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CMCS Informational Bulletin

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SUBJECT: Information on School-Based Services in Medicaid: Funding, Documentation and Expanding Services.

School-based services (SBS), which are Medicaid-coverable services provided to children and adolescents in a school setting, play an important role in the health and well-being of children and adolescents, particularly for those enrolled in the Medicaid program. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a Medicaid benefit that mandates coverage of services described in section 1905(r) of the Social Security Act (the Act), which include a range of services including medical, dental, personal care, and long-term services and supports, regardless of whether the particular services are covered under the state plan. [1]

Although schools are primarily providers of education, the school setting provides a unique opportunity to enroll eligible children and adolescents in Medicaid and the Children's Health Insurance Program (CHIP), furnish Medicaid-covered services, including behavioral health services (mental health and substance use disorder (SUD) services) to eligible children, and help children who are enrolled in Medicaid access the services they need. Schools are uniquely positioned to increase health equity and to help ensure that all children have access to necessary health care services. This includes services provided through a formal Individualized Education Program (IEP) and Individualized Family Service Plan (IFSP) under the Individuals with Disabilities Education Act (IDEA), or other plan and services provided outside of those plans

[1]Section 1905(r)(5) of the Act - Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.
Nothing in this title shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this title in early and periodic screening, diagnostic, and treatment services.

where the services are made available without charge to the beneficiary, including when the services are available without charge to other students not enrolled in Medicaid.[2]

CMS and the US Department of Education (ED) are supportive of school-based health programs and, where possible, we encourage states to ease administrative burden placed on school-based health providers to promote their participation in the Medicaid program and thereby increase access to Medicaid-covered services for Medicaid-enrolled students, while also maintaining fiscal and programmatic integrity of the Medicaid program. We are issuing this informational bulletin to remind states of the applicable federal regulations and policies related to Medicaid-covered SBS[3], and to help states and school-based providers implement, maintain and expand their school-based programs in the most efficient manner possible. Specifically, this bulletin directs states to relevant existing guidance and strategies to consider, in the form of a "checklist," which is intended to assist states in developing proposals that are consistent with federal requirements and policies. The checklist highlights existing state flexibilities and best practices for maximizing Medicaid coverage for services furnished to beneficiaries in schools.

This guidance is one of several steps CMS is taking to support access to Medicaid SBS. Section 11003 of the Bipartisan Safer Communities Act (P.L. 117-159) builds upon the efforts CMS has underway, and specifies several actions for the Department of Health and Human Services (HHS) to take in support of this goal. In the coming months, CMS intends to issue additional guidance and resources for states, including the release of an updated SBS guide that will provide more detailed information regarding payment for Medicaid-covered services furnished in schools. This updated SBS guide will encompass an update to the existing Medicaid School-Based Administrative Claiming Guide and Medicaid and Schools Technical Assistance Guide in accordance with Section 11003 of the Bipartisan Safer Communities Act. While this CIB addresses school-based health services under Medicaid, including M-CHIP, the upcoming guide will also address CHIP issues related to school-based services. Additionally, the Bipartisan Safer Communities Act requires CMS, in collaboration with the US Department of Education, to establish a technical assistance center to support State Medicaid agencies, local educational agencies and school-based entities seeking to expand their capacity for providing Medicaid SBS, by reducing administrative burden, supporting such entities in obtaining payment for providing Medicaid SBS, and providing guidance with regard to utilization of various funding sources.

Background

Since the inception of the Individuals with Disabilities Education Act (IDEA) in 1975, SBS have become an important and growing resource for Medicaid-enrolled IDEA eligible children and their families in the provision of medically necessary services. The 1988 amendment to IDEA, included in the Medicare Catastrophic Coverage Act, clarified that Medicaid funds could be used to pay for Medicaid-coverable services that are part of the eligible child's IEP. IEP services are delivered without cost to the child's family. It is important to note that IEP/IFSP services, such as speech therapy, are designed to assist a child's success in school or to advance their development. A child with an IEP may also need Medicaid-covered services, such as speech

[2] www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf

[3] Unless stated otherwise, all references to Medicaid beneficiaries also include beneficiaries enrolled in Medicaid-expansion CHIPs.

therapy, for medical reasons. Thus, State Medicaid agencies are encouraged to work with schools and families to ensure that both the special education and medical needs of the child are addressed.

SBS have become an important and growing resource for Medicaid-enrolled children to get the health care they need. CMS is committed to increasing access to health care services and quality education in ways that can narrow disparities in rates of care, promote achievement, and build a reliable system of support for every young person. This recognizes research that consistently demonstrates a positive link between scholastic attainment and improved health outcomes while also acknowledging that the educational environment is an optimal place to promote wellbeing. We encourage state Medicaid agencies looking to advance SBS to partner with State Education Agencies (SEAs), Education Services Agencies (ESAs), Local Education Agencies (LEAs) including charter schools that are LEAs, public boards of education or other public authorities within a state that maintain administrative control of public elementary or secondary schools in a city, county, township, school district, or other political subdivision of the state.

Medicaid covers many services provided through schools to students enrolled in Medicaid. This includes services provided by school-based health centers, which can significantly improve key health and educational outcomes among students. State Medicaid agencies, SEAs, ESAs and LEAs can work together to explore opportunities to obtain payment for Medicaid-covered services for Medicaid-enrolled students. Many services such as immunizations, health screenings, oral health care, substance use disorder treatment, and behavioral health care can be covered by Medicaid in schools and may be eligible for Medicaid coverage and payment. As discussed in further detail in the managed cared section of this CIB, states are encouraged to ensure proper coordination of services and care.

