach program; and reducing the time and paperwork burden on the school personnel.

Citation: HCFA Draft Guidelines, Pages 3/4 Section III. INTERAGENCY AGREEMENTS - B. Requirements:

"Any local education agency (LEA) or school that receives payments for administrative activities under Medicaid may be acting as an agent or contractor for the State Medicaid Agency. To claim Federal funding for allowable administrative activities, there must be a formal intergovernmental/interagency agreement between the LEAs or schools and the State Medicaid Agency".

References/Comments:

The consortium model is designed to achieve several important program implementation and management efficiencies specifically: Reduced administrative burden on the State due to the use of a uniform methodology and utilization of statistical sampling methodologies to achieve valid results while minimizing service interruption in the schools. Ultimately, consortium models allow schools of all sizes to have an equal opportunity to participate efficiently and effectively. It is important to note that this model can be adapted to meet the data collection and claim calculation requirements of the state, and information is not aggregated at a state level where it would distort the reimbursement received.

C. States' ability and authority to design and implement a flexible program that accommodates its unique needs are seriously limited. Additionally, although numerous local public agencies receive administrative outreach reimbursement, only the schools appear to be subject to these nationally standardized provisions.

Citation: HCFA Draft Guidelines, Page 5, Section IV. CONSTRUCTING TIME ACTIVITY CODES – A. General: 2nd paragraph, last two sentences:

Subsection C provides standard activity codes developed in accordance with these principles. These codes may be used by States, school districts, and schools as the basis for time studies, which would be used to allocate administrative costs for purposes of making claims under the Medicaid program.

References/Comments:

This is one of several areas in which the draft guidelines appear to be establishing new policy and are unusually prescriptive when viewed in the context of national application. While it is acknowledged that broad, uniform guidelines need to be established for the administrative outreach program, there are such significant demographic and economic differences among the states that the flexibility to design and administer is essential to ultimate success of the program on a state-by-state basis. Some of the primary factors that vary extensively from state to state include: the extent to which schools are authorized to participate in a state's existing Medicaid program (FFS); the extent to which schools' participation in the FFS program where available is cost effective; the amount of state and local dollars that are expended per capita for public education (some states such as Michigan commit almost twice as much money per student than do other states, such as Texas); and the broader and higher age ranges and income eligibility limits that some states have established.

D. The draft guidelines reinterpret existing statutes and regulations through their lack of acknowledgement of EPSDT and its broader role in defining proper and efficient administrative activities.

Citation: HCFA Draft Guidelines, Page 6, Section IV: CONSTRUCTING TIME ACTIVITY CODES – B. 1. Proper and Efficient Administration last para:
The principle of proper and efficient administration must be applied in developing time study activity codes. For example, outreach activities would be considered to be in support of the Medicaid program if they were in regard to explaining Medicaid requirements. By contrast, outreach with respect to explaining the requirements of education program requirements would not be in support of the Medicaid program and must be separately accounted for.

Citation: HCFA Draft Guidelines, Page 6, Section IV CONSTRUCTING TIME ACTIVITY CODES – B. 2. Claiming for Allowable Activities Only:
Medicaid does not pay for administrative expenditures related to, or in support of, services that are not included in the State Medicaid plan or services that are not reimbursed under Medicaid. For example, where school employees assist a Medicaid-eligible child to obtain medical services that are included in the child's Individualized Education Plan (IEP), if the provider furnishing such services is not participating in the State's Medicaid program or is not part of a managed care organization (MCO) participating in the State's Medicaid program, FFP would not be available for the services: furthermore, FFP would not be available for the administrative activities to assist the child in accessing such services. These activities would be (sic) 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 Plan).

References/comments:
As referenced previously, there is no reference to EPSDT and this appears to be in direct conflict to previous HCFA Guidelines. The second guideline reference cited above is also in direct conflict with HCFA's own Technical Assistance Guide, dated August, 1997, which articulates, on page 17, that "**The school would not need a Medicaid provider number simply to perform administrative functions.**" The Technical Assistance Guide also articulates on page 47, "**Under administrative claiming, schools and school districts may perform certain**

Medicaid administrative functions without having to meet provider requirements." Also on page 47, **"The statutory, regulatory and administrative requirements for the performing of claiming for administrative activities differ from those for providing and claiming for medical assistance services."**

In addition to the exclusion of any consideration of the EPSDT requirements which contain numerous parallel provisions to IDEA, perhaps the greater concern raised by the draft guidelines is the manner in which they broadly exclude activities because they are for educational purposes rather than recognizing the similarity of the **results** of the schools' efforts to the desired outcomes of the Medicaid program which are primarily, to assist all children is accessing needed health care services whether in the school or in the community.

E. Elimination of reimbursement for administrative activities associated with referral, coordination and planning of screens or services is not consistent with IDEA provisions in the Medicaid statute. As defined in the proposed draft guidelines, the majority of activities for which schools are currently and appropriately reimbursed would be eliminated.

Citation: HCFA Draft Guidelines, Page 6, Section IV CONSTRUCTING TIME ACTIVITY CODES – B. 2. Claiming for Allowable Activities Only:
In addition, Medicaid does not pay for health care services that are rendered free of charge to the general population. Consequently, any administrative activity that supports the referral, coordination, planning of screens or services that are provided free to the general population would not be considered as Medicaid administration.

References/Comments:
The above proposed guideline is especially confusing. Schools do not provide "free care" even when a service is required for which there are no Federal or state funds available. The service still must be provided even if the schools have to literally borrow the funds to pay for it. Further, this appears to raise a significant legal question related to proposed application of the "free care rule" to administrative outreach activities.

In regard to IDEA, the free care rule does not, based on the following requirements, appear to be applicable. IDEA, while mandating that the provision of special education and related services be "free and appropriate" to all students with disabilities, section 612(e) does not permit a State to reduce medical or other assistance or to alter eligibility under Titles V, XIX of the Social Security Act. This obligation is further clarified in Appendix A to 34 CFR Part 300, which states; "This new statutory provision emphasizes the obligation for interagency coordination educational and noneducational public agencies to ensure that **all services** (emphasis added) necessary to ensure FAPE are provided to children with disabilities, and that **the financial responsibility of the State Medicaid agency or other public insurer shall precede that of the LEA or State agency responsible for developing the child's IEP** (emphasis added)."

F. Contrary to previously stated HCFA policy, IDEA provisions, and Medicaid statute, all schools, regardless of state policy relating to provider enrollment would be required to enroll as Medicaid providers to be eligible to receive reimbursement for administrative activities.

While schools in some states do meet this criterion, the documentation requirements are frequently so onerous and the reimbursement rates so low, it is not a cost effective option for the schools.

Citation: HCFA Draft Guidelines, Page 6, Section IV CONSTRUCTING TIME ACTIVITY CODES – B. 2. Claiming for Allowable Activities Only, last para., last sentence:
Administrative expenditures related to, or in support of, EPSDT are reimbursable under Medicaid, so long as the providers who furnish such services participate in the Medicaid program.

References/Comments:
While schools in some states are enrolled as FFS providers, in most states the schools are not even recognized by the Medicaid State Plan as being eligible to enroll as a provider of medical services. Additionally, to be eligible to claim time spent referring and coordinating services for a child with a community based provider, school personnel would be required to assume the unreasonable burden of having to know which providers (e.g., clinics, other public agencies, and individual physicians), are currently enrolled in the Medicaid program.

This proposed requirement appears to create new policy that is contradictory to existing HCFA policy and at least one previous DAB ruling. The August 1997 Medicaid and School Health: A Technical Assistance Guide, states that "[e]ven if a school does not directly furnish medical services, we encourage efforts to inform potential eligibles about the Medicaid program and the EPSDT benefit." Id. at 17. Also as referenced in HHS Departmental Appeals Board Decision No.1256 (1991) HCFA was required to reimburse county welfare departments that had interagency agreements under which they would *"perform outreach activities and inform and refer eligible recipients to the county health departments' EPSDT programs."* The county welfare agencies performed reimbursable Medicaid activities even though they were not enrolled providers of direct medical services.

