Medicaid Funding Stream for School-Based Services

National Alliance for Medicaid in Education

13th Annual Conference
Baltimore, MD

October 6, 2015

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CMS Funding Session Objectives

• Learn the basic statutory and regulatory basis for the funding framework of the Medicaid program.

• Understand how Medicaid funds for Medicaid-covered services provided in the school setting are authorized and flow to school systems.

• Gain perspective on how your role as school administrator, teacher, medical provider, or interested party impacts the process of Medicaid funding for school-based services (SBS).
Statutory Authority

Title XIX of the Social Security Act

• Medicaid is jointly funded by the states and the federal government
• Medicaid programs must be in effect statewide
• States must operate their programs with “efficiency and economy”
Legislative Background

- **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 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) amended section 1903(c) of the Act to permit Medicaid payment for medical services provided to children under IDEA through a child’s Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).
CMS-Issued Guidance

- **May 1999:** CMS issues policy concerning Medicaid payment for transportation in the school setting.
- **May 2003:** “Medicaid School-Based Administrative Claiming Guide.” (will be folded into new guidance expected in 2016)
- **November 2005:** Approval of first time study for identifying school-based direct medical service expenditures.
- **FY 2010:** School-Based Services and School-Based Administration added as mandatory expenditure reporting line items to the Form CMS-64.
Medicaid Financing Definitions

- Total Computable (TC) State Medicaid Expenditure: The total state expenditure for a Medicaid service.
- Federal Financial Participation (FFP): The federal funding of its share of the TC Medicaid service or administrative expenditure.
- Federal Medical Assistance Percentage (FMAP): The % of the TC Medicaid expenditure that determines the limit of FFP
§1905(b) of the Social Security Act specifies FMAP for states

- FMAP range for direct services: 50%– 74.17%

- Enhanced FMAP is provided for some initiatives:
  - Health Home Services: 90% (1st 8 qtrs.)
  - Family Planning: 90%
  - Community First Choice (CFC): +6%
  - Medicaid Management Information Systems: 90/75%

- Indian Health Services: 100%

- Administrative expenditures: 50%
### Medicaid Covered Services

Section 1905(a) of Title XIX of the SSA lists services eligible for Medicaid payment:

<table>
<thead>
<tr>
<th>Inpatient Hospital</th>
<th>Pharmacy</th>
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<tbody>
<tr>
<td>Outpatient Hospital</td>
<td>Nurse Midwife and Birthing Center</td>
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<tr>
<td>Lab and X-ray</td>
<td>Nurse Practitioner</td>
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<tr>
<td>Nursing Facility</td>
<td>Hospice</td>
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<td>Physician</td>
<td>Case Management</td>
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<tr>
<td>Other Licensed Practitioners</td>
<td>Personal Care</td>
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<td>Home Health</td>
<td>Home and Community Care</td>
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<td>Clinic</td>
<td>Community Supported Living</td>
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<tr>
<td>Dental</td>
<td>Other remedial care</td>
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<tr>
<td>Physical Therapy</td>
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Medicaid Covered Services

• There is no service category in Medicaid for “school-based services,” or “early intervention services,” or Individualized Education Program (IEP) services or EPSDT.

• Medicaid-covered services provided in schools are subject to all Medicaid statutory and regulatory requirements.
Medicaid Services That Might Be Delivered In The School Setting

- Physical therapy
- Occupational therapy
- Services for speech, hearing, and language disorders
- Rehabilitative services
- Preventive care services
- Screening services
- Personal care services
- Specialized transportation
Medicaid Payment Methods

Services are paid in 2 ways:

• Fee schedule rates paid to all qualified Medicaid providers who provide the service

  OR

• Identification and allocation of costs incurred by the provider
If a state is proposing to pay something other than the fee schedule rate for the services, the state will document, describe, and allocate its cost to determine the amount eligible for FFP

- A State may pay providers the Medicare rate or the state’s fee schedule rate paid to other similar providers without demonstrating cost.

- This policy helps to assure that payment meets the requirements of section 1902(a)(30)(A) that payments be economic and efficient.
States often select their payment methodology based on how they will fund the nonfederal share of the expenditure.
Funding the Non-Federal Share of Medicaid Services

- Appropriations to the State Medicaid Agency
- Certified public expenditures (CPEs)
- Intergovernmental transfers (IGTs)
- Health Care Related Taxes
- Provider Related Donations
Local Government Funding of Medicaid Expenditures

• §1902 (a)(2) of the Social Security Act – Requires that reimbursement not be contingent upon funding.

• 42 CFR 433.51 - Local Govt. participation in funding.