Federal law allows states to set payment rates for Medicaid-covered services in a manner that is consistent with section 1902(a)(30)(A) of the Act and its implementing regulations in 42 C.F.R. §447. Below, we provide a basic overview of the parameters for Medicaid coverage and payment of services furnished in schools:

- There is no benefit category in Medicaid called "school-based services." SBS are Medicaid-covered services that are provided in school settings by qualified Medicaid providers enrolled in the Medicaid program.
- To receive payment for providing Medicaid covered services, SBS providers must be enrolled in the Medicaid program and must meet specific federal and state requirements regarding provider qualifications for participation in the Medicaid program.
- To be eligible for payment by Medicaid, services must be included among those listed in Title XIX of the Act, such as those described in section 1905(a) of the Act, and coverable under the State plan (or waiver of such plan).
- Like services furnished elsewhere, Medicaid-covered services provided in schools must meet applicable statutory and regulatory requirements.
- Generally, the Medicaid statute requires Medicaid to be the payer of last resort.
- Section 1903(c) of the Act provides that Medicaid may cover services in an IEP or IFSP under the IDEA. IDEA requires special education be delivered at no cost to the child's family. Families must not be subject to copays or other fees.

School-Based Health Services Checklist
The following checklist includes strategies and guidance state Medicaid agencies can follow to implement or enhance SBS.

1. Medicaid "Free Care" Policy[4]

In State Medicaid Director Letter (SMDL) #14-006, CMS announced a new policy regarding the availability of Medicaid payment for services covered under a state's Medicaid plan to an eligible Medicaid beneficiary when the services are made available without charge to the beneficiary (including when the services are available without charge to members of the community at large). Such services sometimes are referred to as "free care." Before 2014, Medicaid payment generally was not allowable for services that were available without charge to the beneficiary, with limited exceptions. However, SMDL #14-006 withdrew the previous "free care" policy and announced that Medicaid payment would be available for Medicaid-covered services furnished to Medicaid beneficiaries, regardless of whether there is any charge for the service to the beneficiary (or to a member of the community at large). This policy is not limited to services identified in an IEP; however, generally applicable Medicaid coverage and payment requirements must be met, including that services must be furnished by a qualified, Medicaid-participating provider.

For example, a qualified and Medicaid-enrolled audiologist that comes into the school and provides hearing assessments for the entire student body can now bill Medicaid for those services whether or not other third-party payers are also billed for the hearing assessment. Likewise, if a school nurse administers fluoride treatment to the entire student body, so long as that nurse or the school is enrolled as a Medicaid provider, the fluoride treatment could be eligible for Medicaid payment. Some states have not taken the opportunity to incorporate these types of activities in their payment methodology specific to school-based services in their Medicaid program, as discussed in section eight of this informational bulletin. Providers in the community that provide Medicaid services, and bill under their own licensure, can bill for services directly according to the state plan specified Medicaid fee schedule. However, most often, an employee or contractor of the school is acting as the provider with the school submitting a bill to Medicaid, and states have payment methodologies specific to the school setting and those states may need to consider submitting a plan amendment to include the non-IEP/IFSP services in the payment methodology.

Since the issuance of SMDL #14-006, approximately sixteen states[5] have received approval of State Plan Amendments (SPAs) to allow Medicaid payment for covered services furnished in a school setting by a Medicaid participating provider. CMS encourages states to promote the use of schools as a setting in which to provide Medicaid-enrolled children and adolescents with medically necessary Medicaid-covered services, where appropriate to the student's needs and the

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[4] *See* State Medicaid Director Letter #14-006, "Medicaid Payment for Services Provided without Charge (Free Care)" (Dec. 15, 2014), https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf

[5] California, Nevada, Arizona, Colorado, Minnesota, Missouri, Louisiana, Michigan, Kentucky, Florida, Georgia, South Carolina, North Carolina, Connecticut, Massachusetts, and New Hampshire

capabilities of the setting and practitioners, thereby promoting access to needed care and promoting health equity.

CMS reminds states and stakeholders of the following:

- Medicaid payment is available for covered services that are provided to Medicaid enrolled beneficiaries, regardless of whether there would otherwise be any charge for the service to the beneficiary (or to a member of the community at large).
- Medicaid payment can be made (and federal financial participation is available) for Medicaid-covered services, including those identified in students' IEPs, IFSPs, and individual service plans per section 504 of the Rehabilitation Act of 1973, commonly called a Section 504 plan.
- Covered services may include, but are not limited to, EPSDT services like screenings, vaccinations, check-ups, and other EPSDT services. See number "3. Providing EPSDT Services" below for more information.[6]
- Services not in a child's IEP can also be covered including behavioral health services and nursing services, such as nutrition services, medication monitoring, and counseling.
- Services provided to Medicaid-enrolled students must satisfy applicable medical necessity criteria, be coverable under a Medicaid coverage authority (e.g., the Medicaid state plan or a section 1115 demonstration project), and be furnished by a qualified, Medicaid-participating provider.
- Covered services may be delivered to all Medicaid-enrolled children in school settings, not just those with a special education plan documented in an IEP, IFSP, or Section 504 plan.