G. Requirements to reconcile billed medical services to services captured on the time study will provide imperfect results due to differences in data collection techniques. Furthermore, this requirement would place undue administrative burden on both the states and the schools for an activity of limited value.

Citation: HCFA Draft Guidelines, Page 7, 3rd paragraph, Section IV. CONSTRUCTING TIME ACTIVITY CODES – B. 3 Capture 100 Percent of Time:

If a portion of a sampled employee's time is also billed as medical services, then the administrative time study results should be validated by comparing the time coded to direct medical services (Code 4) to the actual amount of hours billed directly.

References/Comments:

It would not be cost effective for states to attempt to distinguish between and track direct services that are not reimbursable and those that are. Many schools provide a wide array of direct services that are reimbursable for which the schools cannot bill because the state does not authorize schools to be enrolled providers. **Also, existing Medicaid requirements stipulate and ensure that all of the time and costs related to school staff performing direct services, whether or not they are billable to Medicaid, are not claimed for reimbursement under the administrative outreach program.**

H. Contrary to existing law, the guidelines assert that reimbursement is not available for appropriate activities if other funding mechanisms are also available.

Citation: HCFA Draft Guidelines, Page 8, Section IV. CONSTRUCTING TIME ACTIVITY CODES 5. Duplicate Payments:

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

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

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

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

References/Comments:
This proposed guideline appears to represent new policy. Existing Medicaid law and regulations do not prohibit reimbursement for services and /or activities that may also be funded from other sources. A primary example is IDEA, under which, in the absence of sufficient funding from other sources, schools must use whatever additional local funds are needed to provide the entitled services for students with disabilities. This provision would also be impossible for schools to comply with because they do not have access to information regarding the services provided by or funded by other state and local agencies.

I. Contrary to current Federal policy, the guidelines eliminate authorization for multiple agencies to perform administrative activities. Furthermore, they ascribe to MCOs the primary legal responsibility for Medicaid services that are currently provided by the schools. These provisions impose an inequitable and onerous burden on schools to assume primary coordination responsibility for administrative outreach services and force them to compete for dollars already allocated to managed care organizations.

Citation: HCFA Draft Guidelines, Page 9, Section IV. CONSTRUCTING TIME ACTIVITY CODES 6. Coordination of Activities: *In addition to avoiding duplicate payments, as indicated in Principle 5., duplication of activities or effort should also be avoided. Under Principle 1., allowable administrative activities must be necessary "for the proper and efficient administration of the (Medicaid) State plan. Therefore, it is important in the design of school-based administrative claiming programs that the local education agency (LEA) or school not perform activities that are already being offered or should be provided by other entities, or through other programs. As appropriate, this requires the close coordination between the LEAs, schools, State Medicaid Agency, State Department of Education, other providers, community and non-profit organizations, and other entities related to the activities performed.*

The following are examples of activities that should be coordinated:

- *Activities performed by a managed care organization (MCO) for the Medicaid or other program enrollees of the MCO, such as case management functions. To avoid duplication of these functions by school personnel, coordination mechanisms should be established between the school and appropriate entities, such as the MCO and State Medicaid Agency. Reimbursement rate setting mechanism.*
- *As appropriate, the rate setting mechanism under which the rates for functions which are performed by schools, but reimbursed by other entities, may need to reflect such functions. For example, the capitation rate paid to an MCO may include amounts for the performance of functions performed by schools; that is, such functions are the responsibility of the MCO. However, after coordination efforts, such functions may still need to be performed by the schools. In such cases, the MCO*

reimbursement rates may need to be adjusted to reflect the activities and services being furnished in the school setting.

- *An activity that is provided/conducted by another governmental component. For example, it is not necessary for EPSDT educational materials, such as pamphlets and flyers that have already been developed by the State Medicaid Agency, to be redeveloped by schools. It would be inefficient in the allocation of Medicaid program and school resources to do so. In order to avoid this, school districts/schools should coordinate and consult with the Medicaid State agency to determine the appropriate activities related to EPSDT and to determine the availability of existing materials.*

References/Comments:
This provision inaccurately defines MCO's as the only recognized provider of outreach. In most states, the MCO's invest little if any effort and funding in performing outreach. Further, the MCO's possess no legal authority or duty to either dictate what services other eligible providers (schools, local public health clinics, mental health agencies, etc.) offer or to contract with other local providers including schools for the provision of any services. Lastly, few if any MCO's cover any of the direct or supportive health services provided by schools.

J. Contrary to the intent of EPSDT legislation and IDEA provisions in Medicaid statutes, reimbursement for administrative outreach activities, as defined by the guidelines, is limited almost entirely to the Medicaid eligible population, thus excluding activities that are in support of the Medicaid plan.

Citation: HCFA Draft Guidelines, Page 11 Section IV. CONSTRUCTING TIME ACTIVITY CODES 8. Allocable Share of Costs: *Since many school-based medical activities are provided to both Medicaid and non-Medicaid eligible students, the costs applicable to these activities must be allocated to both groups. This allocation of costs is sometimes referred to as "discounting" and involves the determination and application of a proportional share of Medicaid students to the total students and the total costs applicable to a specific activity in a particular school or school district. Development of the proportional Medicaid share (also referred to as the Medicaid percentage) should relate to and be based on the claiming unit (the entity submitting the claim). For example, claims may be developed on an individual school basis, a school district wide basis, or a specific unit of government such as a county.*

References/Comments:
Although it is completely reasonable (and consistent in principle with existing practice) that costs must be apportioned/allocated between those activities that are non-discounted and those that should be discounted by the Medicaid Eligibility Rate percentage, this proposed provision is nonetheless confusing. While restricting the provision of administrative outreach to non-Medicaid eligible students to only two of the draft codes, this provision, contrary to existing approved programs, would still require that the other five draft allowable codes be further discounted by application of the Medicaid Eligibility Rate.

Additionally, from the Draft Guidelines, it appears that the Medicaid percentage must be calculated either on a school district basis or at a specific unit of government basis, such as a

county. In many states the enrolled school district providers represent consortiums of multiple school districts and counties for cost effectiveness purposes. These districts use a single, composite consortium wide MER. This practice is based on approvals granted in both Arizona and Texas.

K. Contrary to existing policy the guidelines virtually eliminate reimbursement at the 75% FFP rate for skilled professional medical personnel engaged in activities that require their skilled medical knowledge.

Citation: HCFA Draft Guidelines, Page 11 Section IV. CONSTRUCTING TIME ACTIVITY CODES 9. Enhanced FFP Rates:

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: ...

(IV). A State documented employer-employee relationship exists between the State Medicaid Agency and the SPMP and staff directly supporting the SPMP.

(V). The enhanced FFP rate of 75 percent is available for SPMP and directly supporting staff of other public agencies if all of the applicable criteria i. through v. are met, and the public agency has a written agreement with the State Medicaid Agency verifying that those requirements are met.

References/Comments:

In this area, the guide appears to indicate an acceptance of the fact that 75% FFP is available for SPMP personnel in certain circumstances. Moreover, in existing programs throughout the country, HCFA has approved activity codes that allow schools to claim the 75% FFP rate for SPMP's. However, the guide does not present a single time study activity that allows or authorizes the use of the 75% FFP rate.

