MEDICAID AND SCHOOL HEALTH: A TECHNICAL ASSISTANCE GUIDE

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This guide contains specific technical information on the Medicaid requirements associated with seeking payment for coverable services rendered in a school-based setting. This document was written before the passage of the Balanced Budget Act of 1997; thus, the information stated herein is reflective of Medicaid statute and policy prior to those new legislative provisions. The information contained in this guide does not have copyright restrictions; school districts are encouraged to share and distribute this information to interested parties. A copy of this guide as well as further information on the Medicaid program can be obtained on the Internet at <<www.hcfa.gov>>.

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PURPOSE OF THIS GUIDE

School health services play an important role in the health care of adolescents and children. Whether implemented for children with special needs under the

Individuals with Disabilities Education Act (IDEA), or for routine preventive care, on-going primary care and treatment in the form of a school-based or linked health clinic, school-centered programs are often able to provide medical care efficiently and easily without extended absences from school. Recognizing the important role school health services can play, the Medicaid program has been supportive of school-centered health care as an effective method of providing access to essential medical care to eligible children.

There are, however, challenges in the collaboration between the Medicaid program and the schools. Federal Medicaid requirements are complex and the implementation of Medicaid varies by state. Because many schools are unaccustomed to these requirements and the complexity of operating in the "medical services world," understanding and negotiating Medicaid in order to receive reimbursement often has the effect of placing a considerable administrative burden on schools.

The purpose of this guide is to provide information and technical assistance regarding the **specific Federal Medicaid requirements** associated with implementing a school health services program and seeking Medicaid funding for school health services. Because of the numerous types of school-based arrangements in existence throughout the country, in this guide, "school health and school-based services" refers to any type of Medicaid-covered school-based health services provided by or within a school system, whether in the school, through a school-based or school-linked clinic or through the IDEA.

The following is a brief summary of each section of this guide:

Coverage of School Health Services - This section details the requirements for coverage of services under the Federal Medicaid statute and regulations, the Federal Medicaid requirements for coverage of services under the IDEA and the Federal Medicaid requirements for providers furnishing services to Medicaid beneficiaries.

Medicaid Managed Care and School Health Services - This section discusses the waivers of the Medicaid statute needed by states to implement mandatory managed care and the implications of mandatory implementation of Medicaid managed care on school-based health providers. This section also provides examples of coordination as a guide for schools whose state is moving toward implementation of Medicaid managed care.

Medicaid Payment for School Health Services - This section discusses the Federal Medicaid payment requirements, including the state plan process as it pertains to school health services, Medicaid provider responsibilities, allowable payment methodologies and necessary documentation.

Third Party Liability and Free Care - This section details the Medicaid free care and third party liability requirements and their impact on schools seeking payment for school health services.

Administrative Claiming - This section discusses the Medicaid requirements associated with schools/school districts claiming administrative costs for activities performed related to the administration of the Medicaid program.

Transportation - This section explains Federal Medicaid policy regarding schools seeking payment for transportation of Medicaid beneficiaries to school-health services.

Case Management - This section defines the provision of case management for Medicaid-eligible children and the requirements for schools seeking payment for these services.

Confidentiality - This section explains the Medicaid confidentiality requirements, in addition to providing examples of how the provision of Medicaid-covered school health services has been achieved within these requirements.

The document concludes with a page of definitions for referencing complex terminology used in this guide and a list of Medicaid regional office and state Medicaid agency contacts.

Because Medicaid policy often changes and evolves, this guide should not be considered an authoritative source in itself. The guide is intended to be a general reference summarizing current applicable law and policy and not intended to supplant the Medicaid statute, regulations, manuals or other official policy guidance. As noted throughout this guide, Federal Medicaid guidelines provide only a framework for state Medicaid programs. Therefore, in order to determine specific state requirements, schools should contact their state Medicaid agency.

OVERVIEW OF MEDICAID

Title XIX of the Social Security Act (the Act) established a Federal-state matching entitlement program which provides medical assistance for certain low-income individuals. The program, known as Medicaid, was enacted in 1965. Within broad Federal guidelines, the Medicaid program is jointly funded by the Federal and state governments and is administered by each individual state to assist in the provision of medical care to pregnant women and children and to needy individuals who are aged, blind, or disabled. Medicaid is the largest program financing medical and health-related services to the nation's poor.