2. Ensuring Every Medicaid-Eligible Child is Enrolled *and* Has Access to Services

CMS encourages all states to ensure that every eligible child is enrolled in Medicaid coverage and able to receive covered SBS. Research strongly suggests that when young people have health coverage and receive necessary and preventive health care, their academic and other important life outcomes improve. One study, for example, found that compared with children who were uninsured, children who were enrolled in Medicaid were more likely to do better in school, miss fewer school days due to illness or injury, finish high school, graduate from college, and earn more as adults.[7] One study found that, although access to health coverage for uninsured individuals has increased as a result of the Patient Protection and Affordable Care Act (Affordable Care Act), the number of children who are eligible for, but not enrolled in Medicaid remains high. In 2019, 2.3 million children were eligible for, but not enrolled in Medicaid or CHIP.[8] Schools can be a valuable resource for states to help ensure that Medicaid-eligible children and families are enrolled and connected to Medicaid-covered services:

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[6] https://www.hhs.gov/guidance/document/epsdt-guide-states-coverage-medicaid-benefit-children-and-adolescents.

[7] Cohodes, S. et al. (2014). The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions. (No. w20178). National Bureau of Economic Research

[8] Haley, J. et al. (2021). Uninsurance Rose among Children and Parents in 2019. Urban Institute. https://www.urban.org/sites/default/files/publication/104547/uninsurance-rose-among-children-and-parents-in-2019.pdf

- o LEAs can use school registration processes to help eligible students and family members enroll in Medicaid or CHIP, or if ineligible, to apply for financial assistance for a plan through the Health Insurance Marketplace. States should look to outreach and enrollment resources such as the Connecting Kids to Coverage National Campaign to assist in accomplishing enrollment and coverage goals. [9] Expenditures for administrative activities in support of these school-based services, including outreach, may be claimed as costs of administering the Medicaid state plan. States can receive federal financial participation (FFP) at the applicable administrative match rate for outreach and enrollment activities.
- o While Medicaid-enrolled students do not need an IEP to receive coverage for SBS, states should establish a process to determine coverage for particular services, including, for example, whether applicable medical necessity criteria are met. Any medical necessity criteria or other utilization management controls that a state implements must be consistent with 42 CFR § 440.230, and should not establish unreasonable or arbitrary barriers to accessing the required coverage.
- o Medicaid is focused on "whole child care," and we encourage integrating and coordinating any care provided in school with care provided across other settings and within the family unit. A care plan developed in the school should consider how care provided in a school-based setting, including, for example, behavioral or other care interventions, may be supported outside of school and within the family setting. School-based providers should coordinate with primary care and other community-based providers as well as members of the household who may be able to reinforce and provide continuity of care. For more information on creating a coordinated system of care, please see guidance from the Substance Abuse and Mental Health Services Administration (SAMHSA), The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program. [10]
- o Screening and diagnostic services provided in schools may indicate the need for further evaluation of a child's health, and the child should be appropriately referred for diagnosis and treatment without delay. Ultimately, the goal of the EPSDT benefit is to assure that children get the health care they need, when they need it – the right care to the right child, at the right time, in the right setting.

3. Providing EPSDT Services

The Medicaid program provides most enrolled children and adolescents with a unique benefit known as the EPSDT benefit. EPSDT provides a comprehensive array of prevention, diagnostic,

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[9] The Connecting Kids to Coverage National Campaign is a national outreach and enrollment initiative originally funded under the Children's Health Insurance Program Reauthorization Act (CHIPRA), the Affordable Care Act (ACA), and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This program motivates families to enroll and renew their children in Medicaid and CHIP and provides outreach guides and toolkits that can help states conduct successful outreach activities. More information about this program here: https://www.insurekidsnow.gov/campaign-information/index.html and https://www.medicaid.gov/state-resource-center/downloads/kids-coverg-outreach-enrolmnt-retention-strategies.pdf

[10] The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program, Report to Congress 2017, was written by staff at Westat pursuant to a contract (contract number 283- 12-1105) under the direction of the Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. https://store.samhsa.gov/sites/default/files/d7/priv/cmhi-2017rtc.pdf

and treatment services for most low-income individuals under age 21. As specified in sections 1902(a)(10)(A) and 1905(a)(4)(B) of the Act, EPSDT is a mandatory benefit, which is defined in section 1905(r) of the Act. Section 1902(a)(43) of the Act requires that states must inform all EPSDT-eligible beneficiaries of the availability of these services, as well as provide or arrange for the provision of EPSDT screening services when requested, and arrange for corrective treatment as indicated based on the screening services. States are encouraged to leverage schools as providers of services in meeting EPSDT coverage obligations.

- Section 1905(r) of the Act defines the EPSDT benefit to include certain minimum screening, vision, dental, and hearing services, as well as "[s]uch other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services, whether or not such services are covered under the State plan."
- Most beneficiaries under age 21 are entitled to EPSDT services, regardless of whether they are enrolled in a managed care plan or receive services in a fee-for-service (FFS) delivery system.
- Determinations of medical necessity are made by the state or, under delegated authority, by the managed care plan and must be made on a case-by-case basis, considering the individual child's or adolescent's particular needs and guided by information from the child's health providers.
- Hard, fixed, or arbitrary limits on coverage for services (e.g., based on dollar amounts, standard deviations from the norm, or lists of specific diagnoses) are not permitted; however, states may set reasonable limits based on criteria such as medical necessity or appropriate utilization control, *see* 42 C.F.R. § 440.230(d).
- Medicaid-covered services furnished in schools must fit under an applicable state plan benefit category or waiver or demonstration authority, and must be furnished by a Medicaid-participating provider who meets the provider qualification requirements associated with the particular benefit.
- If a state pays for services of a particular provider type, that Medicaid provider type should meet certification, registration, credentialing, education, training, and other state-specific requirements consistent with the rules of the benefit category.
- Providers of therapy services (physical therapy, occupational therapy, speech therapy, audiology) must meet federal provider requirements in 42 C.F.R. § 440.110, regardless of the section 1905(a) benefit category under which these services are covered.
- States should work with SEAs and LEAs to determine specific federal and state requirements regarding provider qualifications specific to participation in the Medicaid program, procedures for enrollment with the state Medicaid agency, and the scope of practice laws for provider types furnishing SBS.
- CMS shares with states the same goal of ensuring that Medicaid services provided in the schools are of high quality, and states should establish qualifications of school providers consistent with those of providers in the community.
- Medicaid-participating practitioners in school-based settings are also subject to the screening requirements in section 1866(j)(2) of the Act and 42 C.F.R. §§ 455.400 – 455.470. *See* section 1902(a)(77) and (kk) of the Act.