Also, in this area, it is not clear what supporting records should be available for reviews and the documentation required by the proposed guidelines is unreasonable. Administrative outreach is not targeted case management, yet this proposed requirement would be more suitable to targeted case management or other fee-for-service activity. While it is agreed that all outreach activities should be documented, including those for which 75% FFP is requested, the guidelines hold schools to a much higher standard in this regard than that enforced on all other administrative activities claimed by state Medicaid agencies. In the absence of any indication that similar requirements are proposed for all other entities currently being reimbursed for outreach activities, it is can only be assumed that these guidelines will be singularly imposed upon the schools.

L. The guidelines appear to incorrectly interpret existing Medicaid regulations by stipulating that the 90% FFP rate for family planning services is only available if the school is providing the complete continuum of allowable family planning services.

Citation: HCFA Draft Guidelines, Page 16 Section IV. *CONSTRUCTING TIME ACTIVITY CODES 9b. Claiming for Administration of Family Planning Services:* *The enhanced family planning matching rate of 90 percent is available only for the "offering, arranging and furnishing" of family planning services (Section 1903 (a)(5), emphasis added). This enhanced rate is available to personnel who administer as well as directly provide certain family planning services and supplies (42 CFR 432.50(b)(5) as referenced by 42 CFR 433.15(b)(2))*

References/Comments:
The statutory history related to reimbursing family planning services at the 90% FFP rate does not support the interpretation as set forth in the draft guidelines. Prior to 1973, HCFA applied the rate of 90% FFP only to administrative activities supporting access to family planning services. Only after Congress clarified its intent in 1973 with the passage of P. L. 93-233, was the availability of the 90% FFP rate of reimbursement extended to also include the provision of family planning services. Clearly, the statutory history acknowledges, for purposes of eligibility for reimbursement at the 90% FFP rate, a distinction between arranging for and providing family planning services. There does not appear to be any legal basis for interpreting the "and" as all-inclusive.

M. The draft guidelines contradict Congressional intent with the stipulations that IDEA/IEP related activities "are considered to be education program related activities"; and that they "would not be considered necessary for the proper and efficient administration of the Medicaid State plan".

Citation: HCFA Draft Guidelines, Page 18, Section IV, CONSTRUCTING TIME ACTIVITY CODES 11. Individualized Education Program (IEP) Activities:
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 wouldnot be considered necessary for the proper and efficient administration of the Medicaid State plan.

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

Various education-related statutes obligate schools to furnish or make payment for services provided in the school setting for which Medicaid payment is not available. While there are exceptions set forth in section 1903(c) of the Social Security Act. With respect to Parts B and C of IDEA, no other education-related statutes obligate Medicaid payment. For example, Section 504 of the Rehabilitation Act of 1973 requires local school districts to provide or pay for certain services to make education accessible to

handicapped children; these services are described in an Individualized Service Plan (ISP). The 1903(c) exception does not include ISP services, and therefore, to the extent a local school district is obligated to furnish or make payment for such services, no Medicaid payment is available.

The guidelines go on to also state that any activities related to *'Child Find", "Initial Evaluation/Reevaluation", and the "Individualized Education Program (IEP)", "are for the purpose of fulfilling education mandates under education statutes (e.g., IDEA); as such, the associated costs of these activities are not allowable as administrative costs under the Medicaid program.*

References/Comments:

The statement that IDEA/IEP related activities "are considered to be education program related activities"; and that, in general, they "would not be considered necessary for the proper and efficient administration of the Medicaid State plan" appears to completely contradict Congressional intent related to responsibility for funding of IDEA as specifically addressed in Appendix A to CFR Part 300, which states that: "This new statutory provision emphasizes the obligation for interagency coordination between educational and noneducational public agencies to ensure that all services necessary (emphasis added) to ensure FAPE are provided to children with disabilities, and that the financial responsibility of the State Medicaid agency or other public insurer shall precede that of the LEA or State agency responsible for developing the child's IEP (emphasis added)." This expression of Congressional intent was recently reaffirmed on June 17, 1999, at a hearing of the Senate Finance Committee, during which Chairman William V. Roth, Jr. (R –DE) stated: *"I want to be clear that we are not here to question whether Medicaid should be paying for school-based services. That decision was made years ago, and Medicaid is appropriately responsible for reimbursing the costs of health care services provided in schools to Medicaid eligible children".*

In regard to the proposed denial of reimbursement for any activity related to schools compliance with the unfunded Federal mandates of Section 504, the statement that the "1903(c) exception does not include ISP services," if legally accurate, nonetheless applies only to the direct medical services that may be included in the ISP. The "1903(c) exception" cannot be legally construed to be unilaterally applicable to legitimate administrative outreach activities associated with the identification, evaluation, referral and coordination of physical and mental health services which a 504 eligible child may need. Again, this is an issue that, in the best interests of the children, the **results**, i.e., access to needed health care, rather than the purpose, i.e., educational, of the schools' efforts are what should be afforded primary consideration in determining the relevance of those activities to the "proper and efficient administration of the State Plan."

N. The guidelines are contrary to existing regulations and establish new policy by limiting the pool of funds available to provide match for reimbursements dollars.

Citation: HCFA Draft Guidelines, Page 40, Section V. C. Offset of Revenues:

"The costs which need to be allocated must be offset by certain revenues in order to reduce the total amount of costs in which the Federal government will participate. To the extent the funding sources have

paid or would pay for the costs at issue, Federal Medicaid funding is not available and the costs must be removed from total costs (See OMB Circular A- 87, Attachment A, Part C., Item 4.a.). The following include some of the revenue offset categories which must be applied in developing the net costs:

- *All Federal funds, along with maintenance of effort and other State/local matching funds required by the Federal grant.*
- *State funds specifically targeted or earmarked for the delivery of program services (such as medical assistance), must be used for the purposes for which they are targeted or earmarked and cannot be used to match other expenditures; for example, the costs of administrative activities. These funds must be offset in developing net costs."*

References/Comments:

In regard to the first bulleted provision above, neither the cited OMB reference nor the Federal regulations for IDEA at 34 CFR 300.231 (relating to maintenance of funding effort from state/local sources), speak to, let alone exclude or prohibit, the use of state/local funds as "match" for other Federal funds, including Medicaid. In regard to the other bulleted provision above, many if not all state appropriated funds for public education are "targeted or earmarked" in some manner for certain programs, especially those designed for specific populations of students at risk of poor school outcomes, such as children with disabilities. This is universal practice among State legislative bodies in order to ensure that schools use the state funds for the purpose intended. Again, the OMB Circular A-87 reference cited above does not include any reference to the offset of any state funds, which are "targeted or earmarked" for certain, programs such as special education.

Because these specific provisions appear to reinterpret existing Federal accounting requirements for schools, the guidelines do in fact represent new policy.

O. Although the following citation identifies time spent "actually transporting a child to a service" as being allowable, the draft Transportation activity code limits reimbursement only for time spent in "scheduling and arranging transportation to Medicaid covered services."

Citation: HCFA Draft Guidelines, Page 46, Section V. CLAIMING ISSUES, K. Transportation as Administration:

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

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.

References/Comments:

This section is especially confusing because the discussion intermingles the provision of transportation as a direct service and as an administrative activity. With few exceptions, schools are cognizant of the distinction between transportation provided as a direct medical service and transportation as an administrative activity.

Some state plans, however, do not recognize special transportation as an allowable direct medical service. When they do, in reference to school based services, the designation of transportation as a direct medical service is applicable only to certain Medicaid eligible students enrolled in special education. However, schools must arrange and provide transportation services for any student who requires the support in order to access needed health services.

The provisions set forth above are also inconsistent with the transportation related activities defined as allowable in the proposed activity Code 5.b. The last sentence in the first paragraph above states "time spent in assisting or actually transporting a child to a service," while Code 5.b. limits reimbursement to only "scheduling or arranging transportation to Medicaid covered services".