States operate their Medicaid programs within the broad parameters of Federal Medicaid laws and regulations. Within this framework, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. Each state describes its program in a state plan. On the Federal side, the Health Care Financing Administration (HCFA) reviews each state's proposed state plan for conformity with Federal requirements, including the requirements to provide a basic core package of federally mandated services to certain eligible populations in each state. The structure of HCFA is that there are 10 regional offices located throughout the country that are responsible for direct oversight of the state Medicaid programs. The central office of HCFA, located in Baltimore, Maryland, serves as the focal point for Medicaid policy considerations, and works closely with the regional offices on issues regarding state Medicaid policy and administration. HCFA also determines which expenditures by a state Medicaid agency are necessary and proper for carrying out the requirements of the Medicaid program; approves state agency estimates of expenditures on a quarterly basis; conducts financial management studies and survey and certification reviews; provides leadership in special program initiatives; conducts research and demonstration projects and studies as directed by Congress; and provides technical assistance and policy guidance to the states in the development of their individual Medicaid programs.

Funding for the Medicaid program is shared by the state and the Federal governments, and the amount of total Federal payment to states for Medicaid has no set limit. Federal Financial Participation (FFP), which is the Federal government's share for states' Medicaid program expenditures, are generally claimed under two categories, administration and medical assistance payments.

FFP for administrative expenditures for functions such as outreach, follow-up, eligibility determination, and provider relations, are usually Federally matched at a fixed rate of 50%. This means the Federal government will provide funds equal to the sum the state contributes toward total administrative expenditures. However, higher matching rates of 75%, 90% or even 100% are authorized by law for certain administrative functions and activities. For expenditures for those activities, the Federal government will provide funds in a higher proportion than the state's contribution.

State expenditures for the cost of medical assistance is Federally matched at varying percentage rates. FFP matching rates for medical services expenditures are determined annually for each state by a formula that is based on the relationship of the state's average per capita income level with the national per capita income. Called the Federal Medical Assistance Percentage (FMAP), this matching rate by law, is limited to a minimum of 50% and a maximum of 83%, with poorer states receiving a higher match and wealthier states receiving a lower match. Some services provided by the state Medicaid programs, such as transportation and case management, may be treated as either administrative or medical assistance payments; and under some circumstances may be divided between the two categories.

As mentioned earlier, in order to receive Federal matching dollars for medical services under the Medicaid program, each state maintains a state plan. This state plan details the scope of the Medicaid program in a particular state by listing the eligibility groups and standards, the services provided, any applicable service requirements, and payment rates for those services. While states generally have flexibility in forming their Medicaid programs, Medicaid state plans must include certain elements of information, and must be consistent with mandates detailed in Federal statutes. Broad Federal coverage and reimbursement guidelines give structure to the state plans and promote some consistency among the many state Medicaid programs. Within Federal Medicaid statutory and regulatory guidelines, states have the flexibility to change their state plans in terms of the services covered and payment rates offered by submitting a state plan amendment (SPA) to HCFA. While formulating a state plan is a specific function of the state agency, schools or local education agencies (LEAs) can be involved in helping develop the state plan language pertaining to school health services. In the provision of such covered services and payment rates, LEAs or schools will also be responsible for fulfilling specific state requirements. Therefore, it is imperative that those entities

involved work closely with the state Medicaid agency to ensure that all requirements are satisfied.

FORGING A RELATIONSHIP WITH THE STATE MEDICAID AGENCY

Because state Medicaid agencies are responsible for the operation of their Medicaid program, it is imperative the education agencies, LEAs, etc. attempt a concerted effort to formulate a relationship with the state Medicaid agency. Education agencies interested in Medicaid should request applicable sections of the state plan and become familiar with this document as a first step. In this manner, the education agency can work with the state Medicaid agency in developing or augmenting existing Medicaid services. If both parties can make an effort to establish a working relationship, communication will decrease confusion and foster understanding, thereby improving the provision of services to children.

In some states, the state Department of Education (DOE) will take a leadership role in working with the state Medicaid agency. If not, it is essential for LEAs and local school districts to look to contact the state Medicaid agency. However, in other states, LEAs or the state Department of Education choose to involve private consultants as an intermediary or to facilitate the process. Although consultants are helpful in that they can provide advice on the requirements associated with seeking Medicaid payment, the Medicaid agency is the authority of the specific requirements associated with seeking Medicaid reimbursement in the state. In addition, consultants can be costly, as they can charge up to 20 percent on the amount of Medicaid payment they acquire. We recommend that any LEA or education agency considering the use of private consultants check out the consultants' references and conduct a realistic assessment of what the consultants are offering to deliver. This will ensure that the proposals formulated by the consultants for the state will meet the necessary Federal standards when submitted by the state, which can facilitate Federal approval of the proposal.