- Claims for payment for Medicaid-covered items or services that were ordered or referred for a beneficiary must include the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services.

4. Medicaid SBS through Managed Care[11]

About 76 percent of Medicaid beneficiaries (over 61.7 million) are enrolled in managed care.[12] CMS encourages states that use managed care delivery systems for Medicaid-covered services to work with managed care plans (MCPs) including managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs), as well as schools, to aid in the provision of and payment for SBS.

- States may elect to deliver some services through the MCPs and retain some services under fee-for-service delivery.
- An MCP contract must clearly describe which services are included, with enough specificity to avoid confusion about what the benefit includes and whether the MCP is responsible for covering it to ensure that eligible individuals under age 21 have access to the full EPSDT benefit.
- Any EPSDT services not covered under the MCP contract remain the responsibility of the state Medicaid agency, and states must ensure that EPSDT-eligible individuals under age 21 have full access to the EPSDT benefit.
- When designing and implementing a managed care delivery system, states should include schools as integral partners to promote the effective and efficient delivery of services in school-based settings. Where managed care is already established, states should include schools during MCP re-procurement and contracting processes to provide states with opportunities to shape new, or revisit existing, MCP requirements.
- States should consider requiring MCPs to establish relationships, strengthen partnerships, and coordinate care with school-based providers, including school-based health centers, in managed care contracts and/or through managed care performance standards. These expectations can be established in a variety of ways, including through performance improvement projects, MCP incentive programs, and quality improvement initiatives, as appropriate.
- To improve care coordination activities between MCPs and ensure access to covered services, states should consider:
  - Developing formal arrangements, such as including school-based clinics in MCP provider network requirements:
    - States may establish specific network adequacy requirements, such as requiring that MCPs contract with all, or a specified percentage of, qualified school-based providers.

[11] www.medicaid.gov/federal-policy-guidance/downloads/cib010517.pdf This figure includes comprehensive MCOs and limited benefit plans (PIHPs and PAHPs) and excludes PCCMs. Medicaid Managed Care Enrollment and Program Characteristics, 2020.

[12] This figure includes comprehensive MCOs and limited benefit plans (PIHPs and PAHPs) and excludes PCCMs. Medicaid Managed Care Enrollment and Program Characteristics, 2020. https://www.medicaid.gov/medicaid/managed-care/downloads/2020-medicaid-managed-care-enrollment-report.pdf

        - In areas where there are several MCPs operating, LEAs might need to contract with several different plans to ensure Medicaid payment is available for services furnished to all students who are Medicaid beneficiaries.
- Establishing referral and treatment protocols between schools and the MCPs' other contracted providers for instances in which care needs exceed the capabilities of providers in the school-based setting.
- Promoting school participation in MCP quality assurance and utilization review programs. SBS can help MCPs achieve Federal and state-specific quality metrics for their Medicaid populations, including many child-specific measures (e.g., child vaccination rates and well-child visits).
- Facilitating the development of coordination of care programs between schools and MCPs in which, for example, schools provide MCPs with written medical reports when care is provided in the school-based setting, and when care is needed beyond the school-based setting and a referral has been provided. MCPs can notify school-based providers of completed referrals (i.e., a child has received services for which the school has referred them).
- Facilitating coordination between MCPs and cooperating on back-to-school health coverage enrollment events, health fairs, and vaccination efforts.

5. Providing Medicaid Services in Schools via a Telehealth Delivery Systems

CMS encourages states to consider telehealth options as a delivery mechanism to increase access to care in schools. States have broad flexibility to cover and pay for Medicaid services delivered via telehealth, including to determine which telehealth modalities may be used to deliver Medicaid-covered services.

- States are encouraged to facilitate appropriate care within the Medicaid program using telehealth technology to deliver services covered by the state.
- CMS allows states the flexibility to design and establish program parameters defining when and how services are covered when delivered via telehealth and encourages the use of flexibility inherent in federal Medicaid law to create innovative payment methodologies for services that incorporate telehealth technology.
    - States should review the range of providers and practitioners authorized to bill Medicaid in their state, including those delivering services in school settings. Not every provider, practitioner, or direct support professional can deliver every service via telehealth. However, states are encouraged to maximize the use of telehealth, including in school-based settings, to address the service needs of students and mitigate gaps in service continuity.
    - States should establish which services can be delivered appropriately via one or more telehealth modalities.
    - States should consider whether a provider's professional scope of practice precludes them billing for a service delivered via telehealth, and whether any changes to that scope of practice are warranted.
- States are not required to submit a SPA or an amendment to a waiver or demonstration authority to pay for services delivered via telehealth if payments for services furnished via

telehealth are made in the same manner as when the service is furnished in a face-to-face setting.

