CMS Policy on Medicaid in Schools

Coverage, Reimbursement, and Time Studies

PRESENTERS:
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Reimbursement – Mary Cieslicki
Time Study - Judi Wallace/Sharon Brown
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
• Understand the CMSO organizational structure
• Learn about current issues, hot topics, and regulatory updates affecting the provision of SBS.
The Facets to the review of SBS:

- Reimbursement
  CMS/NIPT

- Time Study
  Methodology
  CMS/ACT

- Coverage
  CMS/DEHPG
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 non-Medicaid services
Steps in the SPA Review Process

- States submit a SPA.
- CMS 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 medical services.
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 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 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 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

- Rate must be based on actual cost (no community rates).
- Annual reconciliation (identifying the difference between payment 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 in light of “economy and efficiency”.

- Not all costs recognized by OMB Circular A-87 are considered economic or efficient by CMS.

- The State should only include cost that has been recorded through its general ledger system, which supports its audited financial statements.
CMS’s current policy on cost

- SBS cost is composed of direct and indirect costs.
- Direct cost is limited generally to personnel and identifiable medical supplies used to deliver services.
- CMS reviews individual items of cost.
CMS policy on personnel cost

• The direct services cost pool may include only those practitioners to whom a service would normally be attributed through fee-for-service billing in a community setting. Supervisors, coordinators, and administrative staff, for example, may not be included.

• Providers must identify salary and benefit cost of individual practitioners that meet the criteria for inclusion in the direct services cost pool.
CMS policy on personnel cost (continued)

- Personnel cost is included in the medical rate up to the percentage of direct services time identified through the CMS-approved time study. (Please note that this cost is further adjusted by the ratio of Medicaid children with IEPS to total children with IEPs.)
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

- Medical Cost % ID’d Through Time Study
- Medicaid Cost ID’d Through Medicaid Eligibility %
- Educational, Admin and Medical Costs
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 MMIS

- Although cost is identified in the aggregate, without respect to the number of claims submitted, states are still required to submit claims for SBS through the MMIS.
- This is because the 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 an SBS rate review

- May be lengthy and detailed.
- 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).
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 purposes.
- It captures how staff spend their time.
- It is used for cost settlement purposes.
- It is used to capture all activities engaged in by school staff and to distinguish between educational, direct services and administrative functions.
Operational Principles -
100% Time and Parallel Coding

- The time study must reflect all of the time and activities (whether allowable or unallowable under Medicaid) performed by employees.

- The codes must capture and distinguish between direct services and administrative activities, Medicaid and non-Medicaid activities.

- There are different time study designs that can be used – (i.e., random moment, worker log).
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.
SBS Time Studies

- The Direct Medical Services Codes are subdivided into IEP and non-IEP medical services.
  - Examples of non-IEP services include first aid and medication administration.

- An IEP Medicaid ratio is applied to the IEP Direct Medical Service code results to determine the amount of SBS costs attributable to Medicaid covered services provided pursuant to IDEA.
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 MAC/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
Conditional Approval Criteria

- The State agrees to submit documents that are subsequently developed for use for CMS review and approval prior to modification.

- The State agrees to monitor the Implementation process and provide quarterly reports to the RO.

- The State agrees to provide oversight of any outside entity contracted to operate the time study process.
Conditional Approval Criteria – Cont.

• The State agrees to comply with any regulations or national guidelines issued by CMS.

• Any costs claimed under the approved program are subject to review or audit.

• The State agrees to subsequently amend its Public Assistance Cost Allocation Plan to reflect the time study methodology approved by CMS.
Example of Time Study Cycle for Random Moment Design

Participants Identified each Quarter

Data is calculated on State-wide basis

Random Moments Selected

Participants Entered into State-wide Pool

1

2

3

4
## Example of Online RMTS Time Study Form

<table>
<thead>
<tr>
<th>Certified Uncoded RMS Entries</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Random Moment Time</strong></td>
</tr>
<tr>
<td><strong>Who was with you?</strong></td>
</tr>
<tr>
<td><strong>Why were you performing this activity?</strong></td>
</tr>
<tr>
<td><strong>What were you doing?</strong></td>
</tr>
<tr>
<td><strong>Note</strong></td>
</tr>
</tbody>
</table>

**Notes**

Code & Go to next uncoded moment  | Code & Return to RMS list  | Skip & Go to next moment  | Return to RMS list
Hot Issues

- Regulatory updates
  - School-based Administrative/Transportation rule rescinded
  - Interim Final Targeted Case Management rule partially rescinded
- Mandatory Report to Congress
- DAB decisions
- NAME Q&As from 2008
- CMS New leadership
School-Based Administration/Transportation Rule

- On June 30, 2009, CMS issued a rule in the Federal Register (CMS-2287-F2) finalizing the proposed rescission of a rule (CMS-2287-F), published December 28, 2007, that would have eliminated reimbursement for school-based administrative costs and costs of transportation to and from schools.