In addition, using consultants should not substitute for educational agencies establishing a close working relationship with the state Medicaid agency. The state Medicaid agency can coordinate program planning and reimbursement, provide technical assistance to schools and expedite problem solving with

Medicaid on policy issues for LEAs.

Title XIX of the Act requires states must cover certain basic services to certain categories of eligible individuals. Examples of mandatory services a state must cover are physician services, family planning services and supplies, rural health clinic services and federally qualified health center (FQHC) services and early and periodic screening, diagnostic and treatment services (EPSDT) for individuals under the age of 21.

States may also elect to cover optional services. Currently, there are over 30 optional services states can choose to cover in their state plan. Some of the most common optional services states choose to cover are clinic services and prescription drugs.

In their state plans, states also specify the populations covered, and the amount,

duration and scope of services to be covered for both mandatory and optional services in their state plan. The purpose of this section is to explain the requirements for coverage of services under the Medicaid statute and regulations, the Federal Medicaid requirements for coverage of the health-related services under IDEA and the Federal Medicaid requirements for providers (in particular school-based providers) furnishing services to Medicaid beneficiaries.

Requirements for Coverage of Medicaid Services

Section 1905(a) of the Act lists the mandatory and optional services a state can cover in its Medicaid program. Federal Medicaid law requires that the amount, duration and scope of each service must be sufficient to achieve its purpose. In addition, the Federal Medicaid comparability provisions (42 CFR 440.240), require that, with certain exceptions, all individuals within an eligibility group must be offered comparable amount, duration and scope of services. And, for mandatory services, a state cannot place arbitrary limitations, such as diagnosis, on who may receive covered services.

States may place appropriate limits on the coverage of Medicaid services based on such criteria as medical necessity or utilization control. For example, states may place a reasonable limit on the number of covered physician visits or may require prior authorization to be obtained before service delivery to ensure that the provision of the services is warranted. Medical necessity refers to the appropriateness of medical intervention and treatment for certain medical conditions. States themselves define what medical necessity means for the purposes of covering services under their Medicaid programs. Furthermore, unless waivers of the Federal Medicaid statute are obtained (discussed in more detail in the section of this guide on Medicaid Managed Care), the state plan must allow beneficiaries freedom of choice among health care providers participating in the Medicaid program. This means that within reasonable limits, beneficiaries are allowed to choose among all available qualified providers who are willing to furnish services to them.

In order for Medicaid to reimburse for health services provided in the schools, the services must be included among those listed in the Medicaid statute (section 1905(a) of the Act) and included in the state's Medicaid plan or be available under the Early and Periodic Screening, Diagnostic and Treatment benefit (EPSDT, described below). There is no benefit category in the Medicaid statute titled "school health services" or "early intervention services." Consequently, a state must describe its school health services in

terms of the specific section 1905(a) services which will be provided. Except for services furnished under EPSDT, a service must be specifically identified in the state's Medicaid plan to make Medicaid payment available for it.

Typically, schools which provide medical services provide a number of different Medicaid-covered services. Some Medicaid coverage categories in the regulations are more specific, in that the services are described along with the providers who can furnish those services. Other Medicaid service categories are more general, (such as the rehabilitation benefit), which is more broadly defined in terms of the services as well as the providers of the services. The end of this section contains a chart describing the various Medicaid service categories that could generally be provided by or within the school health system.

EPSDT

In addition to being eligible for the Medicaid services offered under a state Medicaid program, children under the age of 21 are entitled to the mandatory Federal Medicaid benefit known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT). EPSDT is Medicaid's comprehensive and preventive children's health care program geared toward early assessment of children's health care needs through periodic examinations. The goal is to assure that health problems are diagnosed and treated as early as possible, before the problems become complex and treatment more costly. States must develop periodicity schedules for each service after consultations with organizations involved in child health care.

Many states call the EPSDT program in their state "catchy" names other than EPSDT, to emphasize the importance of child health and to "market" the benefit to eligible beneficiaries. Examples of such names include KIDMED (Louisiana); KAN BE HEALTHY (Kansas); Health Check (North Carolina, Wisconsin, Georgia, Wyoming and Nebraska); Health Kids Club (South Dakota) and Well Child Care (New Jersey).