- A state would need an approved state plan, waiver, or demonstration payment methodology (and thus, might need to submit a SPA or an amendment to a waiver or demonstration) to establish rates or payment methodologies for telehealth services that differ from those applicable for the same services furnished in a face-to-face setting.
- States are strongly encouraged to include costs associated with providing services via telehealth within Medicaid payment methodologies and ensure rates are adequate to facilitate access to telehealth services.
- Supplementary costs associated with the site where the beneficiary is located may be incorporated into fee-for-service rates or separately reimbursed as an administrative cost by the state when a Medicaid service is delivered, as specified in an approved state plan, waiver, or demonstration payment methodology that specifies the supplementary costs and circumstances when those costs are payable.
- It is important for states to adopt clear and consistent guidelines for paying for Medicaid-covered services that are furnished via telehealth technologies to Medicaid-eligible children and adolescents, and to ensure Medicaid-participating providers are aware of the guidelines.

For more information about state flexibilities to cover and pay for Medicaid services delivered via telehealth, see the Medicaid and CHIP Telehealth Toolkit.

6. Clear and Consistent Documentation Guidance to LEAs through Outreach and Education

Federal regulations require that providers maintain documentation that covered Medicaid services have been provided to beneficiaries. However, CMS understands that most school-based settings are not traditional health care providers with a sophisticated billing infrastructure in place. Recently, a number of HHS Office of Inspector General (OIG) audits have noted that schools have not been adequately documenting the services provided in school settings. In particular, these findings have noted a lack of clear and consistent billing requirements listed in state provider billing manuals.

Current Documentation Requirements:

- *Minimum Claim Documentation Requirements*[13] in Medicaid for each claim for FFP 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
- Other Requirements:

[13] Section 2500.2 of the State Medicaid Manual.

    - For services provided under IDEA, states must maintain records of a signed IEP/IFSP documenting that the school-based provider provided services pursuant to the IEP/IFSP.[14]
    - For transportation services provided under an IEP/IFSP, states must document that the transportation was to and/or from a medical appointment and required in the IEP/IFSP.
- Examples of the types of documentation and materials that can be used or combined as the "Minimum Claim Documentation" described above and should help states in meeting the various documentation requirements needed to create a proper audit trail. These documentation materials can include:
    - Attendance Records [15]
    - Prior Authorizations
    - Medical Records
    - Clinical notes of the service performed[16]
    - Service Claims
    - Time Study Logs
    - Payroll Records and Contracts
    - Transportation Logs[17]

- The state must ensure compliance with applicable federal audit and documentation requirements, including but not limited to, regulations described at:
    - 42 C.F.R. § 431.107 Required provider agreement
    - 45 C.F.R. § 447.202 Audits
    - 45 C.F.R. § 75.302 Financial management and standards for financial management systems

Potential Best Practices and Approaches for Meeting Requirements for Documentation:

To ensure clear and consistent billing and documentation standards and to help alleviate burden on school-based providers, states should:

- Review and update their provider billing manuals to make sure the billing and documentation requirements for providers are clear and concise, and reasonably can be met by providers furnishing services in school-based settings.
- Conduct front-line training to school-based providers on Medicaid documentation standards and audit processes.
- Ensure LEAs have adequate funding to support necessary Medicaid billing infrastructure and training. When such investments and activities are undertaken as Medicaid administrative activities, federal matching funds can be available.

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[14] Section 1903(c) of the Social Security Act.

[15] Attendance records can generally be used to document the student was present on the day a Medicaid service was rendered or the student was present on a day they were included in transportation logs as receiving transportation to receive a needed Medicaid service.

[16] Written IEP/IFSP alone is not an adequate record of Medicaid services provided.

[17] Transportation logs can be used, in conjunction with attendance logs, to show that a student was in school on the day in which the student was transported off-site to medical care.

- Consider increasing Medicaid payment rates for services provided in school-based settings to account for higher overhead costs associated with services provided in school settings, including staffing and training needs at the LEA or school.
- Track services provided in school-based settings using MMIS systems. These claims are important to document that covered services were actually delivered to an eligible beneficiary and can be used to trigger interim payments to LEAs under a cost-based Medicaid payment methodology.
- Work directly with CMS and the US Department of Education to align state and federal documentation requirements, where feasible.

School-based providers must maintain adequate documentation to allocate costs to the Medicaid program. For instance, providers using a Medicaid Enrollment Ratio (MER) to allocate costs to Medicaid for services furnished pursuant to an IEP or IFSP must maintain adequate documentation to support the use of the MER. The MER is an allocation statistic that is the result of all children at one specific time in the school that has an IEP/IFSP divided by the total number of Medicaid enrolled children in the same school, at the same specific time, that have an IEP/IFSP.

$$\text{MER} = \frac{\text{\# of Medicaid-enrolled children in the school with an IEP/IFSP}}{\text{Total \# of children in the school with an IEP/IFSP}}$$

Adequate documentation would include an LEA-specific record of both the number of children enrolled in **all** IEPs/IFSPs and those enrolled in Medicaid with IEPs/IFSPs.

7. Evaluate Random Moment Time Study (RMTS) Methodologies

When using a cost-based methodology, states are required to use statistically valid methodologies to allocate costs for SBS per 45 CFR 75.430(i)(5). Allocation methodologies may include, but are not limited to, random moment sampling (i.e., via RMTSs), worker day logs, case counts, or other quantifiable measures of work performed. A time study is a cost allocation methodology used to ascertain the portion of time spent on activities that are related to various programs. Federal regulations permit the use of "substitute systems" for allocating salaries and wages to Federal awards in place (or in addition to) work records as specified in 45 CFR 75.430(i)(1), when employees work on multiple activities or cost objectives. Any such system must meet acceptable statistical sample standards and be approved by CMS.

