CMS Policy on Medicaid in Schools
Coverage, Reimbursement, Time Studies and Audit Review Process

PRESENTERS:
Coverage – Melissa Harris/Jean Close
Reimbursement – Mary Cieslicki
Time Study - Judi Wallace/Sharon Brown
Audit Review –De Earhart

CMS Session Objectives

- Understand Medicaid school-based services (SBS) concepts and CMS policies and principles.
- Understand key issues of coverage, cost reimbursement, methodology and the time study.
- Understand how SBS SPAs are reviewed.
- Learn about existing policy, and audit requirements affecting the provision of SBS.

The 3 Facets to review of SBS:

- Coverage CMS/DEHPG
- Time Study Methodology CMS/ACT
- Reimbursement CMS/NIPT
Legislative Background

Three Federal Laws Have Impacted Medicaid Coverage of Children in Schools

- 1965. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program
- 1975. The Education for All Handicapped Children Act (now the Individuals with Disabilities Education Improvement Act of 2004 – IDEA 2004)
- 1988. Section 1903(c) of the Act – Medicaid payment for covered 1905 (a) services in an IEP or IFSP

Medicaid Rules

- There is no service category in Medicaid entitled "school-based services," or "early intervention services," or Individualized Education Program (IEP) services.
- To be eligible for payment by Medicaid, services must be included among those listed in Title XIX, section 1905(a).
- Services must be in the regular State plan which makes services available to children 0-21 available to all beneficiaries under EPSDT.
- Health services covered by Medicaid and provided in schools must be defined in terms of Medicaid's statutory and regulatory requirements.

Medicaid Services that might be delivered in the school setting

- Physical therapy
- Occupational therapy
- Services for individuals with speech, hearing, and language disorders
- Rehabilitative services
- Preventive care services
- Screening services
- Private duty nursing services
- Personal care services
- Psychological services
Coverage Components

- Provider qualifications
  - Therapy providers must meet requirements of 42 CFR 440.110
  - Individuals may provide services under the direct supervision of qualified therapy providers
- Provision of 1905(a) services
- Role of IEP
  - IEP may only serve as basis for medical necessity if IEP team providers are qualified to make that determination in accordance with their scope of practice
  - IEP may contain both educational and Medicaid services

Steps in the SPA Review Process

- States submit SPAs.
- CMS CO and RO staff work together to review coverage, reimbursement pages.
- Internal calls held with CMS team members and follow-up calls to State, as needed.
- RAI questions sent to State, as necessary.
- State responds to the RAI.
- SPA approved or disapproved.

CMS’s policy on the rate

- Because schools are public providers of primarily non-medical services and because, in general, third party payers other than MA do not reimburse for services provided in the schools, MA requires that States demonstrate that rates paid for SBS are no higher than the actual cost of providing the medical services.
- This policy helps to assure that payment meets the requirements of section 1902(a)(30)(A).
Reimbursement options

- Most States reimburse school-based services at cost because services are funded using CPEs.
- If States choose to pay a rate then the provider must receive and retain the total amount of the rate. Additionally, some States require school districts to provide the non Federal share of payment through an intergovernmental transfer (IGT).

Funding the non-Federal share of school-based services

- Certified public expenditures (CPEs),
- Intergovernmental transfers (IGTs), or
- Appropriations to the State Medicaid Agency

- Most States use CPEs to fund the non-Federal share.

What are Certified Public Expenditures (CPEs)?

- A CPE is an expenditure made by another unit of government on behalf of the single State Medicaid Agency.
- A governmental provider may certify its actual incurred cost. Additionally, a unit of government that reimburses a non-governmental provider a rate may certify the cost of the rate.
- When a governmental agency is itself the provider then it may not certify the cost of a rate that it pays to itself.
- When a unit of government certifies to a rate that it pays the non-governmental provider then the provider must receive and retain the total amount of the rate, including the Federal and non Federal share of the payment.
Funding and the rate methodology

CPEs
- Payment must be actual cost
- Annual reconciliation (identifying the difference between any interim payments and cost) is required.
- In the case of overpayment, the State must settle to cost. Cost settlement cannot occur as an adjustment to future rates.

IGTs or Appropriations
- Community rates can be used.
- If the community rate is not used, the rate must be based on cost, but can be trended for a limited period of time.
- No reconciliation required.
- Current policy – IGT must be made prior to payment by the Medicaid Agency. Provider must retain the entire payment.

