DEPARTMENT OF HEALTH & HUMAN SERVICES 1-1721

Health Care Financing Administration

F-172 Memorandum

Sept. 2 1992

From

Director
Medicaid Bureau

Subject

Maximization of Federal Matching Funds Proposals For Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Activities In Schools and School Dirtrfcts--ACTION

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All Associate Regional Administrators
Division of Medicaid

It has come to our attention that a proposal is being advertised to States *to interest* them in maximizing the Federal share *of* Medicaid matching funds by implementing a fundfng strategy for EPSDT, and other Medicaid services, in schools and school districts. We have attached an example of *such* a proposal which should be reed to better understand our analytical comments below. In addition, one regional office (RO) has asked *for* clarification on the permissibility of claiming costs for therapists in *one* State's public schools. The purpose of this memorandum is to reopond to the funding strategy proposal being marketed to States, end to reiterate the Health Care Financing Administration's (HCFA) policy *concerning* claiming costs for therapists in public schools.

Initially, we wish to reaffirm the importance of the Medicaid EPSDT program, and the variety of roles that schools play, both in administration of and in providing health services under the Medicaid program. For example, making a site available or performing client outreach *may* qualify as Medicaid administrative activities. Providing medical care may qualify as Medicaid covered services. In additfon, other activities such as cast management and transportation may, depending *on* the circumetancos, qualify *as either* Medicaid administrative costs or as medical services. HCFA has long encouraged the participation of schools in the Medicaid EPSDT program.

There are several elements to be addressed, related to the fundlng strategy, and we will touch *on* these below. Also, we will indicate HCFA's response with respect to each proposal element as well as to some questions we have received from the States. Variations in State specific situations will require States to apply these general principles to their specific situations as appropriate.

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0 **Proposal** : Establish school **districts** as Medicaid providers, reimburse them on cost based rates, simplify **service** definitions, and **grant** relief with credentialing requirements for **service** provider personnel.

Response: With respect *to* the *notion of* developing a new Medicaid provider type **tailored** just for **school districts,** it would be somewhat difficult to place all school **based** services under one provider type. **First, in** order for any service to be covered under the Medicaid program, it must be included among **those** listed in **section 1905(a)** of the Social Security Act. After determining that the **specific** service or services are covered, then it becomes necessary to look **to** whether an entity, which wishes to become a provider, is qualified to enroll as a provider of services. Some Medicaid provider qualifications are dictated by the Medicaid **program** (for example, regulation8 at 42 **CFR** 440.110 ***prescribe*** the qualifications of a "qualified physical therapist") while other provider qualifications are established by the State **(for** example, 42 CFR 440.130 covers **certain** licensed practitioners **of** the healing arts **who practice** within the scope of State law). Where States **have** established provider qualifications, they must be applied consistently among all **entities** seeking provider status.

Except **for** services furnished under **EPSDT,** if the service is not specifically identified in the State plan no Medicaid payments may be available, ***If the*** service **is** available under ***the*** State plan, whatever provider **qualifications** have already been established for **the service category under which the *State*** has **chosen** to provide the **services** would apply. **Once** the provider **qualifications** are established, the State must allow all qualified providers to participate. However, since there are no services or practitioners identified **as** "individualized Education Plan **(IEP)** Health **Services Providers ," States must describe the types of services** involved **as** well as the provider **qualifications.**

If the offeror proposes to utilize a broad coverage option such as clinic or **rehabilitation** services, the proposal should specifically describe the individual services which will be provided **(e.g.,** physical therapy or occupational therapy) and how each Medicaid service provided would meet the requirements of such broad coverage categories. Also, schools providing Medicaid

services included in IEPs are reimbursed based on specific service providers' qualifications being met for each service provided, which service is included in the State Medicaid plan, For example, providers of speech therapy and psychology services must meet Medicaid provider qualifications; it is not sufficient that the provider meet the Department of Education or some other credentials, Medicaid agencies cannot "grant credentialing relief," from Federal Medicaid requirements as suggested in the proposal. In addition, what the proposal describes as "simplifying service definitions" seems to be a collapsing of State billing codes, which is impossible to evaluate in terms of the principles outlined above without knowing what is being collapsed.

With respect to reimbursing providers using cost based rates, Medicaid regulations require the State Medicaid plan to describe the policy and methods to be used in setting payment rates that are consistent with efficiency, economy, and quality of care. HCFA must approve these rates based on the assurances of the State that its findings meet the requirements set forth in the regulations.