Regulations in 45 CFR 75.430 require that charges to federal awards must be based on records that reflect the actual work performed. Those records must:

- Be supported by a system of internal controls that provide reasonable assurance charges are accurate, allowable, and properly allocated,
- Reflect the total activity for which the employee is compensated,
- Encompass both federally assisted and all other activities for which the employee is compensated, and
- Support the distribution of the employee's salary or wages among specific activities or cost objectives.

When a RMTS is used, the only staff who can be exempted from mandatory participation in the RMTS are those whose activities are entirely (100%) for the direct benefit of the Medicaid program, or entirely (100%) for the benefit of some other program or payer. The RMTS must reflect all of the time and activities (whether allowable or unallowable under Medicaid) performed by employees performing activities in support of the Medicaid program. The RMTS must carefully document all work performed by the staff subject to the RMTS over a set period of time and include all days on which school is in session.

Because the time study must capture 100% of the time spent by staff participating in the RMTS, activity codes must be designed to reflect all administrative activities and direct services that may be performed, regardless of whether activities are reimbursable under Medicaid. The time study methodology is used to capture the time spent on administration, direct services, and all other activities. To avoid duplication of costs claimed, the same RMTS should be used to allocate costs of both administrative activities and direct services.

When designing an RMTS, states and stakeholders should consider the following:

- The HHS Office of Inspector General (OIG) has expressed concerns about staff participating in the RMTS given any advance notice of their assigned random moment, and the potential bias that could be created by providing advance notice. To avoid such concerns, participants in the RMTS should record their responses at the exact time of their assigned random moment (i.e., the participant should not be notified until the exact time and date of his or her moment and should complete the random moment activity documentation at that exact time).[18] CMS also recommends no prior notification to staff participating in an RMTS but has approved RMTS methodologies that allow staff participating in the RMTS up to 2 business days to respond with information about their activity at their assigned random moment to accommodate circumstances in which a participating staff member may not be able to respond immediately to the RMTS request. This policy is intended to help ensure the reliability of the RMTS results. CMS believes that the more time that has passed from the sampled moment, the more likely the participant's recall of his or her activity performed during the assigned moment may be compromised.
- Oversight and monitoring of the RMTS system are the responsibility of both the state and the individual claiming entity (e.g., the LEA) to ensure compliance with state and federal requirements. Sufficient resources should be allocated to ensure that only those costs that are properly allocable to the Medicaid program are claimed for Medicaid payment.
- The state and/or claiming entity (e.g., LEA) should have a system of controls in place to ensure the compliance with applicable laws and regulations.

8. Work with LEAs to Determine Payment Methodology Options that Work Best to Promote School-Based Services.

The vast majority of school-based providers are reimbursed under the Medicaid state plan at their actual cost to render Medicaid SBS. This is because many localities and states finance SBS through the use of Certified Public Expenditures (CPEs) which are based on local governments

[18] HHS Office of Inspector General Audit (A-02-17-01006), issued November 8, 2019. https://oig.hhs.gov/oas/reports/region2/21701006.asp

funds to support the actual cost of providing services. When using CPEs, public entities must account for and certify that they spent funds on Medicaid covered items or services that are eligible for federal matching funds. In these cases, schools may submit interim bills to states that are reconciled to the provider's incurred Medicaid SBS cost. However, states have additional options to finance SBS. As schools are often units of state or local governments, in addition to CPEs, states have the option to finance Medicaid payments through the use of permissible Intergovernmental Transfers (IGTs) as well as CPEs and appropriations from state general funds. States are encouraged to consider financing SBS through IGTs and/or state general fund appropriations and to pay providers using a rate methodology if a certified cost process is too burdensome for schools and LEAs to complete.

Options to Financing the Non-federal Share of Medicaid Payments:

Medicaid is jointly financed by the federal and state governments, with most Medicaid service expenditures matched at the state-specific, statutorily defined federal medical assistance percentage. Section 1903 of the Act and implementing regulations in 42 C.F.R. § 433.51 describe allowable sources of the non-federal share and specific mechanisms that may be used by units of state and local governments to participate in financing the non-federal share. Such allowable sources include:

- State legislative appropriations –
    - States can use general revenue fund appropriations to pay school-based providers for services rendered. Typically, with this funding, the state will pay a rate (e.g., under the state's fee schedule) for school-based services. However, the appropriation from the state general revenue fund must be under the administrative control of the state Medicaid agency and, once payment is made to the provider, the provider generally must retain 100 percent of the payment. Retention of less than 100% could trigger a net applicable credit with return of associated FFP to CMS. See section 1903(d)(3) of the Act for information regarding overpayments.
- Intergovernmental Transfers (IGTs) –
    - Units of state or local government, including but not limited to public schools and LEAs, can participate in the financing of the non-federal share of Medicaid expenditures through IGTs, provided all applicable requirements are met.
    - When IGTs are used to support payments to school-based providers, the public school or LEA must make the IGT(s) to the state Medicaid agency before the Medicaid agency pays the school-based providers for services furnished, as IGTs are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control in accordance with 42 C.F.R. § 433.51(b). If IGT funds are transferred after a Medicaid payment is paid to the provider, then the provider may not be receiving or retaining the full Medicaid payment rate for services under the state plan.

  - Once payment is made to the school-based provider, the school-based providers generally must retain 100 percent of the payment. Retention of less than 100% could trigger a net applicable credit with return of associated FFP to CMS.