School staff frequently must not only schedule and arrange for such transportation, but must provide the transportation, and subject to the health status of the child may have to accompany the child to the service, even when someone else is actually providing the transportation. **42CFR431.53, 42CFR441.56(2)(ir)** and **42CFR441.62** encompass all aspects of transportation that might be "necessary" for recipients to go to and from providers.

The draft guidelines are also inconsistent with HCFA's Medicaid and School Health Technical Assistance Guide, issued in 1997, the guide articulates on page 56, *"States may also choose to cover transportation as an administrative expense, and thus receive FFP at the 50% administrative rate. The state has more flexibility in covering transportation under this method. Arrangements may include the use of vendors, or other transportation alternatives, such as direct reimbursement to the beneficiary in the form of vouchers or tokens, or cash reimbursement for needed transportation with supporting documentation (e.g., a receipt). Furthermore, the freedom of choice principles do not apply, which allows the state to restrict the providers from which a beneficiary can obtain transportation or the type of transportation provided.*

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July 24, 2000

Mr. Bruce Hunter
Senior Associate Executive Director
American Association of School Administrators
1801 N Moore St
Arlington, VA 22209

Re: HCFA Medicaid Administrative Claiming Guide

Dear Bruce,

As you know, the school environment offers unique advantages and opportunities to reach children and families to inform, encourage and assist them to access needed health care services and to enroll in the Medicaid program. A number of federal statutes and regulations define schools as a vital link for families to needed health care and as a cost effective, timely, and accessible source of service delivery. Additionally, the issue of uninsured children continues to burden many states and unmet health needs often further place children at risk for poor education outcomes. Schools are entitled to Medicaid reimbursement for the longstanding roles they have served in both delivering medical services to Medicaid beneficiaries and in assisting states to administer the State Medicaid Plan.

Last February, HCFA issued a draft Medicaid Administrative Claiming Guide as an attempt to clarify the highly technical and confusing array of requirements that schools and the Medicaid agencies in their states must follow to obtain administrative reimbursement for schools for their role in administering a state's Medicaid plan. The draft guide created concern among the education community that Medicaid Administrative Claiming policy was being changed, that the program was going to become more restrictive and that states not currently claiming administrative reimbursement for their schools would have a difficult time implementing a program in the future. In addition, the draft claiming guide has been extensively distributed and treated as existing policy by many HCFA entities despite being only a draft intended to elicit comments and suggestions.

Both your association and you have played leadership roles over the past several months in efforts to bring clearer guidance to states, schools, their administrators and other education stakeholders regarding Medicaid Administrative Claiming. Most schools do not perceive that the draft claiming guide, in its current form, achieved its intended goals.

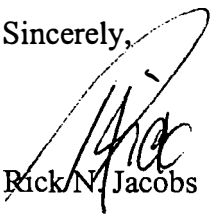
As you know, we serve many of your members as clients and have attempted to assist our clients in understanding the implications of the draft Medicaid Administrative Claiming guide that was proposed by HCFA last February and in putting forth suggestions for improvement. In order to advance the process in a constructive fashion, our firm has incorporated our knowledge of Medicaid Administrative Claiming and the perspectives of our clients. We prepared a draft proposal (attached) that we think would achieve the results that HCFA and others originally sought.

We have undertaken this initiative with a single purpose in mind. We would like to see the process of providing states and schools with effective guidance regarding Medicaid Administrative Claiming succeed. Therefore, we have attempted to rewrite the draft HCFA guidance with the schools in mind while maintaining the important technical and regulatory aspects.

Since it is our goal to see a claiming guide go into effect that schools can live with, the review of the attached and your suggestions on how it can be improved are vital to advancing the guidelines to acceptance and would be greatly appreciated. Hopefully, with the support of associations such as AASA, and the leadership you have brought to the process, we can all anticipate a satisfactory outcome and a clearer set of claiming guidelines that assist schools and states in obtaining reimbursement for the vital roles they play in serving children.

It is important that any feedback or suggestions on the attached draft are shared with all interested parties. We would be pleased to facilitate that by forwarding all the comments or suggestions we receive to everyone who submits them. Please provide any comments, revisions or suggestions regarding the attached draft to me. You can reach me at 847.753.8555 by phone or by email at rijacobs@dc.com. My partners, staff and I look forward to working with you, your association and your members in implementing a Medicaid Administrative Claiming guide that all stakeholders can live with and that assures an effective, fair and accountable program. Thank you for your assistance and continued support of this important program for schools.

Sincerely,



Rick N. Jacobs

/rj
Attachment
cc: Dan Fuller, NSBA w/out att.
Jeff Simering, CGCS w/out att.

Medicaid School-Based Administrative Claiming Guide

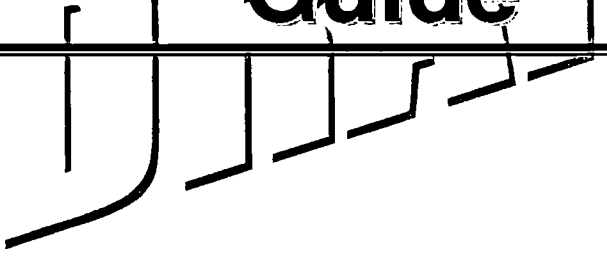


Table of Contents

Medicaid School-Based Administrative Claiming Guide - DRAFT

Introduction

The purpose of this Administrative Claiming Guide is to provide further guidance to all State Medicaid Agencies regarding the requirements for claiming Medicaid reimbursement for administrative activities performed in the school-based environment. Additionally, HCFA believes that this Guide will be of significant benefit in helping school districts and all other interested parties better understand the intent of the school-based administrative claiming program. It is expected that this Guide will promote greater consistency in claiming practices to ensure program integrity, and ~~to~~ assist states in the implementation of effective administrative claiming practices.

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

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

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

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

The Health Care Financing Administration (HCFA) is legally responsible for assessing all such programs in accordance with the applicable Federal Medicaid requirements. Therefore, state's programs for administrative claiming for school-based activities must be reviewed and approved by HCFA, prior to implementation. HCFA review and approval should occur in a reasonable

timeframe and the submission date of the state's intent to claim for administrative costs defines the first quarter for which the LEA will receive reimbursement. This Guide should be useful for LEAs, State Medicaid Agencies, and HCFA staff in the process of development, review, approval, and implementation of school-based Medicaid administrative claiming programs.

I. Program Basis and Authority

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

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

II. Program Agreements

A. Interagency Agreements

In order to claim Federal matching funds for the costs of Medicaid administrative activities performed in schools, the State Medicaid Agency must enter into an interagency agreement[1] with the state education agency or another appropriate entity with oversight of LEAs in accordance with regulations at 42 CFR 431 Subpart M. The interagency agreement serves to describe and define the responsibilities of each party under the agreement. Additionally, the interagency agreement should describe the relationship between the LEAs and the parties to the interagency agreement. For example, the agreement should address whether LEAs will participate in preparing and submitting Medicaid Administrative Claims independently or as participants in a consortium of LEAs.

The interagency agreement should include:

- A statement regarding the general purpose, basis and mission for the agreement
- The mutual objectives and responsibilities of all parties with respect to this program
- Provisions for a participation agreement with LEAs, either through a consortium or independently

[1] See 42 CFR 431.10(b)

- The activities or services each party performs and under what circumstances
- The general principles of reimbursement
- General guidelines regarding how the program will be structured and administered
- Provisions regarding program oversight and monitoring
- The cooperative and collaborative relationships at the state and local levels
- The methods of payment or reimbursement, exchange of reports and documentation, and a continuous liaison between the parties, including the designation of state and local liaison staff

A cost allocation plan amendment is also required and a copy should be provided as an attachment to the interagency agreement to provide more specific details regarding claim calculation methodology and reimbursement.