How is cost identified?

- Cost is recognized using OMB Circular A-87
- These cost principles are for the purpose of cost determination and are not intended to identify the circumstances or dictate the extent of Federal or governmental unit participation in the financing of a particular program or projects.

How is cost identified?

- CMS permits the inclusion of costs that directly support the provision of school-based services.
- All costs must be documented in the accounting system.
CMS’s current policy on cost

- SBS allowable costs are composed of direct and indirect costs.
- Direct cost is generally limited to personnel and identifiable medical supplies used in the delivery of the covered Medicaid service.
- CMS reviews individual items of cost, rather than general categories of cost.

CMS policy on personnel cost

- The direct services cost pool includes only Medicaid qualified practitioners that will be providing Medicaid covered services, not administrators.

Cost of qualified providers

- During the SPA review CMS requests States to complete a chart which specifies the providers it proposes to include in the direct services cost pool. This chart also permits States to document that these providers are Medicaid qualified.
CMS policy on personnel cost (continued)

- Personnel cost is included in the medical rate based on the percentage of direct services time identified through the CMS-approved time study. This cost is further adjusted by the ratio of Medicaid children with IEPs to total children with IEPs to allocate medical time to Medicaid.

- When a supervisor is also a Medicaid qualified provider some of that person’s time/cost may be attributed to direct services to the extent that it is directly related to the provision of care. Supervisory time for non clinical activities may not be included.

How is indirect cost identified?

- Under OMB Circular A-87, CMS is required to recognize indirect costs through the use of the cognizant agency indirect cost rate.
- CMS does not permit States to include indirect costs, including administrative or educational costs, outside of this rate.
Identification of Medicaid SBS Costs

Educational, Admin and Medical Costs

Medical Cost %
ID'd Through Time Study

Medicaid Cost ID'd Through Medicaid Eligibility %

How is cost treated when CPEs are used?

- When services are funded using CPEs, cost must be reported at the level of the individual provider, which is usually the school district or LEA.
- Cost reports must be prepared and completed by each LEA.
- The LEA as provider must certify the total amount of cost including the non-Federal and Federal share.

Billing Through the State’s MMIS

- Although cost is identified in the aggregate when CPEs are used, without respect to the number of claims submitted, states are still required to record claims for SBS in the MMIS.
- MMIS provides for prompt eligibility verification, a complete audit trail from service to claim and payment data necessary for the Surveillance and Utilization Review Subsystem (SURS).
Conducting a SBS SPA review

- When paying cost, State is required to provide:
  - a finalized cost report,
  - cost report instructions,
  - documentation on the time study methodology, and
  - a copy of the certification of expenditures form (for CPE-funded programs only).

State Plan Language

- All SPA language must be comprehensive enough to establish that the payment methodology results in an economic and efficient payment.
- When a CPE is used the State plan includes:
  - The SBS services reimbursed at cost
  - The step-by-step methodology for identifying cost
  - Timeline for settlement of cost

State Plan Language

- When fee for service rates are paid the state plan must include the effective date of the fee schedule with a weblink to the fees or a listing of the actual rates so that providers can know what the current rates are.
SBS Rate Methodology-Summary

- Rate methodology, coverage, and the time study are reviewed at the same time by appropriate staff at CMS.
- Reimbursement methodology cannot be approved without a statistically valid CMS-approved time study.
- Rate methodology is linked to funding of non-Federal share.

SBS Rate Methodology – Summary (continued)

- Rate may be no higher than cost, regardless of the funding source. Community rate is deemed to be at or below cost.
- State is required to provide documentation for any cost-based rate methodology.

What is the purpose of the Time Study?

- The time study is used for cost allocation.
- It captures how staff spend 100% of their time. It is used to capture all activities engaged in by school staff and to distinguish between educational, direct services and administrative functions.
- It is used for cost settlement purposes.
Time Study Requirements for Cost Reimbursement

- States must use a statistically valid CMS-approved time study methodology.
- No staff shall appear in more than one cost pool (mutually exclusive cost pools).
- All direct medical services and staff must be in the approved State plan.
- All providers whose costs are included in the cost pool must be included in the sample universe for the time study.

Implementation Plan Requirements

- A State must submit a Time Study Implementation Plan for review and approval by CMS.
- A State must amend its Cost Allocation Plan after CMS grants conditional approval for the implementation plan.
- The time study is referenced in the State plan reimbursement pages.
- The time study is approved separately from the SPA process, so it is not "on a clock."