The following are required EPSDT services (under Section 1905(r) of the Act):

Screening services, which must contain the following 5 elements:

(1) Comprehensive health and developmental history, including assessment of both physical and mental health development;

(2) Comprehensive unclothed physical exam;

(3) Appropriate immunizations according to the ACIP (Advisory Committee on Immunization Practice) schedule;
(4) Laboratory tests, including blood lead level assessment, and
(5) Health education, including anticipatory guidance.

Vision services, which at a minimum must include diagnosis and treatment for defects in vision, including eyeglasses.

Dental services, which at a minimum must include relief of pain and infection, restoration of teeth, and maintenance of dental health.

Hearing services, which at a minimum must include diagnosis and treatment for defects in hearing, including hearing aids.

Other necessary health care, diagnostic services and treatment services. As with all Medicaid services, any limitation that the state imposes on EPSDT services must be reasonable and the benefit provided must be sufficient to achieve its purpose. In addition, states must provide other necessary health care, diagnostic services, treatment and other measures described that are listed under the Medicaid statute, to correct and ameliorate defects and physical and mental illnesses and conditions discovered by screening services, whether or not covered in a particular state Medicaid plan. **This means that if the state does not cover an optional service under its state plan, such as occupational therapy, the State would have to make medical assistance available for the service when furnished to a child eligible for EPSDT if occupational therapy is medically necessary.** As such, EPSDT constitutes an exception to the comparability requirements in that the state does not have to make comparable services to all Medicaid beneficiaries. This is an important point because this means that if medically necessary, a Medicaid eligible child is entitled to any Medicaid-coverable service, regardless of whether the state covers it in the state plan or not. However, a state may still subject these services to prior authorization for purposes of utilization control.

Provision of medically necessary interperiodic screening. Interperiodic screenings, outside of the state's established periodicity schedule, must be made available to EPSDT beneficiaries when an illness or condition is suspected that was not present during the regular scheduled periodic screening. Referrals for interperiodic screens may be made by a physician, school nurse, parent or by self-referral. The provider performs the necessary screening components, which need not include all five elements of the required periodic screening, and provides or

refers for any additional diagnostic or treatment services.

The referral for interperiodic screening can be made by any health or developmental education personnel who comes in contact with the child, within or outside of the health care system. The purpose of the interperiodic screening is to assure that children are assessed as soon as a problem is suspected even if they are not scheduled for a complete screening for many months. For example, a teacher might suspect a speech delay in a child based on the child's performance in the classroom. The child could have already received his or her periodic screen. The teacher can refer the child to a speech pathologist (either through or outside the school system) for an interperiodic exam to determine if the child does indeed have a speech delay needing treatment. State Medicaid agencies cannot require prior authorization for either periodic or interperiodic screens as this would be an inappropriate limitation on the very service which is needed to determine that a medical or mental health problem exists.

Because of the proximity of schools to the target population, HCFA has always encouraged the participation of schools in the Medicaid program as they can play a particularly useful role in providing EPSDT services. School-based health services can represent an effective tool which can be used to bring more Medicaid-eligible children into preventive and appropriate follow-up care.

In addition, schools present a wonderful opportunity for Medicaid outreach. That is, because schools are by definition "in the business of serving children," they can be a catalyst for encouraging otherwise eligible Medicaid children to obtain primary and preventive services, as well as other necessary treatment services. Even if a school does not directly furnish medical services, we encourage efforts to inform potential eligibles about the Medicaid program and the EPSDT benefit. Examples of how schools can get reimbursed for activities such as outreach are discussed in the section of the guide on administrative claiming.

Medical Services Under IDEA

The Medicaid program can pay for certain medically necessary services which are specified in Medicaid law when provided to individuals eligible under the state plan for medical assistance. The Individuals with Disabilities Education Act (IDEA), formerly called the Education of the Handicapped Act, authorized Federal funding to states for two programs that impact Medicaid payment for services provided in schools. 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 Plan (IEP) or Individualized Family Service Plan (IFSP). This amendment was enacted to ensure that Medicaid would cover the health-related services under IDEA.