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

B. Cost Allocation Plan

1. Overview

Federal regulations[2] require that under the Medicaid State plan, the single state agency shall have an approved public assistance cost allocation plan (CAP) on file with the Federal Department of Health and Human Services (DHHS) that meets certain regulatory requirements.[3] As indicated in OMB Circular A-87, Attachment D, a state's public assistance cost allocation plan is an official document which describes the grouping and allocation of administrative costs to federal awards performed by the State under such programs as Temporary Assistance to Needy Families (TANF), Medicaid, Food Stamps, Child Support Enforcement, adoption assistance, Foster Care and Social Service Block Grants.

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

2. General Principles

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

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

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

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

3. Time Allocation Methodology

Overview

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

Time Study Surveys

OMB A-87 provides a variety of options for collecting data to allocate the time spent by individuals who work on multiple activities and cost objectives. The most common mechanism for identifying and categorizing activities performed by the LEA employees is a time study.[4] A time study is a survey documenting how personnel eligible for reimbursement (or a sample of eligible personnel) are spending their time. Activities are recorded based upon predefined activity codes, over a predetermined period of time. The time study should incorporate a comprehensive, all-inclusive list of the activities performed by staff whose costs are to be claimed under Medicaid. The time study should account for 100% of the time and activities (whether allowable or unallowable)

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

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

performed during the time study period by employees participating in the Medicaid administrative claiming program.[5]

Sampling Universe

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

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

The sampling universe must include all employees whose salaries are to be allocated to the Medicaid program (e.g., physical therapists or speech therapists). Costs associated with direct support personnel[6], are allocable and reimbursable at the same level as the employees they support. Direct support personnel would not need to be included in the sample population since they do not directly perform Medicaid administrative activities. However other paraprofessional staff who do perform Medicaid administrative activities, such as physical therapy aides, or speech therapy aides, should be included since they do not qualify as direct support personnel.

Sampling Guidelines

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

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

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

[6] **42 CFR §432.50 In the context of FFP relating to skilled professional medical staff, defined as follows:**
(v) The directly supporting staff are secretarial, stenographic, and copying personnel and file and records clerks who provide clerical services that are directly necessary for the completion of the professional medical responsibilities and functions of the skilled professional medical staff.

Training

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

Documentation

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

The documentation for administrative activities should clearly demonstrate that the activities are performed for administering services covered under the Medicaid State plan.[7]

Reimbursable Activities

"There is much flexibility in what services may be properly claimed as administrative, and some activities can be billed as either medical services or administration."[8] According to section 1903(a)(7) of the Act and the implementing regulations at 42 CFR 430.1 and 42 CFR 431.15, for the cost of any activities to be allowable and reimbursable under Medicaid, the activities must be "found necessary by the Secretary for the proper and efficient administration of the plan" (referring to the Medicaid State plan).

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

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[7] 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).

[8] Medicaid And School Health: A Technical Assistance Guide, p. 72

Non-Reimbursable Activities

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

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

Activity Codes

General Guidelines

A key objective of these HCFA guidelines is to help States address certain basic tenets with regard to Administrative Claiming. HCFA and States determine allowable Medicaid administrative activities in accordance with the regulations related to reimbursable administrative activities (see Appendix C, page 17). However, because the Medicaid Administrative Claim program is a Federal Medicaid program implemented by the State Medicaid Agency, each State should implement a program that reflects the unique delivery model in that State.

Activity Code Categories

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

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

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

Activity codes should be designed to effectively differentiate and distinguish between the types of activities that fall into each of these categories. Appendix B provides general examples of appropriate activities for each designation. However, specific activity codes

should reflect the distinct characteristics of each state and be compatible with the State Medicaid plan.

Capture 100 Percent of Time

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

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

Administrative Case Management

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

Identification of Activities Eligible for Enhanced FFP

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

4. Cost Reporting Methodology

General Overview

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

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

Duplicate Payments

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

Indirect cost rates

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

Offset of Revenue

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

- All federal funds, along with any state/local matching funds required by the federal grant.
- All state expenditures which have been previously matched by the federal government (includes Medicaid funds for medical assistance (e.g., fee-for-service funds).

Documentation

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

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

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

5. Claim Calculation Methodology

Overview

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

Criteria for Enhanced FFP for Skilled Professional Medical Personnel

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

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

When the individual meets the SPMP qualifications, those administrative activities that require the use of medical knowledge are eligible to be reimbursed at the enhanced rate of 75 percent. The coding structure and/or time study methodology should include the means to differentiate allowable activities for which the SPMP required his/her specialized training and expertise. Allowable administrative activity codes are discussed on page 7 and in Appendix B.

Criteria for Reimbursement of Family Planning at 90 Percent FFP

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

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

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

See Committee Print accompanying the Social Security Amendments of 1973, Brief Description of Senate Amendments to H.R. 3153, at p. 41 (statement by Conference Committee that "Federal payments for family planning expenditures[are] not limited to administrative costs. - - . . .90 percent Federal matching for family planning is available for the cost of providing family planning services and not merely for the cost attributable to administering such programs").

Allocable Share of Costs

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

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

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

6. Review / Approval Requirements

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

In accordance with federal regulations and OMB Circular A-87, a public assistance CAP must be amended and approved by the Division of Cost Allocation (DCA) within DHHS before FFP would be available for school-based administrative claims in the Medicaid program. The public assistance CAP amendment must provide (in accordance with the approved interagency agreements) for reimbursement of the administrative activities performed in the school setting and for claims which will be made on behalf of the LEAs by the State Medicaid Agency. The public assistance CAP amendment must make explicit reference to the methodologies, claiming mechanisms, interagency agreements, and other relevant criteria that will be used by the LEAs for making such claims and appropriately allocating costs. HCFA does not have direct authority for approval of the public assistance CAPs; that is the purview of the DCA. However, HCFA works directly with the DCA in the public assistance CAP review and approval process; under this process, the DCA will not approve such public assistance CAPs without HCFA's review and approval of the methodologies referenced in the public assistance CAP.

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

Timely Filing

Section 1132(a) of the Act requires that a claim by a State for FFP with respect to an expenditure made during any calendar quarter must be filed within the two-year period that begins on the first day of the calendar quarter immediately following such quarter. This section also provides that with certain exceptions, no payment shall be made for expenditures not claimed within this period.[12]

State Law Requirements

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

III. Program Integrity

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

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

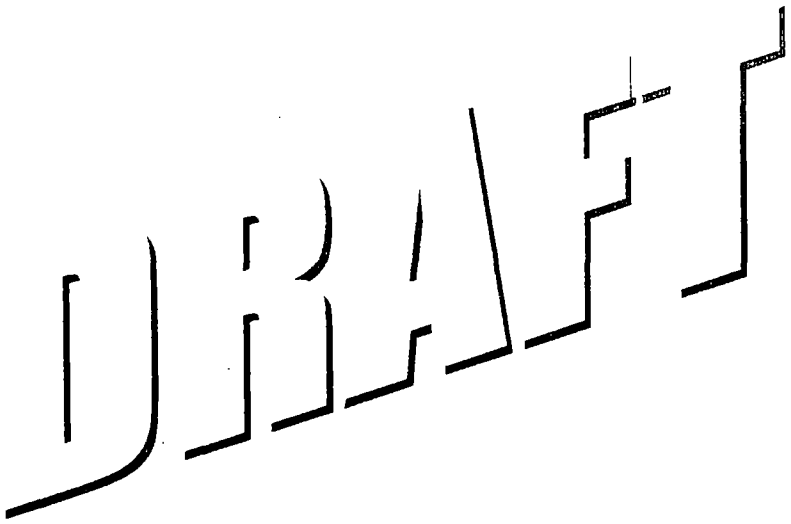
Please see Appendix C for recommended monitoring parameters.