Time Study Checklist

- Interagency MOUs,
- Consultant contracts
- Sampling plan / time study methodology
- Activity codes/Examples
- Cost Allocation Plan
- Training materials
- Oversight and monitoring protocol
- Funding issues review
- Software Review
Oversight and Monitoring

- The State is responsible for ensuring compliance with State and federal regulations.

- Components of the Time Study to be monitored include:
  - Participant list, sampling methodology, time study results
  - Review of central coding, training, documentation compliance
  - Financial reporting
  - Local level oversight
  - Moment validation
  - Non-response protocol

Example of Time Study Cycle for Random Moment Design

1. Participants Identified each Quarter
2. Random Moments Selected
3. Participants Entered into State-wide Pool
4. Data is calculated on State-wide basis

Administration Claiming and School Transportation Policy

- May 2003 CMS Medicaid School-Based Administrative Claiming Guide:

- For transportation, current policy on a May 21, 1999 State Medicaid Director Letter:

- OMB Circular A-87:
  http://www.whitehouse.gov/omb/circulars_a087_2004

- CHIPRA Translation SHO:
Audits and Reviews
Who Performs Audits and Reviews Related to Medicaid Payments?

- CMS
- Internal Auditors
- GAO & OIG
- State Medicaid, Education or Legislative Auditors
- State Public Auditors
- State’s Attorney General
  Medicaid Fraud Control Unit

Reasons Audits Are Initiated

- Variance analysis shows significantly higher administrative costs relative to medical costs;
- Review of Medicaid expenditures reveals a significant increase or decrease in school-based expenditures;
- Errors or issues noted during a CMS 64 quarterly review;
- Major changes in legislation or regulation;
- Hotline calls from providers or the public; and,
- Internal or State auditor reports identify significant problems, errors or issues related to payment.

Reference Materials for Audit

[Diagram showing various levels of laws and regulations]

Federal Law (Social Security Act)
Federal Regulation (CFR)
Federal Guidance (Medicaid Memos, OMB 87, GAAP)
State Law
State Regulations
State Guidance (State Plan)
What are source documents?

- Attendance Records
- Transportation Logs
- Medical Records
- Payroll Records and Contracts
- Prior Authorizations
- Clinical notes of the service performed
- Service Claims
- Time Study Logs

Minimum Documentation

Each claim must include:

- Date of Service
- Name of Recipient
- Medicaid Identification Number
- Name of Provider Agency
- Person Providing the Service
- Nature, Extent or Units of Service
- Place of Service

Common Audit/Review Procedures

- Ensure that prior authorization, if required, was obtained prior to the service being performed (or as per the State’s requirements).
- Ensure there is a current IEP/IFSP for each recipient receiving service and the medical service is documented in the IEP/IFSP.
- Ensure the date of service corresponds to the IEP/IFSP period.
- Verify that the provider of medical services is appropriately certified or licensed for the services performed.
Common Audit/Review Procedures (Cont.)

- Verify that the rate paid for the claim equals the State Plan rate.
- Verify that the child receiving services attended school on the date of service.
- Review the clinical notes for the date of service to ascertain exactly what service was performed.
- Verify that the services provided on the date of service are the services that should be provided per the description in the State Plan.
- If transportation was provided, verify that the child was in attendance on the day claimed and that a medical service was performed.

School Documentation

The school is given a list of SBS medical claims to be reviewed as part of the sample. For each claim in the sample, the school should provide:

1. A copy of the claim
2. Enrollee’s medical record
3. Individualized Education Program (IEP) or Individual Family Service Plan (IFSP)
4. School attendance records for the date of service on the claim
5. Prescriptions/referral for IEP services
6. Documentation of the service performed on the date of service including clinical notes signed and dated by provider
7. Documentation regarding where the service was provided and who provided the service

Additional Documentation Required

- Medical provider qualifications associated with licensing and certification
- Payroll records associated with school personnel providing services
- Copies of contracts with medical providers
- Cost Report
- Time Study Source Documents
- Sign-In Sheets from Training Sessions
- Copies of any manuals related to the time study, cost allocation plan, procedures associated with Medicaid SBS reimbursement
Availability and Maintenance of Documentation

- The State must determine that the actual provider of each covered service meets all Federal and State qualification requirements and has executed a valid provider agreement pursuant to 42 C.F.R. 431.107.
- If the school is enrolled as a clinic or other provider type, it must execute an interagency agreement/contract with the Medicaid Program, which is generally referred to as a “provider agreement”.
- The provider agreement obligates the school district to “keep any records necessary to disclose the extent of services the provider furnishes to recipients”.
- Section 1902 (a) of the Act also requires sufficient documentation to be maintained in support of a claim.