- Certified Public Expenditures (CPEs) –

  - CPEs refer to a unit of state or local government's expenditures for the provision of Medicaid-covered services to beneficiaries. The unit of state or local government *must certify the actual amount of the expenditures* that were incurred providing allowable Medicaid services to the state Medicaid agency. Based on the state Medicaid agency's claim for FFP, the federal government provides the FFP associated with the certified expenditures to the state Medicaid agency.
  - Units of state or local government, including but not limited to public schools and LEAs, can participate in financing the non-federal share through CPEs, provided all applicable requirements are met.
  - Provider payments supported by CPEs must be made according to a reconciled cost payment methodology in the approved state plan, which is explained in more detail below.
  - The state Medicaid agency is not required to pass the federal share of the certified expenditures down to the school-based provider, and CMS acknowledges that the state may choose to direct some or all of this FFP to the school-based provider. However, CMS strongly encourages states to pass on the federal share of any costs claimed as expenditures for which the non-federal share is supported by a CPE certified by a public school or LEA to the school-based providers, as additional funding and investment will help to support additional efforts to improve the delivery and administration of SBS. Please note that federal funds cannot be used to match other federal funds, except as authorized by federal law, *see* 42 C.F.R. § 433.51(c).

<u>Options for Paying School-Based Service Providers</u>

Section 1902(a)(30)(A) of the Act requires that states "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." As such, states have considerable flexibility in how the provider payment rates are set. Generally, states' options to pay SBS providers include:

- State plan rates established for services provided outside of school settings:

  - States may use the existing state plan payment rates for the same services provided in settings other than the school-based setting when those services are provided by practitioners in schools, as these practitioner rates are approved under the Medicaid state plan as economic and efficient payments for Medicaid services.
  - State Medicaid agency may also opt to develop unique payment rates for school-based providers that more closely reflect the costs incurred by such providers. The

state will be asked to document the rate calculations for these services in the school settings and assure that those rates are consistent with efficiency, economy and quality of care.

- Cost-based rates specific to schools:
  - States may use cost-based rates that are not reconciled to the actual cost of providing services.
  - For instance, states can use prior year cost reports from LEAs to establish current or future cost-based rates.
  - States may also consider the salaries of the individuals providing care and overhead associated with the services provided to establish a general cost per service amount for services provided in school-based settings.

- Actual Cost of Providing Medicaid-Covered Services to Beneficiaries (required for CPEs)

  - To determine the portion of the actual cost of furnishing SBS that can be certified to the state Medicaid agency for use as non-federal share, states generally require school-based providers to use a uniform cost report.
  - The amount that may permissibly be certified by a public school or LEA as a CPE is the portion of the incurred cost that is properly identified and allocated to Medicaid via the school-based provider's cost report.
  - The state must develop a cost identification and allocation methodology that meets the requirements of 45 C.F.R. Part 75 and the school-based provider's cost report must appropriately identify and allocate all direct and indirect costs associated with the provision of Medicaid-covered services provided in school-based settings.
  - Through the cost report, the school-based provider must first identify 100 percent of all actual direct and indirect costs to be allocated to the Medicaid program cost objective(s) and to other cost objectives.
  - To ensure proper identification of costs, most school-based providers use audited financial statements as the first step to develop their cost reports. The audited financial statements will include an adjusted trial balance. This adjusted trial balances lists all the expenses incurred and the applicable revenues received by the school-based provider. These balances are then transferred to the cost report to be apportioned and allocated until Medicaid's portion of allowable cost is identified. Cost reports must clearly include the following:

    - *Clear and understandable cost report instructions.*
    - *Direct Cost Identification* - 45 C.F.R. § 75.413(a) defines "direct costs" as those costs that can be identified specifically with a particular final cost objective, such as a Federal award, or other internally or externally funded activity, or that can be directly assigned to such activities relatively easily with a high degree of accuracy. Costs incurred for the same purpose in like circumstances must be treated consistently as either direct or indirect (facilities & administration) costs.

- *Indirect Cost Identification* – Indirect (facilities & administrative (F&A)) costs (45 C.F.R. § 75.2; *see also* § 75.414) means those costs incurred for a common or joint purpose benefitting more than one cost objective, and not readily assignable to the cost objectives specifically benefitted, without effort disproportionate to the results achieved. Indirect cost pools must be distributed to benefitted cost objectives on bases that will produce an equitable result in consideration of the benefits derived.
    - *Indirect Cost Rate* - Appendix VII to Part 75 - States and Local Government and Indian Tribe Indirect Cost Proposals [19]
        - States have options for determining the allocation of indirect costs, using the following procedures:
            - Use an approved federally-recognized indirect cost rate negotiated between the subrecipient and the Federal Government.
            - Develop an allocation of indirect costs to the total direct cost using a methodology approved by CMS.[20]
            - Use a rate negotiated between the pass-through entity (in this case, the state Medicaid agency) and the subrecipient of the federal grant award (in this case, the school-based provider), in compliance with 45 C.F.R. § 75.352.
            - Use a de minimis indirect cost rate as provided in 45 C.F.R. § 75.414(f).

    Once the states and/or provider elects the method of indirect cost finding, the selected indirect cost rate is multiplied by the total direct cost amount to determine the allowable indirect cost.
- *Apportionment of cost to identify Medicaid's portion of allowable cost*, may include:
    - Application of Random Moment Time Study statistics to personnel cost. (See previous section)
    - Application of other applicable allocation statistics based on the nature of the cost or the item being allocated. For instance, where medical services occur in a dedicated space in the school, a square footage statistic can be used to identify the portion of facilities/indirect cost that should be allocated to Medicaid relative to the rest of the school building. The cost of electricity to that room, for example, could be allocated based upon the percentage of square footage in that dedicated room relative to the square footage of the rest of the school.