IV. Conclusion

This Guide contains information for LEAs, State Medicaid Agencies, HCFA offices and staff, and other interested parties about the existing requirements by which LEAs can claim Medicaid reimbursement for activities that are performed under the administrative claiming program. It is important to note that to minimize the possibility of confusion, this Guide does not, except where there are potential issues of overlap or duplication, address requirements related to LEAs' provision of direct medical services, commonly referred to as fee-for-service (FFS) programs. With regard to the school-based administrative claiming program, this Guide does not supercede or reinterpret any existing statutory or regulatory

[12] 45 CFR §95.4 Definitions *State Agency*
45 CFR §95.7 Time limit for claiming payment
45 CFR §95.13 In which quarter we consider an expenditure made.

requirements. This Guide is intended to support and enhance the goals shared by Medicaid and education of ensuring that all children, especially those who are economically disadvantaged or disabled, have access to needed health care; that all eligible children are enrolled in Medicaid, and that LEAs have equal access to the resources available to support those efforts.



Appendix A: Details Regarding Basis and Authority

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

Statute/Regulations

- Proper and efficient methods of administration: section 1903(a)(7) of the Social Security Act (the Act)
- Federal matching rate for administration: section 1903(a)(7) of the Act
- Maintenance of Documentation section 1902(a)(4) of the Act
- Timely filing: section 1132 of the Act, Title 45 of the Code of Federal Regulations (CFR) Subpart A 95.1 ff
- Skilled Professional Medical Personnel (SPMP): section 1903(a)(2)(A) of the Act, 42 CFR 432.50
- Family Planning: section 1903(a)(5) of the Act, 42 CFR 433.15(b)(2), 432.50(b)(5)
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT): section 1902(a)(43) of the Act; 42 CFR Part 441, Subpart B
- Medical Assistance Case Management: section 1905(a)(19) and 1905(r)
- Section 504 of the Rehabilitation Act: 34 CFR Part 104, Subparts A and D
- Individuals with Disabilities Education Act (IDEA): section 612(A)(B) and (C)
- Regulatory citations related to documentation

42 CFR	Description
Subpart M	Interagency Agreements
430.1	Scope of subchapter C - Proper and efficient administration
430.10(b)	Interagency Agreement
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
431.17	Maintenance of Records
431.53	Assurance of transportation

431.107	Required provider agreements
432.2	Definition of SPMP
432.30	Training Programs: General Requirements
432.50	FFP: Staffing and training costs - Availability of FFP at various rates, allocation basis for personnel costs
432.50(b)(5)	FFP for Family Planning
432.55	Reporting training and administrative costs
433.15	Rates of FFP for administration
433.15(b)(2)	FFP for Family Planning
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
441.61	Utilization of providers and coordination with related programs

45 CFR

Part 74	Subpart C – Post Award Requirements
Part 95	Subpart A – Time Limits for States to File Claims
Part 95	Subpart E – Cost Allocation Plans

OMB Circular A-87

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

Appendix B: Skilled Medical Personnel

42 CFR §432.50

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

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

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

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

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

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

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

Appendix C: Activity Code Categories

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

100% Medicaid Share:

These activities are not subject to the application of the Medicaid share percentage.

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

Citations: 42 CFR 433.135, 42 CFR 435.905, 42 CFR 435.940, 42 CFR 432.30, 42 CFR 441.61, SMM 5230

Proportional Medicaid Share:

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

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

Citations: 1903(a) SSA, SMM 4302.2(G)(2), 42 CFR 431.53, 42 CFR 441.62, 42 CFR 441.56(a)(3), 42 CFR 432.5(b)(5), 42 CFR 433.15(b)(2)

Reallocated Activities:

These activities support the general requirements of the position and are partially reimbursable.

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

Citations: 45 CFR 95.507

Non-Reimbursable Activities:

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

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

Citations: OMB A-87 Attachment A, C. 1. a. and h.

Appendix D: State Oversight

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

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

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

Time Allocation Methodology

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

Recommended activities may include:

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

Cost Reporting Methodology

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

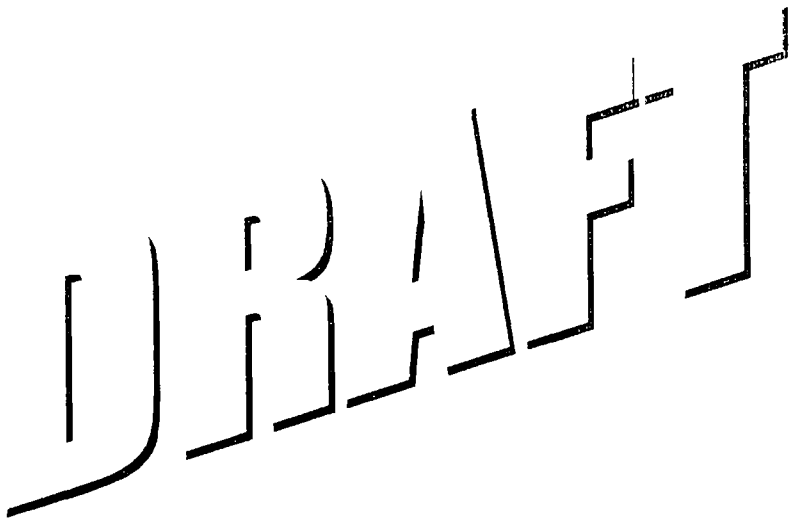
- Desk reviews of a sample of LEAs conducted by an independent audit professional services firm to determine the accuracy of submitted data.
- Periodic on-site visits to verify that reported expenditures conform to OMB Circular A-87, applicable claim guidelines and Generally Accepted Accounting Procedures.

Verification of SPMP Criteria

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

Claims Processing

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



FAX COVER SHEET

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Phone: _____ Phone: _____

REMARKS:_____

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

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.

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

Return to Medicaid Professional/Technical Information Page

Last Updated May 24, 1999

Testimony of

SALLY RICHARDSON, DIRECTOR

CENTER FOR MEDICAID AND STATE OPERATIONS

HEALTH CARE FINANCING ADMINISTRATION

on

MEDICAID COVERAGE OF

SCHOOL-BASED SERVICES

before the

SENATE FINANCE COMMITTEE

JUNE 17, 1999

HCFA
MEDICARE · MEDICAID
Health Care Financing Administration

Testimony of
SALLY RICHARDSON, DIRECTOR
CENTER FOR MEDICAID & STATE OPERATIONS
HEALTH CARE FINANCING ADMINISTRATION
on
MEDICAID COVERAGE OF SCHOOL-BASED SERVICES
before the
SENATE FINANCE COMMITTEE
June 17, 1999

Chairman Roth, Senator Moynihan, distinguished Committee members, thank you for inviting us to discuss Medicaid funding for school-based services. I want to emphasize the important role school-based services play in assuring that children receive needed health care. School-based programs can also play a powerful role in identifying and enrolling children who are eligible for Medicaid, as well as the new State Children's Health Insurance Programs. We strongly support Medicaid funding for school-based health services to children enrolled in Medicaid.

I have had the privilege of working closely with your Committee to understand the recent growth of Medicaid reimbursement in the schools. We recently sponsored a site visit for key Committee staff to see first hand the essential role school-based services play in ensuring that Medicaid-eligible children receive needed care while minimizing disruption to the education process.

However, your Committee, our staff, and now the General Accounting Office have identified serious concerns with Medicaid payments for school-based care in a handful of States. These include:

- "bundled" payment for groups of services to disabled children without documentation of the actual delivery of services or their costs;
- billing for transportation costs that Medicaid does not cover; and
- billing for administrative activities that Medicaid does not cover.

