CMS Policy on Medicaid in Schools
Coverage, Reimbursement, Time Studies

National Alliance for Medicaid in Education
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CMS Session Objectives

• Understand Medicaid school-based services (SBS) concepts and CMS policies and principles.
• Understand key requirements related to coverage, reimbursement policy including the role of the time study.
The 3 Facets to review of SBS:

- Time Study
- Methodology
- Coverage
- Reimbursement
  CMS/NIPT
- CMS/ACT
- CMS/DEHPG
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).
- 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
Common Coverage Questions

When can a service listed in the IEP be reimbursed through Medicaid?

Services included in an IEP may be reimbursed as long as:
1) The services are medically necessary and coverable under a Medicaid coverage category (i.e. speech therapy, physical therapy, etc.),
2) All other federal and state regulations are followed, including those for provider qualifications, comparability of services and the amount, duration, and scope provisions; and
3) The services are included in the state’s plan or available under EPSDT.
What qualifications must a speech pathologist have in order to provide Medicaid reimbursable speech/language services?

CFR 440.110(c)(2) defines a “speech pathologist” as an individual who meets one of the following conditions:

1) Has a certificate of clinical competence (CCC) from the American Speech and Hearing Association (ASHA).

2) Has completed the equivalent education requirements and work experience necessary for the certificate.

3) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.
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• 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, CMS requires that States demonstrate that rates paid for SBS are no higher than the actual cost of providing the medical services.
• A State may pay providers the Medicare rate or the rate paid to other similar providers in the community without demonstrating cost.

• This policy helps to assure that payment meets the requirements of section 1902(a)(30)(A).
• Generally, states select their payment methodology based on how they will fund the non federal share of payment.
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.
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
CMS’ Policy on Cost

• SBS allowable costs are composed of direct and indirect costs. Indirect cost is limited to the Cognizant agency (i.e., Department of Education) assigned indirect cost rate.

• 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.
New Payment Models

- States moving away from volume-based payment
What is an Integrated Care Model?

Integrated Care Models is a broad description of approaches to providing coordinated, person-centered and comprehensive care.
Integrated Care Models

• July 10 – CMS issued two SMD letters
• Guidance on designing and implementing care delivery and payment reforms that improve health, improve care, and reduce costs within Medicaid programs
• More letters are expected to follow on shared savings, quality metrics, and managed care
ICMs under the Medicaid State Plan

• Section 1905(a)(25) and, by reference, 1905(t)(1) of the Act – Medicaid state plan PCCM authority.

• Authorized services
  • Coordinating
  • Locating
  • Monitoring.
State Plan ICM Service Providers

State plan ICM providers include:

• An individual practitioner, physician, nurse practitioners, certified nurse-midwives, or physician assistants;

• Physician group practices, or entities employing or having arrangements with physicians to provide such services.
ICMs under the State plan must follow all statutory and regulatory requirements:

- Comparability (42 CFR 440.240)
- Freedom of Choice (42 CFR 431.51)
- Beneficiary Protections (1905(t) of the Act)
- Access to Care Requirements (1902(a)(30)(A) of the Act)
- Comprehensive Reimbursement Description (42 CFR 430.10)
- State match funding requirements still apply.
Innovation and School Based Services

- No state has submitted a SPA yet that marries reimbursement for school based services and to an ICM or other innovative payment model.
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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.
• 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.
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.
School-Based Resources


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