Part B of IDEA was designed to ensure that children with special education needs receive a free appropriate public education. Part H of IDEA provided for financial assistance to the states to develop and implement comprehensive, interagency early intervention programs for infants and toddlers with disabilities. Implementation of Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 has resulted in the expansion of many state Medicaid programs to include payment for services provided in accordance with an IEP or IFSP of a Medicaid-eligible child.

As schools and school districts are aware, under Part B of IDEA, school districts must prepare an IEP for each child which specifies all special education and "related services" needed by the child. The Medicaid program can pay for some of the "health related services" required by Part B of IDEA in an IEP, if they are among the services specified in Medicaid law. In addition, the services must be included in the state's Medicaid plan or available through the EPSDT benefit. Examples of such services include physical therapy, speech pathology services, occupational therapy, psychological services and medical screening and assessment services. Within Federal and state Medicaid program requirements regarding allowable services and providers, the Medicaid program can pay for some or all of the cost of these health-related services when provided to children eligible for Medicaid. The 1997 reauthorization of IDEA strengthened the expectation that schools work closely with the state Medicaid agency to coordinate provision of services to disabled children in schools.

Part H of IDEA provides for early intervention programs that include all of the available developmental services needed by the infant or toddler with special health needs and the development of an IFSP. Many of the health services included in IFSPs can be covered by Medicaid as well.

In addition, if medical evaluations or assessments are conducted to determine a child's health-related needs for purposes of the IEP/IFSP, payment for some or all of the costs may be available under Medicaid. However, if the evaluations or assessments are for educational purposes, Medicaid reimbursement is not available. Medicaid payment is only available for the part of the assessment that is medical in nature and provided by qualified Medicaid providers. In addition,

reimbursement for non-medical services, such as special instruction, is not covered.

Health-related services coverable under an IEP/IFSP are still subject to the Medicaid requirements for coverage of services including amount, duration and scope, comparability, medical necessity and prior authorization. Often the medical necessity criteria as well as the prior authorization requirement places a cumbersome burden for schools in claiming reimbursement for health-related services in an IEP/IFSP. For example, a school provider might have to go through the process of obtaining prior authorization for a Medicaid-covered service in an IEP/IFSP from the state Medicaid agency before rendering the service. Some states (such as Louisiana), in an effort to alleviate the administrative burden on schools in this area, deem prior authorization to be based on the IEP/IFSP and also use the IEP/IFSP to establish medical necessity. However, a state must determine that these services meet all of the requirements for Medicaid coverage.

In summary, HCFA policy is that health-related services included in a child's IEP or IFSP can be covered under Medicaid if all relevant statutory and regulatory requirements are met. A state may cover services often included in an IEP or IFSP as long as: 1) the services are medically necessary and coverable under a Medicaid coverage category (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.

Medicaid Provider Qualifications

In order for schools or school providers to participate in the Medicaid program and receive Medicaid reimbursement, they must meet the Medicaid provider qualifications. It is not sufficient for a state to use Department of Education provider qualifications for reimbursement of Medicaid-covered school health services.

After determining which specific Medicaid service or services the school will provide, it then becomes necessary to specify what entity will become a provider of each service, and whether it is qualified to enroll to provide those services. Federal Medicaid regulations (42 CFR 431.107) require that there be a provider agreement between the state Medicaid agency and the provider furnishing the service. Any entity wishing to become a provider of Medicaid services, including

schools or school districts, must be qualified to enroll to provide those services. Some Medicaid provider qualifications are dictated by the Federal Medicaid program by regulation, while other provider qualifications are established by the state. Where states have established provider qualifications, the requirements must be applied consistently among all entities seeking provider status. Where a school or school district provides a variety of Medicaid covered services, the school must meet all Federal and state provider qualifications associated with each service it provides.

Further, Medicaid regulations require that provider qualifications be uniform and standard. This means that states cannot have one set of provider qualifications for school providers and another set of provider qualifications for all other providers. Schools should check with the state Medicaid agency to determine specific state requirements regarding provider qualifications for participation in the Medicaid program.

Provider Agreements

In order for a school or school district to participate in the Medicaid program and receive Medicaid reimbursement, there must be a provider agreement between the state Medicaid agency and the actual health care provider. Schools may enroll as Medicaid providers, either by qualifying to provide services directly, or, under certain conditions, by contracting with independent practitioners to provide the services. There are several arrangements schools may choose to provide Medicaid services.