[19] Appendix VII to Part 75 - https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-75/appendix-Appendix%20VII%20to%20Part%2075

[20] One such methodology is described in the "Certified Community Behavioral Health Clinic Cost Report Instructions" (OMB #0398-1148) published on December 14, 2015, Chapter 7. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/ccbhc-cost-report-instruction.pdf

        - Application of a statistic to allocate to cost to specific payers, such as Medicaid. (See previous discussion regarding the MER.)
    - *Certification Statement* – A form on which the portion of the public school's or LEA's cost of furnishing SBS that is properly allocated to Medicaid is certified by the public school or LEA to the state Medicaid agency for use as the non-federal share of Medicaid expenditures.
- It is **highly** recommended that states which use CPEs or reconciled cost methodologies develop interim payments for Medicaid-covered services provided to beneficiaries in school-based settings. These interim payments can then be reconciled and settled based on actual costs that are identified and allocated via the cost report.

9. Third-Party Liability for Medicaid SBS

Generally, the Medicaid statute requires Medicaid to be the payer of last resort, which means state Medicaid agencies are required to take reasonable measures to identify and recover payments from third parties that are liable to pay for services furnished under the state plan. Section 1903(c) of the Act, however, permits an exception to the Third-Party Liability (TPL) requirements in that, for Medicaid covered services listed on a Medicaid eligible child's IEP/IFSP, Medicaid is primary for IDEA-related services. This means that Medicaid will pay primary to the ED for Medicaid-covered services listed in a child's IEP/IFSP even if a liable third party is likely liable. After the state Medicaid agency makes the primary payment on a claim for an IEP/IFSP service, it will then seek to recoup that payment from any liable third party (this is known as "pay and chase"). This removes the burden of seeking TPL for services from the school provider and places it on the state Medicaid agency.

With respect to services that are not part of a child's IEP/IFSP, the IDEA exception does not provide any exemption from pursuing other liable third-party payers, such as private insurance, before billing Medicaid. This is known as "cost avoidance" and generally occurs when a state Medicaid agency rejects a claim because of a known or suspected TPL. Therefore, for these children, schools or their school-based providers must meet federal and state Medicaid provider requirements, including billing the beneficiary's third-party health insurance first (where applicable), before billing Medicaid, to determine the extent of the insurer's payment liability.

Whether or not an individual has an IEP/IFSP under the IDEA, the state Medicaid agency may suspend or terminate efforts to seek reimbursement from a liable third party if they determine that the recovery would not be cost-effective per the requirements set forth in 42 C.F.R. § 433.139. Additionally, states may exempt certain items or services from TPL requirements when submission of claims for those items or services would always result in denial because they generally are not health care services covered by health insurers. The state must have clear and convincing documentation of non-coverage by insurers. If a state has adequate documentation of non-coverage, there is no need to further verify by submitting claims because there would be no liable third party and Medicaid TPL rules would not come into play. The controlling regulation is found at 42 C.F.R. § 433.139(b)(1), which states that "[t]he establishment of third-party liability takes place when the agency receives confirmation from a provider or a third-party resource indicating the extent of third-party liability."

- States may suspend or terminate efforts to seek reimbursement from a liable third party if they determine that the recovery could not be cost-effective pursuant to 42 C.F.R. § 433.139(f), including for IDEA or 504-plan services. This could ease administrative burden at schools.
  - States may exempt certain items or services from TPL requirements when submission of claims for those items or services would always result in denial.
  - State may elect not to identify or follow up on specific diagnosis and trauma codes, based on experience that the codes are not productive of recovery from third parties.
  - State Medicaid agencies do not need to submit a SPA or TPL Action Plan to change the codes subject to diagnosis and/or trauma code editing. However, CMS still requires that the state plan reflect how frequently the state Medicaid agency completes diagnosis and trauma edits and also outlines a procedure for identifying the trauma codes that yield the highest third-party collections and giving priority to following up on those codes. State Medicaid agencies set threshold amounts for recoveries and may accumulate billings until it would be cost-effective to seek payment.
    - A state may specify in its state plan the threshold amount or other guideline to use in determining whether to seek payment from a liable third party or describe the process it uses to determine whether recovery would be cost-effective. The state must submit documentation to CMS supporting that recovery would not be cost-effective below those thresholds.
    - A state may specify in its state plan a dollar amount or period of time for which the state Medicaid agency will accumulate billing with respect to either an individual Medicaid beneficiary or a particular third party.
- State education agencies can elect to pay a third party's liability using its own funds.
- States may use billing agents or other contractors to assist with billing.

Conclusion

As noted above, the Bipartisan Safer Communities Act directs CMS to provide additional guidance to states in the near future related to Medicaid-covered SBS. For example, CMS in consultation with the US Department of Education and other relevant federal agencies, will issue updates to the Medicaid School-Based Administrative Claiming Guide and the Medicaid and Schools Technical Assistance Guide. In addition, CMS, in consultation with the US Department of Education, is tasked with establishing a Technical Assistance Center for Medicaid-covered SBS. Finally, the BSCA directs CMS to issue $50 million in discretionary grant funding to states in support of implementing, enhancing, or expanding the provision of medical assistance through school-based entities under Medicaid or CHIP.

CMS is available to provide technical assistance to states to best implement their programs.

States interested in receiving technical assistance should email CMS at: SchoolBasedServices@cms.hhs.gov.