- The rescission reflected concern that the rule could limit the Medicaid administrative outreach activities of schools, and that the overall budgetary impact on schools could potentially impact their ability to offer Medicaid services to students.
School-Based Administration/Transportation Rule – Cont.

- The effective date for the final rescission rule is July 1, 2009.
- As a result, CMS continues to match allowable claims for FFP related to school-based administration and transportation under pre-existing policy.
- Approximately 32 States currently participate in school-based MAC.
School-Based Administration/Transportation Rule – Cont.

- For the School-Based Administration rule, current policy is contained in the May 2003 CMS Medicaid School-Based Administrative Claiming Guide, located online at: http://www.cms.hhs.gov/MedicaidBudgetExpendSystem/Downloads/Schoolhealthsvcs.pdf

Targeted Case Management IFC

- The interim final rule was published on December 4, 2007, and became effective March 3, 2008.
- The rule was placed on moratorium from June 30, 2008 through June 30, 2009.
- These provisions appeared to restrict beneficiary access to needed covered case management services, and limit State flexibility in determining efficient and effective delivery systems for case management services.
- The partial rescission of certain provisions will be followed by future rulemaking to finalize the remaining provisions.
Rescinded Provisions

• The partial rescission of the Case Management rule:

  • Removed 42 CFR Sec. 440.169(c) and Sec. 441.18(a)(8)(viii), because CMS was concerned that these provisions may be overly restrictive in defining "individuals transitioning to a community setting," for whom case management services may be covered under Sec. 440.169(a).

  • Removed Sec. 441.18(a)(5), which would have required case management services to be provided on a one-on-one basis to eligible individuals by one case manager.
Rescinded Provisions – Cont.

The partial rescission of the Case Management rule also:

- Removed Sec. 441.18(a)(8)(vi) because the requirement for payment methodologies in this provision may have been administratively burdensome, may result in restrictions on available providers of case management services, and generally may limit beneficiary access to services.

- For similar reasons, in Sec. 441.18, CMS rescinded paragraphs (c)(1), (c)(4), and (c)(5) that limited the provision of case management activities that are an integral component of another covered Medicaid service, another non-medical program, or administration.
Rescinded Provisions – Cont.

- The partial rescission of the Case Management rule also:
  - Rescinded parts of Sec. 441.18(c)(2) and (c)(3) to remove references to programs other than the foster care program, because we were concerned that these provisions may be overly restrictive in defining State options for the delivery of case management services.

- The final rescission rule can be viewed online at:
Mandatory Report to Congress

- In Section 7001(c)(2) of the Supplemental Appropriations Act, 2008 (SAA, P.L. 110-252), Congress required that CMS enter into a contract with an independent organization to produce a report on four specific Medicaid regulatory regulations publications issued to by CMS.

- CMS contracted with The Lewin Group to perform this study and produce the independent report required by Congress. The Lewin Group is required to produce a comprehensive draft report by September 1, 2009. (Note: The deadline was extended to allow completion of the report.)
Mandatory Report to Congress – Continued

The four regulations that are subject to mandatory report are:

2. Proposed rule, published May 23, 2007 – Medicaid Program; Graduate Medical Education (GME) (CMS-2279-P).
4. Final rule, published December 28, 2007 – Medicaid Program; Elimination of Reimbursement under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School (CMS-2287-F).
Mandatory Report to Congress – Continued

• The report must address:
  
  • The prevalence of the problems that the Medicaid regulations are meant to address
  • Strategies in existence to address these problems
  • An assessment of the impact of each regulation on each State and the District of Columbia
DAB Decisions

- Decision No. 2057 – Colorado Department of Health Care and Policy Financings - December 15, 2006
  - Colorado appealed CMS’s disallowance for costs Colorado claimed as a retroactive adjustment to claims for costs of school-based services provided by local districts.
  - The Board upheld CMS’s determination that Colorado’s claim was not made in accordance with the provisions of Colorado’s approved Medicaid State plan.
  - The Board also upheld CMS’s determination that the State plan did not authorize this type of retrospective recalculation of rates.
DAB Decisions

- Decision No. 2090 – Maryland Department of Health and Mental Hygiene – June 11, 2007
  - Maryland appealed a disallowance based on an OIG audit that reviewed a 100-unit sample of claims in Maryland’s eight highest paid local education agencies (LEAs). Of the 408 claims in the sample, the auditors found 290 claims in error and identified one or more types of error for each claim. Maryland argued that none of the claims were in error and that the methodology used to estimate the amount of overpayment was not valid.
  - The DAB concluded that 230 claims were paid in error and that 55 claims were properly paid. The DAB also concluded that the statistical methodology was valid.
DAB Decisions