MODEL 1, Direct Employment of Health Professionals The school (or school district) itself employs health professionals such as physicians, nurse practitioners and nurses, or operates a clinic, i.e., has direct supervision and control over the clinic activities. The arrangement between schools and providers governs how and by whom Medicaid is billed for services and to whom payment may be made. Where the school employs the staff which provides the health services (or operates a clinic), the school can enter a provider agreement with the Medicaid program and receive Medicaid payments for the covered services provided.

MODEL 2, Contracting with Health Practitioners or Clinics The school (or school district) contracts with health practitioners or clinics to furnish services. Under this type of arrangement, the health practitioner or the clinic (not the school) is the provider of services, and payments under Medicaid must be made, with limited exception, only to the provider of the services.

However, Federal Medicaid requirements permit Medicaid providers to voluntarily reassign their right to payment to a governmental entity, such as a school district. Consequently, if the school and the provider are willing to work out an agreement under which the provider reassigns payment to the school, the school may both bill and receive payment directly from the state

Medicaid agency. Under these circumstances, the provider must be separately qualified and enrolled as a Medicaid provider and must have a separate provider number. In addition, assignment to the school must be accomplished in a way that satisfies all applicable Federal requirements. For example, in accepting assignment of Medicaid claims, the school is also accepting the providers' responsibility for collection of probable third party liability, unless the state has been granted a waiver from cost-avoidance methods of seeking third party liability in accordance with Federal regulations (42 CFR 433.139) or the services provided are preventive pediatric services (see the Third Party Liability section of this guide for more information on these requirements).

MODEL 3, Combination of Direct Employing and Contracting The school (or school district) uses a combination of employed health professionals and contract health professionals to furnish services. In general, when a school provides a service through employed staff and contracts with additional health professionals to supplement the care and services being provided by its own employees, the school can qualify as the provider and receive payment from the state Medicaid agency for the services being provided by both the employed and contract health staff. A key element in making the determination that the school is the provider is that the school itself provides the service through its own employees and includes certain contract health professionals only to supplement that which it is already providing. For example, the school may employ one physical therapist and contract with other physical therapists to supplement the services provided. No additional provider agreements are required for contracted providers under this type of arrangement.[1]

MODEL 4, Mix of Employed and Contracted Providers : This model is similar to model 3 in which the school (or school district) uses a mix of employed and contracted providers. This model is used where the school provides some services directly but wishes to contract out entire service types without directly employing even a single practitioner in a service category. The school may establish itself as an organized health care delivery system under which it provides at least one service directly, such as case management, but provides additional services solely under contract. Under this model, payment may be made to the school on behalf of those contracted providers who have voluntarily agreed to enter into this arrangement with the school.

It is also important that the service being provided by the school or school district employees is the same service that the contract health professionals provide. In other words, if a school or school district operates a clinic and employs most of the necessary health professional to provide clinic services but contracts with a physician to provide services and direction of the clinic, in order for the school to be considered the provider of the services, the services furnished by the physician could not be billed to the Medicaid agency as physician services but must be billed as clinic services. That is, the contract physician is simply supplementing the service that the school/school district is providing. Under section 1902(x) of the Act, every physician used or

[1] According to the Bureau of Primary Health Care in the Department of Health and Human Services, only 11% of all **school-based clinics** have a school or school district as the sponsoring agency. 89% of all school-based clinics are run by a "health care organization partnership" with the school. Therefore, the school-based clinic does not do the contracting itself in most cases.

employed by the school must have a unique physician identifier which appears on Medicaid claims for services under the direction of that physician. This is true whether or not the physician practices independently or in a clinic setting, and whether or not the physician is a Medicaid provider.

Under any model for school-based providers for services, the school must meet a number of basic requirements. A school provider, like all providers, must meet Medicaid service provider requirements, including any Federal and any state requirements in place for the specific services provided. For those schools which seek to provide administrative services, the school must either have an interagency agreement or a contract setting out the responsibilities which the single state agency is delegating to it, as well as providing a reimbursement methodology for those functions as an administrative cost. The school would not need a Medicaid provider number simply to perform administrative functions. If schools wish to coordinate other Medicaid activities with local health or education agencies, interagency agreements should also be in place to delineate these activities. (See the section of this guide on Administrative Claiming for more specific information on this subject).