0 Proposal : Retroactively enroll providers and permit retroactive billing.

Response : The Medicaid statute and regulations do *not* specifically address retroactive enrollment of providers. However, in order for a provider to bill the Medicaid program a provider agreement must be in place at the time the claims are submitted. In addition, it must be established that all Medicaid provider qualifications were met at the time the services were furnished. Finally, in that the Medicaid program prohibits payment for services that are provided for free to non-Medicaid eligibles and because Medicaid is the payor of last resort, all requirements For billing third parties must also be met for any retroactive period. Briefly, in order for a State to bill Medicaid for a child covered under the Individuals with Disabilities Education Act (IDEA), the State must bill any third party insurance plan or program under which the child has coverage, In order for the State to bill Medicaid for children not covered under IDEA, the State must bill on behalf of all children who have third party coverage for services provided in the

schools. Thfs includes both Medicaid eligible children as well as non-Medicaid eligible *children.* Federal financial participation (FFP) may be available if these conditions are met.

- **Proposal** Implement this proposal *either on* a statewide basis, or incrementally by school districts. If statewide, the State would enter into a performance based contract with the contractor. The prime contract would be with the State, but the actual billings would be on behalf of school districts as providers of services. *The* contractor's fee would be linked to Medicaid *recoveries.* If implemented incrementally, convert the school for the deaf and the school for the blind to Medicaid provider etatus for EPSDT purposes, and earmark Medicaid revenues realized to *fund* the subsequent conversion *of* all other school districts in the State.

Response: In order to receive FFP for school based services, there must be a provider agreement between the State and the actual provider of services. If certain requirements are met the school (or school district), may qualify as the provider.

If the school/school district employs health professionala or operates a school clinic which contracts with some of the required health professionals, the school or school district may qualify as the provider, bill Medicaid, and receive payment. Where the school/school district contracts with the necessary health professionals to provide discrete Medicaid services (eg. physicfan services, physical therapy, speech therapy) the provider agreement must be executed between the State Medicaid Agency and the health professional. If the school district will bill for the services of such contract health professionals there must also be a voluntary reassignment of payment agreement between the provider and the school/school district. (Note that all other Federal requirements *concerning* payment to providers need also be met, including requirements for submission of individual claims into the MMIS system.)

The school for the deaf and the school for the blind can qualify as Medicaid providers only if the Medicaid provider qualifications are met. The provider qualifications which the schools must meet will depend upon the specific services they will provide. In addition, providers of services cannot be limited to schools, as is the apparent attempt of *this* item.

- **Proposal** Establish an interagency steering committee to direct the *project.*

  Response; Interagency collaboration to direct the implementation of new projects and ideas is commonly employed. We would support such a group; **however,** such a group could not supereede the authority and responsibility of the Medicaid single State agency. The applicable single State agency provisions are found at 42 CFR 431.10.

- **Proposal :** Allow providers to claim Medicaid for "restorative, corrective and remedial services" uncovered *in* the *screening* process: waive the State plan Amendment (SPA) process.

  Response: The Omnibus Budget Reconciliation Act of 1989 (OBRA) require8 that all Medicaid services listed in section 1905(a) of *the* Social Security Act must be provided under EPSDT whether or not they were previously included in the Approved State plan. This includes the "restorative, corrective and remedial services" referred to above. To the extent that a State plan amendment would be required, there are no waiver provisions which would apply. Therefore, the State plan amendment process cannot be waived.

- Proposal : Identify Medicaid eligibles for billing purposes vfa the sharing of "enumeration data"; this raises the question of whether all students would receive services equally, and whether non-Medicaid students would be treated free of charge.

  Response: With respect to the "sharing of enumeration data", the requirements of confidentiality must be considered We interpret the "sharing *of* enumeration data" to mean that the contractor wishes to acquire Medicaid eligibility data from the State. The proposal would have the State Medicaid agency provide lists of Medicaid recipients to the schools. Release of lists of.recipienta to providers is prohibited by 42 CFR 431.306. While a provider may verify Medicaid eligibility *in* order to file a claim for *specific* services provided to a recipient, the provider may not be given lists of eligibles.