- Decision No. 2140 - Oklahoma Health Care Authority (OHCA) – December 27, 2007
  - OHCA appealed a determination by CMS disallowing $2,035,381 FFP for claims made for school-based services (SBS). CMS based the disallowance on an OIG audit that reviewed a 300 unit sample of claims made for services provided in 11 school districts.
  - Based on the sample results, the OIG estimated that OHCA was overpaid $2,035,381 FFP.
DAB Decisions

- Decision No. 2140 - Oklahoma Health Care Authority (OHCA) – December 27, 2007 (Continued)
  - The DAB upheld that CMS correctly determined that either the requirement in section 440.110(b) for a prescription for occupational therapy or the requirement in section 440.110(c) for a referral for speech language therapy was not met, upheld the part of the disallowance taken on that basis.
  - The DAB also upheld the disallowance of some of the other disputed claims and reverse or remand the disallowance of the remaining such claims. The basis for the disallowances for these claims fell into three categories: overlapping times for services, wrong code, and duration less than a unit of service.
Decision No. 2235 – Texas Health and Human Services Commission – March 19, 2009

- Texas appealed CMS’ disallowance of $7,846,951 FFP claimed under Medicaid for school-based services.
- CMS based the disallowance on an OIG audit that estimated Texas was overpaid $8,749,158 FFP.
- Most of the claims were for counseling, assessments, and nursing services that the OIG found were provided by unlicensed providers. The OIG also found that the assessments were non-medical assessments not covered by Medicaid. In addition, the OIG found claims for speech therapy services that lacked the requisite referral.
- The DAB upheld all of the findings except for one case in which the DAB deemed the provider was licensed.
Question: Please explain why Section 504 students would not be covered by Medicaid.

Answer: Section 504 services may be furnished to individuals who do not have an IEP or IFSP. Furthermore, for individuals with an IEP or IFSP, section 504 services are not identified therein. 504 services are not included in 1903(c) of the Medicaid statute; therefore, traditional “payer of last resort” requirements apply. Since schools are legally liable to pay for section 504 services, Medicaid would pay secondary to schools.
2008 NAME Q&As

• Question: If a parent refuses to allow a school to bill their third party insurance with due diligence met by the school, can they then bill Medicaid?

• Answer: The Medicaid program is obligated under section 1902(a)(25) of the Act to pursue the third party insurance claim. Given that obligation, the school’s ability to bill the Medicaid program may be dictated by its educational obligations. If the school bills the Medicaid program, the Medicaid program will bill the insurance. To the extent that this result is inconsistent with the school’s educational obligations, the schools may not be able to bill Medicaid.
2008 NAME Q&As

• Question: Can costs for clinical supervisors or “under the direction of” for Occupational Therapy, Physical Therapy, Speech/Language Pathology, Psychology, etc. be included in the cost reporting?

  • Answer: With limitations, some costs related to individuals directing or supervising the provision of services can be included as direct costs if those individuals are involved with the direct provision of services to the student and are face to face with the student, provider and supervisor. Otherwise, costs related to their supervisory activity are recognized through the Department of Education cognizant agency approved indirect cost rate.
2008 NAME Q&As

• Question: Most recently approved SPAs for school-based services use annual cost reports. Therefore, why does CMS continue to require States to collect “interim claims” for every student, every service, via the MMIS?
  • Answer: CMS requires SBS providers to submit an interim claim for each service delivered and reconcile payment during the cost settlement process. The MMIS provides for prompt eligibility verification, a complete audit trail from service to claim, and payment safeguards through the Surveillance and Utilization Review Subsystem (SURS).
2008 NAME Q&As

• Question: If a State moves to using community rates to reimburse for school services, are they still required to cost settle with each jurisdiction?

  • Answer: No. Cost settlement is not required when using the community rate. The State must assure that its Medicaid State Plan is modified to reflect that it is using the community rate. However, it is important to note that community rates cannot be used when CPEs based on the school’s costs are used as the non-Federal share of Medicaid expenditures.
New Leadership –
CMS Medicaid School-Based Review Team

Center for Medicaid and State Operations
  Cindy Mann, Director
  Penny Thompson, Dep. Director
  Bill Lasowski, Dep. Director

Disabled & Elderly Health Programs Group (DEHPG)
  Terry Pratt, Acting Director
  Gini Hain, Act Dep. Director

Division of Coverage and Integration
  Linda Peltz, Director
  Melissa Harris (Presenter)
  Jean Cloze (Presenter)

Financial Management Group (FMG)
  Dianne Herftan, Director
  Kristin Fan, Dep. Director

Division of Reimbursement and State Financing
  Janet Freeze, Acting Director

Non-Institutional Payment Team (NIPT)
  Linda Tavener, Team Leader
  Mary Cieslicki (Presenter)

Administrative Claiming Team (ACT)
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  Sharrin Brown (Presenter)
Questions?

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