CMS Medicaid School Based Administrative Claiming Guide

Summary Analysis

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Summary Analysis of CMS Medicaid School-Based Administrative Claiming Guide

Overview of the Medicaid Administrative Claiming (MAC) Program

- Since 1994 schools have been claiming and receiving Medicaid administrative reimbursement for existing activities and services that they are required to perform to prevent and address health needs which interfere with school attendance and performance.
- The school-based MAC Program is a mechanism by which schools can secure the Federal share of Medicaid reimbursement for the documented time spent by school personnel to locate, identify, refer, and coordinate health and health-related services for Medicaid-eligible students and their families.
- The MAC Program allows school systems to function as an "administrative arm" of the State Medicaid Agency.

History of the CMS Guide

- In May 1999, CMS (then HCFA) issued an administrative policy letter expressing intent to develop uniform, national guidelines for the MAC Program.
- February 2000, CMS issued a draft guide with comments due March 6. The guide was never published as final.
- April 2002, an unpublished version of a guide was circulated to which schools nationwide responded with comments.
- November 21, 2002, CMS released a draft final guide for the school-based MAC Program with comments due December 21, 2002. On the same date, CMS also issued a policy letter to all State Medicaid Directors eliminating, effective January 1, 2003, enhanced reimbursement for activities performed by school health professionals who met the Medicaid requirements for Skilled Professional Medical Personnel (SPMP).
- May 28, 2003, CMS issued the final Medicaid School-Based Administrative Claiming Guide with implementation instructions, to be effective no later than October 1, 2003.

Public Policy Issues Contained in the Final Guide

1. The Final Guide that CMS issued on May 28, 2003 includes new policy relating to the following issues:
   - Free Care
   - Provider eligibility
   - Restriction of reimbursement for referrals solely to actively billing Medicaid enrolled providers
   - Restriction of reimbursement solely for activities related to direct service
   - SPMP enhanced reimbursement unavailable for schools (New policy issued effective January 1, 2003)
   - Establishment of policy criteria inconsistent with other public agencies

2. As evidenced by the position that no activities related to Child Find or the development of the IEP are reimbursable under the administrative claiming program, the Final CMS Guide redefines and limits the scope of Medicaid's financial responsibility for school-based services to only those services listed in an IEP and further defines what related support activities are allowable for administrative claim reimbursement. This interpretation is applicable only to school-based Administrative Claiming Programs. Although CMS does reference the EPSDT program, the guidelines do not recognize the overlapping requirements between the EPSDT administrative requirements and IDEA in regard to early identification and referral of children who need health services, and developing a plan of care to enable a child to receive medically necessary services.
3. Existing CMS approvals of state's school-based administrative claiming program are effectively rescinded and those states must revise their programs to be in compliance with the Final Guide.
4. In regard to those states that have implemented or are considering implementing school-based targeted case management (TCM) programs, the guidelines reference that there should be no duplication of TCM services between the schools and other providers and also states that "CMS intends to issue further guidance on TCM in the future".
5. The Guide requires states to establish means of coordinating the schools' administrative claiming program activities with those of other providers such as managed care organizations and suggests that payment rates to MCO's may have to be adjusted to "reflect the activities and services being furnished in the school setting."

Specific Issues – Impact on Schools

Issue	Impact
1. MAC activities that support services provided free of charge to all students (or for which third party insurer is not billed for non-Medicaid eligible students) would not be reimbursable (p. 4 and following).	This requirement and Issue 3. (below) reduce the scope of administrative claim services to only the administrative time related to direct services listed on students' plans of care for which the district is billing third party insurance for non-Medicaid eligible students. Examples of MAC activities that would be eliminated include most follow-up activities related to routine hearing and vision screenings, and all activities related to Medicaid eligible children who do not have an IEP such as Section 504 students.
Analysis Reimbursable Medicaid administrative activities are defined as those that "are necessary for the proper and efficient administration of the Medicaid state plan". There is no stated requirement in statute or regulation that to be reimbursable, administrative activities must be linked to specific direct services, whether or not provided free of charge. There are many contrasting points of view regarding the application of the "free care" principle. However, existing school-based administrative claiming programs have uniformly operated with the understanding that to the extent that the administrative activities identify and link Medicaid eligible children with needed Medicaid covered services, as well as assure through appropriate referral and coordination activities the identified Medicaid covered services are obtained, then the activities met the Title XIX established criteria for administrative reimbursement.	