Because of the different types of provider agreements available for school health services, and depending on the provider types employed and the specific agreement in place, the services provided by and within schools and school districts can be diverse. For example, some schools have a clinic onsite or are linked to a clinic which generally provides primary and preventive health services, including EPSDT screening services. Medicaid-covered IDEA services are generally provided separately in the school by licensed practitioners employed by the school/school district or contracted by the school/school district. Many schools do not have a school-based or school-linked clinic and just provide the Medicaid-covered IDEA services under one of the models listed above. Other schools have both a school-based or school-linked clinic which provides primary and preventive services, in addition to providing Medicaid-covered IDEA services in the school by providers who are employed by the school, through a contract with the school or another arrangement. Depending on the specific health services a school provides and the type of model a school uses to provide these health services, different issues regarding coverage of services, provider qualifications and provider arrangements apply in order to seek Medicaid payment for these services.

Freedom of Choice

Federal Medicaid regulations at 42 CFR 431.51 and section 1902(a)(23) of the Act

require Medicaid beneficiaries to have the freedom to choose from among all qualified providers. Therefore, Medicaid-eligible children cannot be limited to school health providers for Medicaid covered services. In the absence of a Federal Medicaid waiver (described under the section of the guide on Managed Care), states can encourage, but may not require, Medicaid children to receive Medicaid-covered services through or at the school. Medicaid recipients must be permitted to obtain services outside the school health services system if they wish.

In addition, unless operating under a waiver, states must allow all willing qualified providers to participate in Medicaid. States must permit whatever types of providers which furnish school health services to also furnish those services independently of the school system. For example, if a state covers independently practicing physical therapists through school-based programs, it cannot limit participation of physical therapists to those who provide school health services.

The Medicaid service categories that could be typically provided by school providers, along with the Federal Medicaid regulatory citation (or statutory citation) are listed below. This list is an illustration of Medicaid services that could be provided in a school setting. Potentially, health-related services provided by schools may fit into one or more of the Federal service categories. This chart is not necessarily all-inclusive, and while it indicates the general Federal Medicaid regulatory requirements, schools should check with their state Medicaid agency to determine any additional or specific state requirements.

FEDERAL CITATION	**SERVICE**	**DESCRIPTION**
42 CFR 440.50	physicians' services and medical and surgical services of a dentist	services furnished by a physician (or a doctor of dental medicine or surgery for a dentist) within the scope of practice of medicine or osteopathy as defined by state law and by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy.
42 CFR 440.60	medical or other remedial care provided by licensed practitioners	"any medical or remedial care or services provided by licensed practitioners within the scope of practice under state law." This category is used

		by states to cover such services as psychologist services and nursing services other than those nursing services specifically identified in the Medicaid statute and regulations (such as private duty nursing, home health nurses or nurse practitioners).
42 CFR 440.90	clinic services	"preventive, diagnostic, therapeutic, rehabilitative or palliative services that are furnished by a facility that is not a part of a hospital but is organized and operated to provide medical care to outpatients." The services must be furnished under the supervision of a physician or dentist, in a facility which meets the state's definition of a clinic.
42 CFR 440.100	dental services	"diagnostic, preventive or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession."
42 CFR 440.110	physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.	Physical and occupational therapy services must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice under the state's law and must be provided by or under the direction of a qualified licensed physical therapist or occupational therapist. Services for individuals with speech, hearing or language disorders means diagnostic, screening, preventive or corrective services provided by or under the direction of a speech pathologist or audiologist, for which the patient is referred by a physician or other licensed practitioner of the healing arts. It includes any necessary supplies or equipment.

42 CFR 440.130(a)	diagnostic services	"any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under state law, to enable him or her to identify the existence, nature or extent of illness, injury or other health deviation in a recipient."
42 CFR 440.130(c)	preventive services	"provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, and other health conditions or their progression; to prolong life and promote physical and mental health and efficiency."
42 CFR 440.130(d)	rehabilitative services*	"any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level." This optional benefit category is used to cover both mental health and substance abuse services and may include assessments, individual, group and family counseling, therapies, psychosocial rehabilitation services, living skills training, drug abuse treatment, medication monitoring and crisis intervention.
42 CFR 440.170(a)	transportation services	(Please see the Transportation section of the guide for more specific information on transportation and school-based services).
42 CFR 440.166	nurse practitioner services	"furnished by a registered professional nurse who meets the state's advanced