We believe we must act now to clarify issues, eliminate any inappropriate practices that exist, and protect the integrity of Medicaid funding for school-based services. We, therefore, sent State Medicaid Directors a letter May 21, 1999 that modifies and clarifies policy in these areas. Specifically:

- we will no longer approve federal Medicaid matching funds for bundled payments for school-based services;
- we will only pay transportation costs for children with special transportation needs; and
- we will issue guidance this Summer on Medicaid covered administrative costs.

We also will continue to work with Congress and the States to ensure that school-based services covered by Medicaid are billed appropriately and provided efficiently and effectively.

BACKGROUND

Many school-based health programs provide a broad range of services that are covered by Medicaid, affording access to care for children who otherwise might well go without needed services. And, as mentioned above, school-based programs also can play a powerful role in identifying and enrolling children who are eligible for Medicaid, as well as the new State Children's Health Insurance Programs. For Medicaid to cover school-based services, they must be primarily medical and not educational in nature. They must be provided by a qualified Medicaid provider to children in families that meet Medicaid income eligibility requirements. And they must be considered medically necessary for the child. The services can include:

- routine and preventive screenings and examinations;
- diagnosis and treatment of acute, uncomplicated problems;
- monitoring and treatment of chronic medical conditions; and
- provision of medical services to children with special needs under the Individuals with Disabilities Education Act.

Medicaid funding for school-based services was limited to coverage for routine screenings and treatment of acute, uncomplicated problems until 1988. Then Medicaid's role in supporting school-based health care was greatly expanded under the Medicare Catastrophic Coverage Act. It stipulates that Medicaid -- not the Department of Education -- pays for medical services provided to Medicaid-eligible children with special health care needs. Each child must have an Individualized Education Plan, in accordance with the Individuals with Disabilities Education Act, in order for Medicaid to pay for their school-based care.

There has been a surge of State interest in Medicaid reimbursement for school-based health services, mostly for Medicaid-eligible children with special needs under the Individuals with Disabilities Education Act. We have encouraged this because of the potential for school-based services to support "mainstreaming" children with disabilities into regular schools while continuing to ensure that they get the care they need.

As mentioned above, however, three major areas of concern have begun to emerge. We strongly believe we must address these issues now to make sure that taxpayer funds are spent appropriately, to protect the integrity of school-based health care programs, and to ensure that the potential of school-based services to maximize opportunities for children with disabilities is not compromised.

Bundling

Bundled payment for school-based services creates a real potential for Medicaid to pay too much or to pay for care which has not been provided. We have, therefore, told States in a May 21, 1999 letter that we will stop providing federal Medicaid matching funds for bundled payments.

Several Medicaid programs have been paying for school-based services with a bundled rate. This means that States make weekly or monthly payments to schools based on a package of services that are needed by children within various categories of disabilities, rather than paying separately for each individual service. Many services may be included in the bundled rate, such as physical therapy, speech therapy, and vision services. The cost for the bundled rate is based on the average historical cost of services for children in each disability category. The payment is the same regardless of the number of services actually furnished or the specific costs of services involved.

However, in most States that make bundled payments to schools, school-based providers are not maintaining adequate documentation for bundled payments. In fact, most do not have the administrative structure for maintaining such documentation. Also, State Medicaid agencies are

not conducting periodic reviews to reconcile claims to services delivered and plan approved costs. Without proper documentation of services included in bundled rates, there is no reliable basis for determining whether the needed service was delivered at a reasonable rate. This creates the potential for States to obtain Federal matching funds for care which has not been provided.

That is why our May 21, 1999 letter to State Medicaid Directors made clear that we will no longer recognize bundled rates for school-based health services. States that currently pay bundled rates for school-based services must develop and prospectively implement an alternative reimbursement methodology. We will meet with a workgroup of States, the Department of Education, and other interested parties to discuss ways to pay for school-based services that provide full accountability and administrative efficiency. In the meantime, our regional offices also will actively work with States to assist in the development and implementation of non-bundled rates.

We recognize that changing payment methods may require authorization or action by the legislature in some States, and that the work may have to compete with State efforts to make information systems Year 2000 compliant. We will not ask States that have been using bundled rates to give back federal matching funds for school-based payments made before our May 21 letter. However, we expect States to make necessary changes within a reasonable time frame. If they do not, we will take appropriate enforcement actions allowed under the law.

Transportation

Some school-based health care programs have inappropriately billed Medicaid for transportation costs that are not related to medical care. Medicaid covers the cost of transportation to and from school for children with specialized transportation needs identified in their Individualized Education Plan on days when they receive a medical service in school. In addition, if a child with special health care needs requires specialized transportation to and from school for a medical service but lives in an area that does not have routine school bus service, that transportation also may be billed to Medicaid.

In all situations, Medicaid funding is reserved for specialized transportation to school on a day when a child is receiving a medical service. However, several States have been claiming federal Medicaid matching funds for transportation costs not covered by this policy.

Therefore, our May 21 letter to State Medicaid Directors says explicitly that children who ride the regular school bus to school with other non-disabled children in the neighborhood should not have transportation listed in their Individualized Education Plan, and the cost of that bus ride should not be billed to Medicaid.

The letter also makes clear that:

- States must describe the methodology used to establish the transportation rate in the State's Medicaid plan;
- States must require documentation of each transportation service, usually in the form of a trip log maintained by the provider of the specialized transportation service, when claiming these costs as a direct service; and
- States must develop a cost allocation methodology to ensure that Medicaid only pays for transportation-related administrative costs attributable to Medicaid beneficiaries when claiming these costs as an administrative service.

Our regional offices also will provide technical assistance to help States in properly claiming Federal matching dollars for Medicaid-covered school-related transportation costs.

Administrative Claiming

Some school-based health programs may have billed Medicaid for administrative expenses that Medicaid does not cover. Medicaid covers administrative expenses incurred by schools in providing Medicaid services, such as outreach and case management. However, we again have identified important concerns about how these expenses are being accounted for and claimed. Specifically:

- some school-based providers are not adequately documenting Medicaid administrative claims;

- some school-based providers are including administrative activities related to services that Medicaid does not cover or for services to children who are not eligible for Medicaid; and
- some school-based providers may have claimed the same administrative costs twice by including activities that have already been paid for as part of the Medicaid service itself or by the State or local school district under the Individuals with Disabilities Education Act.

We are working diligently with States to foster a better understanding of when school-based administrative activities are eligible for Medicaid coverage. We plan to issue a written guide related to the requirements for school-based administrative activities this Summer.

CONCLUSION

We are committed to supporting school-based health care services and promoting their potential to afford access to children who otherwise might go without needed care. We must, however, make sure that Medicaid payments for school-based services are appropriate.

Thanks to the support and cooperation we have received from this Committee, we have identified and are addressing the concerns that have emerged. Our joint work on this issue is an example of how the Administration and Congress can work together to identify a potential problem, develop an understanding of the practice, and establish sound policy to protect the long-term interests of both taxpayers and beneficiaries.

We will, of course, continue to closely monitor the situation. However, the actions we are taking should halt inappropriate billing and protect the integrity of Medicaid funding for school-based health care. I thank you for holding this hearing, and I am happy to answer your questions.

# # #

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22 OCTOBER 1999

MEMORANDUM TO DAN MENDELSON (by fax to 395-5631)

FROM JANICE ENRIGHT JE

RE MEDICAID'S ADMINISTRATIVE OUTREACH CLAIMING PROGRAM
(Early Periodic Screening Diagnosis and Treatment)

Dan, thanks for your message returning my call.

As I am sure you are aware, on 19 October, the House did pass a bill (H.R. 1180) which pretty much tracks the same language as I transmitted to you the other day with H.R. 3070. My understanding is that the Senate version will require a conference committee.

Attached is some information that attempts to explain some of the concerns that section 407 presents, if adopted.