  The availability of *"free* services" for non-Medicaid eligible children is an issue. The school health program should be funded by multiple sources, It would

be improper to bill only for services to Medicaid eligible children, and provide services to others without charge. HCFA's long standing rule is that the provider must either bill all individuals receiving the services, or at least bill all individuals who have third party coverage. With the exception of title V, and services to handicapped children, billing only the Medicaid agency is not sufficient, and these claims would not be allowable,

- Proposal: School districts would give up the State matching share of their Medicaid claims to maximize the Federal share of Medicaid reimbursements. Also, with respect to the Federal share of the new Medicaid claims, 33 percent would be retained by the State, and 67 percent by the school districts.

  Response: To the degree the school system itself is the provider or employer of the actual providers, it may receive Medicaid payments on behalf of its employees, Also, any amount claimed must be based on the Medicaid fee schedule, and must be reasonably related to provider costs. If 33 percent can be retained by the State, serious questions arise as to the accuracy of the State's ratesetting mechanisms. The ratesetting mechanisms should produce rates that reasonably represent the costs of performing these services. Additionally, if 33 percent of a payment is retained by the State and never paid to a provider or the provider's assignee, we would not consider the 33 percent as a State expenditure eligible for Federal matching. Section 1903(a)(l) of the Act entitles States to FFP only in those amounts which the State actually expends for medical assistance items and services, The term "expenditure" means those funds which a State pays a provider and over which the provider has access or control; in other words, the provider must have some "indicia of ownership" of the funds. Only those funds which a State paid a provider and over which the provider had access or control are, therefore, eligible for FFP. For further details, refer to Part V of the State Medicaid Manual and to EPSDT: A Guide for Educational Programs.

There are also some additional concerns States have about school-based health care:

1. Given that most IEP services are already covered in the State plan and most individual IEP provider types are

already covered in the State plan, is a new SPA requfred? Do all services and providers found elsewhere in the State plan have *to* be regrouped into one new section? This would seem to be an unnecessary requirement if services and *providers* are already recognized,

If the services and provider information are already covered in a State plan, a new SPA is not required. However, it may be desirable for the State to describe the schools' role as providers in a SPA to assure compliance with relevant Federal rules.

2. Policy should allow school districts responsibility for credentialing those providers for whom it has legal authority *to* do so under State law, provided that education standards *are* on par with Medicaid standards. It would also be helpful if HCFA policy would clarify that States can limit qualified providers by requiring a provider to comply with service delivery requirements (i.e. continuum of care, access) so that there is some State control.

As noted on page 2 above, Medicaid agencies *cannot* allow school districts credentlaling authorfty for providers, state Medicaid agencies must ensure that providers meet Medicaid provider qualification requirements. Also, States do have the authority to impose reasonable provider qualifications in accordance with regulations at 42 CFR 431.51(c)(2). The qualifications may function to limit the pool of qualified providers. However, such qualifications must be applied equally to all providers of a service category and must be related to the provision of services rather *than* arbitrary criteria.

3. states believe that State Medicaid agency responsibility and authority should be strengthened and given more emphasis.

We agree that the role of the State Medicaid agency should be clarified in any discussion of school-based health care and proposals such as this one. The principle of the single state Agency and the provisions at *42* CFR 431.10 relating to nondelegation of certain functions must be emphasized.

4. HCFA's policy that all individuals *receiving* services must be billed is not supported by States. States generally disagree that Medicaid is *the only* funding source tapped in these instances because the State or local government is paying 100% of the costs of services to others) therefore calling State funded servicer "free" is *not* correct.

HCFA's free care policy, as stated on page 5 above, is that Medicaid will consider a service to be "free" and thus not eligible for matching unless the person8 obtaining ths service incur a liability and *their* relevant third party payers are billed. With the exception of title V, and services to handicapped children, billing only the Medicaid agency is not sufficient, and these claims would not be allowable. HCFA is currently developing a free care regulation to further interpret this policy.

We believe the considerations provided here address the essential issues which make this proposal extremely difficult to implement. As such, we recommend that States pursue Medicaid coverage of school-based services through consultation with their regional office staff.

We ask that you pleaee issue a statement to your States encouraging them to work with you prior to entertaining the implementation of proposals being marketed in the school-based services area. It is important that these statements indicate the important *role* echoolo play in administering and providing health services under the EPSDT program and our willingness to work with States to assure that these programs are established consistent with Medicaid program requirements.

I am attaching a copy of the materials we have received to date about the proposal8 to cover school based services, If you have additional questions or concerns, pleaee contact Bill Hiscock at 410-966-3275, or Larry Cutler at 410-966-3257.

ORIGINAL SIGNED BY
CHRISTINE H. NYE
Christine Nye

cc:
All Regional *Administrators*

Attachment

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