Issue	Impact
2. Elimination of SPMP (p. 15)	CMS has already communicated this new policy to all State Medicaid Directors. The effective date of this new policy being January 1, 2003, has resulted in immediate claim reductions that impact schools that have already established their budgets for the 2002-2003 school year and required them to amend their budgets for the remainder of that school year.

Analysis

An administrative activity may be similarly described for both SPMP and non-SPMP personnel, however the level of skill required for a particular situation or for a child with complex medical needs will determine which individual will be performing that activity. Non-SPMP qualified staff members will not perform those activities for which they do not have the advanced skill and training.

The same logic used by the courts in differentiating between educational and health related activities below (see Analysis Issue 5.) can be applied to this issue. Activities regarded as eligible for SPMP enhanced reimbursement had they been performed by SPMP qualified staff of, for example, the Department of Mental Health, should not be classified as unallowable solely because they are performed by SPMP qualified employees of the Department of Education. As concluded by the court above, CMS must inquire into the nature of the services, not just into what they are called or who provides them. To deny that SPMP qualified staff are using their medical training and skills in performing the same activities using the same skills as SPMP qualified staff in other public agencies for which enhanced reimbursement is available is clearly discriminatory toward school health professionals.

The Departmental Appeals Board (DAB) has upheld that to the extent that an SPMP qualified individual is using their skilled medical knowledge, however infrequently, in performing MAC activities they should be allowed to document that activity and the activity costs should receive the enhanced reimbursement allowed under 42 CFR 432.50.

The SPMP activity codes are not designed or intended to claim all activities performed by SPMP eligible providers at the enhanced rate. The enhanced rate is only claimed when an eligible SPMP provider has documented that their skilled medical knowledge was required to perform the allowable activity.

Issue	Impact
3. Administrative activities are only reimbursable to the extent they are provided by a Medicaid provider and to the extent that the administrative activity supports a Medicaid-reimbursed direct service listed on a student's plan of care in a school that is an enrolled and participating FFS provider. (p. 16 **Provider Participation in the Medicaid Program** and following)	With the exception of **Medicaid Outreach** and **Facilitating Medicaid Eligibility Determination**, this provision completely eliminates currently allowable MAC activities provided **within** the school unless the school is an enrolled and participating FFS provider. Because the related direct service must be Medicaid reimbursable for the administrative service to be reimbursed, the set of eligible MAC participant categories are also limited to those individuals authorized to bill direct services. Additionally, this provision would impose additional administrative burdens on the schools to ensure that only administrative services relating to Medicaid reimbursable direct services are claimed.

Analysis

As in Issue 1. above, there is no statutory or regulatory requirement that states can only delegate responsibility for the proper and efficient administration of the State Plan to public agencies that are enrolled and participating direct medical services providers. Nor is there a requirement that administrative reimbursement is only available for activities directly linked to a specific direct service. The administrative activities performed in schools to identify and link Medicaid eligible children with needed Medicaid covered services, as well as to assure through appropriate referral and coordination activities that the identified Medicaid covered services are obtained, meet the Title XIX established criteria for administrative reimbursement.

Issue	Impact
4. Referrals are only billable if they are made to a Medicaid provider and to the extent that the referral cost is not already included in the direct service reimbursement rate. (p. 16, 46 and throughout)	For some states currently able to bill Service Coordination or TCM, a portion of this provision may already be incorporated. However, for districts in many other states, this policy will have a detrimental impact because direct service (FFS) reimbursement rates do not currently include costs related to making referrals. Procedurally, CMS is recommending that rather than document which referrals are made to Medicaid providers and which are not, that a Medicaid "provider participation" rate be applied to the referral portion of a MAC claim.

Analysis

In many states reimbursement for all of the direct services provided by the schools is not available to the schools even though the services are covered in the Medicaid State Plan. Regardless of whether direct service reimbursement is available to schools for school based health services, or whether those services are submitted to Medicaid for reimbursement, the services provided are covered under the Medicaid State Plan. There is no requirement that restricts referrals for Medicaid covered services only to providers that bill and are reimbursed by Medicaid. Additionally, the proposed proportional "provider participation rate" represents an additional complex administrative burden upon both the states and the schools.