Given the serious implications that such legislation may have and its effect on good public policy, I would appreciate any thought you could give to the concern and get back to me. It is still our hope that there may be time for a conference among interested parties, who, I am confident would bring much to bear to the dialogue concerning the value of allowing the elements of section 407 to stand.

I hope to hear from you to discuss this, and to get your advice on whether or not it makes sense to contact Kathy King again at this juncture.

cc: Chris Jennings (by fax to 456-5557)

FAX DATE: 10/22/99
TO: DAN MENDELSON
CHRIS JENNINGS
FAX #:
FROM: ICKES OR ENRIGHT
202-887-6726 3
PAGES:

CHILDREN AT RISK:
RECENT HOUSE ACTION JEOPARDIZES FUNDING FOR SCHOOL-BASED HEALTH CARE SERVICES FOR POOR CHILDREN

One of the most significant problems in providing health care to our nation's poor and medically needy children is identifying them and placing them in public programs where medical services can be appropriately delivered. As the GAO has documented for Congress, **there are an estimated 3 million children in the U.S. who are Medicaid eligible, but who are not receiving medical services.** This is a point that **the President** has also emphasized when he recently announced his new Medicaid outreach initiative for children.

Congress requires that states perform outreach to identify and refer children who are Medicaid eligible for appropriate services, and provides federal matching payments for outreach services as part of the state's Medicaid program. **Congress also provides that this outreach responsibility can be delegated to the schools. Schools are one of the best locations for identifying Medicaid-eligible children with unmet health needs.**

Schools perform a number of health related functions. These include:

- Conducting outreach to identify and refer children to establish Medicaid eligibility;
- Assisting applicants with Medicaid enrollment; and
- Arranging appointments with various health care providers for medical and screening services.

Medicaid is also authorized to reimburse schools as qualified providers for covered medical services provided through school personnel and other qualified practitioners with whom the school contracts. Such services include physical, occupational, and speech therapy, as well as diagnostic, preventive, and rehabilitative services. **It is clear that Congress has determined that schools can address the health-related needs of many children.**

Over the past several years, **school districts in 35 states participate in the Medicaid program** as part of either the school based health service initiative or the school administrative outreach program. States such as **Illinois, Michigan, Florida, and Texas** have worked with their state Medicaid agency and the Health Care Financing Administration (HCFA) to implement very successful programs.

Unfortunately, on October 19th, the House of Representatives passed H.R. 1180 (Section 407), which contains provisions, which will in effect, substantially eliminate school district participation in the Medicaid program.

Without the benefit of public dialogue or the normal Committee consideration of these provisions, **the previous Congressional commitment made to the nation's schools to assist in the funding of early identification of medically at risk children, and the provision of necessary medical services to poor children, is undone by H.R. 1180 (Section 407).** ***This bill will end the flexibility that States and local school boards have enjoyed in crafting programs tailored to the needs of their children. Instead, the legislation requires that HCFA bureaucrats "take over" whatever will remain of the program.*** Provisions of this bill will:

- Invalidate within 60 days virtually every existing claims processing contract with consequent massive disruption in school finances;
- Replacing existing flexible billing programs which have been in operation for up to four years in numerous states, with a "one-size, fits all" HCFA-designed program which must be implemented by schools within 90 days;
- Terminate in any meaningful way the billing to Medicaid of special education transportation service; and
- Impose onerous requirements that will make it impossible for schools to provide school based medical services for those children who are managed care enrollees.

Given the widespread devastating consequence of these provisions in H.R. 1180 (Section 407), these sections should be dropped from the bill.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	re: School Based Administrative Claiming Meeting (partial) (2 pages)	03/21	P6/b(6)

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

FOLDER TITLE:
Medicaid and School Based Clinics [Folder 2]

2012-0463-S
rc785

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)]

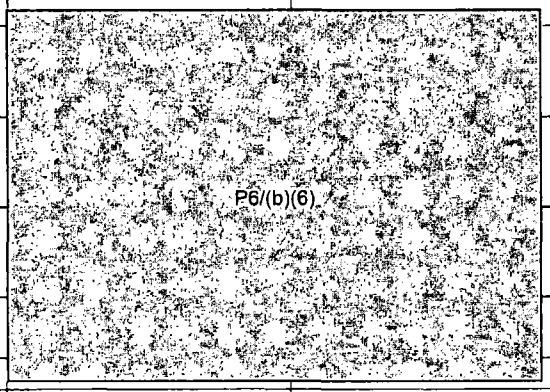
b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial 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]

School Based Administrative Claiming Meeting – March 21st at 3pm Room 476			
Name & Telephone#	Title/Organization	DOB	SS#
Jeanne Lambrew (+1)			
Timothy Westmoreland (+1) 410-786-3870			
Richard Strauss			
Andy Rotherham 6-5575			
Barbara Chow (+1) 5-4844			
Anne Bryant (703-838-6722)	Executive Director of the National School Board Administrators		
Dan Fuller 703-838-6763	Director of Federal Programs		
Michael Resnick	Associate Executive Director		
Connie Marie Milito	Director of Gov't Relations for Hillsboro (FL) County P.S.		
Bruce Hunter (703)875-0738 Karin 0761	American Association of School Administrators		
Jeffrey Simmering	Legislative Director		
Judy Hueman 205-5465 (Liz)	Education - Assistant Secretary		
Amii Limpp (staff to assist Judy)			
Carol Cichowski	Director of Division of SE Rehabilitation & Research Analysis in Budget Services		
Gordon Ambach 408-5505	Executive Director of the Chief State School Officers Association		
Jeffrey Smink	Legislative Associate Director		
Bob Chase 822-7200 Isabell 822-7191	Executive Director of the NEA		
Jerald Newberry	Director of Health Information Network		
Sandra Feldman 879-4400 - Tressa	Executive Director of the AFT	No Attendees	

P6/(b)(6)

[001]

Lois Jean White (former President) 289-6790 POC: Marybeth Oakes	Executive Director of the National Parent Teacher	No Attendees	
Michael Casserly 393-2427 POC: Julie Wright	Executive Director of Council of Greater City Schools		
Audrey Sue Gamm	Chief Specialized Services Officer for Chicago Public Schools		
	Nat'l Assoc. of State Directors of Special ED (NASDSE)		
Gordon Wrobel	National Association of School Psychologists		
FYI – HICFA/Medicaid			



Memorandum

Date March 10, 2000

To Chris Jennings

From Gary Mauro

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

The American Association of School Administrators asked Sara Rosenbaum to complete this analysis of HCFA's Medicaid School-Based Administrative Claiming Guide. I thought you might be interested.

GAO Report is at
www.house.gov/
commerce_democrats/
press/medigap.gao.pdf

Memorandum

To: Bruce Hunter and Nicholas Penning, AASA

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

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

Date: February 28, 2000

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

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

The Child Health and Medicaid Context

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

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

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

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

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

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

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

- States have broad discretion over program design in administering their Medicaid programs, but certain basic rules apply. In order to

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

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

The Draft Guide

In general

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

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

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

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

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

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

Detailed comments

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

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

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

- Page 2: At the bottom of the page there is no mention of the EPSDT state plan requirements (§1902(a)(43)) as part of the legal basis and authority for FFP for administrative costs associated with health care in or by schools. The EPSDT administration requirements cover a full range of activities from identifying children who need health services (a major overlapping function with the IDEA) to costs associated with supporting health services that are furnished.

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

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

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

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

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

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

- The effect of managed care (p. 9, 10, and other locations). HCFA's view of the effects of a managed care contract is, in my opinion, legally incorrect. This entire section has to be rethought and re-formulated. A state may dump many dollars into its managed care rate; the

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

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

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

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

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

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

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

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

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

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

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

Please let me know if you have additional questions.