Documentation Reviewed for State Medicaid and Education Agency

- Copies of the State Plan which correspond to the dates of review
- The CMS approved cost allocation plan
- The CMS approved time study
- State or vendor training materials provided to the schools
- The rate schedule paid for the period under review, including all work papers used to calculate the finalized rates
- Description of the State’s methodology for establishing both the interim and final rates
- A copy of the SBS procedure codes for the period under review
- A narrative or flow chart and/or crosswalk detailing the funding and expenditures of SBS
- Copies of the interagency agreement between the State agencies
- Contracts between the State/LEA and any consultants

School Documentation

- When pulling documentation, double check the date of service of the claim to the specific data being pulled.
- You may have IEPs for several years in the child’s school folder. If the claim’s “date of service” is June 30, 2010, then make sure you pull the IEP that covers that date of service.
- Remember that “date of payment” is different than “date of service”.
What Issues Are Noted in Audits/Reviews

- Lack of Source Documentation
- Payment is not in compliance with State Plan
- Cost report or time study isn’t approved by CMS
- Services are not approved for the period of the review
- Time study is not being implemented consistent with the approved plan
- Inappropriate coding and/or lack of oversight

What happens if an audit identifies problems?

- If a State is out of compliance with CMS regulations or its Medicaid State Plan, CMS may withhold or recover Federal funds.
- If claims for Federal matching funds cannot be supported by appropriate SBS provider records, the State may require school providers to repay reimbursements made for the undocumented or unallowable school-based services.

Translation and Interpretation Services

- On July 1, 2010, CMS issued a State Health Official (SHO) Letter to help States obtain enhanced funding for translation and interpretation services provided under Medicaid and CHIP, as authorized by Section 201(b) of CHIPRA.
- Specifically, CHIPRA provides for increased translation/interpretation match for administrative expenditures for translation or interpretation services in connection with the “enrollment of, retention of, and use of services” under CHIP and Medicaid.
- The increased match is available for expenditures for translation or interpretation services for any individual whose primary spoken or written language is not English. This includes individuals whose primary spoken or written language is American Sign Language or Braille.
Translation and Interpretation Services CONTINUED

The enhanced funding is defined differently under CHIP and Medicaid.

- For Medicaid, the increased match is 75 percent.
- For CHIP, the increased match is 75 percent, or the State’s enhanced FMAP plus 5 percent, whichever is higher.

In order to obtain the increased translation/interpretation match, States and providers may:

- Enter into a contract or employ staff that provide solely translation or interpretation functions and claim related costs as administration, and/or
- Pay for translation or interpretation activities to assist the medical provider of record for the service separately as administrative expenditure, in addition to the rate paid for the medical service itself.

Activities for which the enhanced CHIPRA match is available include:

- costs for translating forms, websites, enrollment and outreach materials
- making translation/interpretation services available in order for beneficiaries to enroll in the program as well as access medical services.

By providing enhanced Federal funding, this provision will help States meet their responsibilities under Title VI of the Civil Rights Act of 1964 and section 505 of the Rehabilitation Act of 1973, which collectively require providers to offer translation and interpretation services to person with Limited English Proficiency and to individuals with sensory or speech impairments in order to receive Federal funds.

Questions?

CMS Contact Staff for Medicaid School-Based Time Study Issues and Audit Issues

- Judi Wallace (410) 786-3197 judi.wallace@cms.hhs.gov
- Sharon Brown (410) 786-0673 sharon.brown@cms.hhs.gov
- De Earhart (804) 771-2905 debra.earhart@cms.hhs.gov
Questions?

CMS Contact Staff for School-Based Reimbursement Issues

- Linda Tavener (410) 786-3838
  linda.tavener@cms.hhs.gov
- Mary Cieslicki (410) 786-4576
  mary.cieslicki@cms.hhs.gov

Questions?

CMS Contact Staff for Coverage Issues

- Melissa Harris (410) 786-3397
  Melissa.harris@cms.hhs.gov
- Jean Close (410) 786-2804
  Jean.close@cms.hhs.gov