Issue	Impact
5. Child Find and IEP development related activities are <u>not</u> reimbursable (p. 18 and following)	In contrast to this policy position relative to the administrative claiming program, schools are reimbursed for these activities in those states that authorize schools to bill for Service Coordination or Targeted Case Management (TCM). However, for most states, this provision will significantly reduce the scope of reimbursable administrative activities. Further, it is unclear as to what extent states will be allowed to add Service Coordination or TCM options for schools. On p 12 of the Final Guide, CMS states that it "intends to issue further guidance on TCM in the future."

Analysis

The Final Guide stipulates that any activities such as child find, evaluation (initial) and reevaluation, and development of an IEP are "educational" in nature and cannot be reimbursed under Medicaid simply because they are required by IDEA. However, these activities authorized under the EPSDT Program and are the same or similar activities for which other agencies are reimbursed under the administrative claiming program.

The statutory requirement under IDEA to identify children in need of special education and related services (i.e. child find) and to develop a plan of care for those services (i.e., the IEP) is intermingled with and overlaps the EPSDT obligation to find children with health problems, screen them, treat them and provide medical assistance case management (including assistance to obtain needed educational services). The Departmental Appeals Board (DAB) as well as the courts have acknowledged that these obligations overlap, and addressed the differentiation of special education and related services for the purpose of establishing financial responsibility.

Both IDEA and Title XIX clearly establish Medicaid as payer of first resort for Medicaid covered related services provided under IDEA to Medicaid eligible children [IDEA §612(a)(12)(A)(i) and SSA §1903(c)]. Special education instructional services are excluded from this requirement under Title XIX. The DAB and the courts have attempted to differentiate special education instructional services from related services to facilitate a determination of financial accountability. They have held that trying to determine whether a particular service is "educational" does seem to be a fair way to decide whether, on the whole, it is medical assistance. What most people think of as education (what the district court referred to as "traditional academic education") is not "medical assistance" under Medicaid. Also, the court has held that services regarded as Medicaid-covered, had they been performed by, for example the Department of Mental Health, could not be classified as uncovered educational services solely because they were performed by employees of the Department of Education. Thus, the court concluded, HHS must inquire into the nature of the services, not just into what they are called or who provides them.

Issue	Impact
6. Time Study Mechanism (p. 36 and 39)	It is unclear if CMS will find Time Study mechanisms other than Random Moment Sampling (RMS) acceptable. RMS involves Time Study participants being asked at any point throughout a quarter to document activities in any given randomly selected 15-minute interval.

Analysis

There are many sampling methodologies which can be used that meet the OMB A-87 criteria for a "substitute system" which meets "acceptable statistical sampling standards" which may be used in place of activity reports. Per OMB A-87, "Such systems may include, **but are not limited to**, random moment sampling, case counts, or other quantifiable measures of employee effort." (Emphasis added).

Issue	Impact
7. Effective Date (p. 2 of Cover Letter)	The Final Guide will be effective for new programs at issuance and for existing programs at the beginning of the school year immediately following their release, i.e., the 2003-2004 school year. This will be difficult for most states and schools to implement because of the need to completely revise/amend their existing methodologies. Additionally, the Final Guide states that for programs that were previously reviewed and paid, but not formally approved, retroactive claim reconciliation may be required. Many states and school districts that have been waiting as long as several years for final approval, could be required to return funds or have them taken out of future claims that were claimed in good faith pursuant to an approved methodology, whether formally or informally approved.

Analysis

There is no requirement for a formal written approval for the Medicaid administrative claiming program. In some states, formal written approval of the methodology was provided by CMS (then HCFA) after extensive negotiations. In other states, after an extensive negotiation process, CMS provided verbal approval of the methodology, instructed the state to submit claims and paid the claims as submitted. The potential retroactive application of the new policy described in the guide on programs that have been submitting claims under negotiated methodologies with formal written CMS approval, as well as on those with long standing verbal approval, is of significant concern.

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