• 42 CFR 433.53(b) – Local Govt. participation cannot exceed more than 60% of the non-federal share. (Aggregate Test)
Funding the Non-Federal Share of School-Based Services

To fund the nonfederal share of the payment, states—

• Typically use CPEs to fund the non-Federal share of SBS

• Sometimes use IGTs
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.
Certified Public Expenditures

• A CPE is a mechanism by which a governmental entity (e.g., city, county, government-owned hospital) documents and certifies its TC cost incurred in connection with the rendering of a Medicaid service.  
• Cost must be identified at the level of the entity whose cost is being certified.  
• The State then claims FFP for that TC cost.
Certified Public Expenditures

Two types of public expenditures that can be certified:

• Certification of provider cost incurred at the governmental provider level:
  - This can occur at the City, County or State level when the local or state government is the actual provider of the Medicaid service.
  - Requires the use of a CMS-approved cost identification, reporting and allocation methodology

• Certification of contract cost incurred to render Medicaid services:
  - If the municipality contracts with another entity, be it a private or governmental entity, the cost of the contract would be the municipality’s cost incurred in providing the service.
Certified Public Expenditures

• Governmentally-operated providers may certify the actual total cost they incurred for providing services to Medicaid eligible beneficiaries less any applicable revenues.

• Only units of government, including government-operated providers, may certify costs in this way.
Because the government provider is funding a “Medicaid payment” based on incurred costs, the cost reporting methodology must be specified in the State Plan.

States implementing funding mechanisms based on CPEs must modify their Medicaid State Plans to indicate that the reimbursement methodology for participating government providers is actual incurred cost.
Benefits and Challenges of CPEs

Pros:

• CPEs provide states with a mechanism to leverage local tax dollars already in the State’s health care system to draw federal matching dollars.

• States can access federal dollars without requiring additional state appropriations.

Cons:

• Requires the use of detailed and potentially burdensome administrative procedures to accurately document costs.

• Federal dollars drawn are not required to be passed back to the unit of government incurring the expense.
Cost Identification

• The use of CPEs requires accurate cost identification at the government program level.

• Surveys or high level budget documents are not sufficient to document costs.

• There is currently no federally mandated Cost report form for SBS.
Cost Reporting Requirements

Title 45: Public Welfare

• PART 75—UNIFORM ADMINISTRATIVE REQUIREMENTS, COST PRINCIPLES, AND AUDIT REQUIREMENTS FOR HHS AWARDS
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.
Time Studies

• A time study is a cost allocation method used to document the activities performed by various program staff and determine what portion are reimbursable by Medicaid.

• The Random Moment Sampling (RMS) process is used to document the activities by staff performing directly related program functions benefiting one or more programs and captures moments.
Time Studies

- The time study must be approved by the funding agency (CMS), be statistically valid, and designed to capture 100% of paid time.

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

Federal rules also allow the use of CMS-approved "substitute systems" for allocating salaries and wages to federal awards when employees work on multiple cost objectives.

- Worker logs
- Service logs (claims)
- Square footage (rare)
Availability and Maintenance of Documentation

• Section 1902(a) of the Act requires sufficient documentation to be maintained in support of a claim.

• The State must ensure 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.

• Schools are obligated to “keep any records necessary to disclose the extent of services the provider furnishes to recipients”.


The minimum documentation of a service must include:

- Date of service
- Name of beneficiary
- Medicaid ID number
- Name and NPI of billing provider
- Name and NPI of person providing the service
- Description and units of service
- Place of service (office, home, school)
For services provided in schools, documentation should include:

- Beneficiary medical record
- Individualized Education Program (IEP) or Individual Family Service Plan (IFSP)
- School attendance records for the dates of services
- Prescriptions/referral for IEP services
- Documentation of the service performed on the date of service including clinical notes signed and dated by provider
- Documentation regarding where the service was provided and who provided the service
Additional Documentation

• Medical provider qualifications associated with licensing and certification
• Payroll records associated with school personnel providing services
• Copies of contracts with medical providers
• Cost reports
• Time study source documents
• Any manuals related to the time study, cost allocation plan, or other procedures associated with Medicaid SBS reimbursement
Common Review Elements

• 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 Review Elements

- 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.
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 federal regulations or its Medicaid State Plan, CMS may withhold or recover federal funds.

- If claims for federal matching funds are denied, the state may require school districts to repay reimbursements made for the undocumented or unallowable school-based services.
New Payment Models

States are exploring ways to move away from volume-based payment to focus more on paying for better access, quality and health outcomes.
No state has yet submitted a state plan amendment that seeks specifically to include reimbursement for school based services in these or other innovative payment models.

However...it is only a matter of time!
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