		educational and clinical requirements, if any, beyond the 2 to 4 years of basic nursing education required."
42 CFR 440.166	Private duty nursing services	"for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of a hospital or skilled nursing facility." These services are provided by a registered nurse or licensed practical nurse under the direction of a physician, usually in the beneficiary's home. However, the nurse is permitted to be taken into the community (such as when the child attends school) with the beneficiary if his or her normal life activities take the beneficiary out of the home and the services have been prescribed by the physician for primary use in the home.
Section 1905(a)(24) of the Act (soon to be published ate 42 CFR 440.167)	personal care services	These services are authorized for an individual by a physician in accordance with a plan of treatment or otherwise authorized by the state in accordance with a service plan approved by the state, and may be provided in a home or other location (however, not in a Medicaid-funded inpatient facility) by an individual qualified to provide such services, who is not a member of the individual's family.
Section 1905(a)(4)(c) of the Act and 42 CFR 441.20	family planning services	"supplies for children who are of childbearing age, including minors who can be considered to be sexually active and desire such services and supplies. These include services to aid those who voluntarily choose not to risk an individual pregnancy or who wish to

		control family size. Federal Medicaid law limits coverage of abortion. In general, family planning services are matched at a higher FFP rate of 90%.

* HCFA has historically differentiated between habilitation and rehabilitation services and does not allow for the inclusion of habilitation services under the rehabilitation benefit category. Habilitation services, which are services to assist an individual in obtaining a skill, are not included in the section 1905(a) list of services and are only available in an institution for the mentally retarded or under a home and community based services waiver. Habilitation services cannot be covered as "rehabilitative" when they are furnished to individuals, for example, suffering from mental retardation or to children experiencing developmental delays, because the services are assisting the child in obtaining a skill rather than restoring lost capabilities. However, because occupational therapy, physical therapy and speech therapy do not have the same requirement to restore lost capabilities, habilitation services are not precluded from coverage under those service categories.

In addition, Federally Qualified Health Center (FQHC) services is a mandatory benefit required under the Medicaid program. A FQHC is statutorily defined as an entity which is receiving a grant under the Public Health Services Act or based on the recommendation of the Health Resources and Services Administration (HRSA) (section 1861(4) of the Act). Some school-based clinics receive grants from HRSA or are associated with larger community health centers that receive grants from HRSA. Either arrangement would result in the school-based clinic being recognized as a FQHC. These clinics are reimbursed differently from other school-based health clinics. They receive an encounter rate that is based on their reasonable costs and are not limited to the standard Medicaid fee schedule (see the Payment section for more information on reimbursement). There are many specific requirements and limited opportunities for any clinic to become an FQHC.

Managed care is a health care system that combines the delivery and financing of health care services. Managed care organizations (MCOs) offer a wide variety of medical specialities and services for their members. Managed care has the potential to offer increased access to preventive and primary care as each patient is assigned to a primary caregiver who coordinates his/her care. Managed care providers are responsible for informing enrolled patients what services are available through the plan and what services are not.

While there are many different types of managed care arrangements, there are general characteristics regarding the delivery and financing of services. For delivery of services, patients must be enrolled with a primary care physician who is responsible for coordinating their care. Primary care physicians provide patients with access to a selected provider network in which services are coordinated with a focus on prevention and early detection of illnesses and conditions.

Managed care plans are generally paid a capitated, prepaid premium for the provision of an agreed upon package of services. In exchange for the prepaid premium, the managed care entities assume financial risk for the provision of an agreed upon package of services. The managed care entities also pay providers, establish a provider network and educate providers and enrollees about the covered services available under the plan.

Types of Medicaid Managed Care Entities

There are many types of managed care arrangements available. Medicaid managed care programs are arranged either with the state paying certain providers a fee to furnish case management services, or the state contracting with managed care organizations and paying them on a pre-paid full risk or partially capitated basis to

provide or arrange for a range of services. These basic models of Medicaid managed care (full-risk capitation, primary care case management and partial capitation) are described in more detail below.

(1) Full-Risk Capitation- In this model, states contract with an entity, such as an HMO or Federally qualified health center, to provide all health care to enrolled beneficiaries for a fixed amount per member per month. Beneficiaries enrolled receive a comprehensive set of services from providers employed by or affiliated with the MCO and the entity assumes full risk for the services provided.

(2) Primary Care Case Management- A state contracts directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid beneficiaries under their care. Generally, these providers receive a case management fee in addition to their fee-for-service reimbursement.

(3) Partial Capitation- In this model, the state reimburses providers for a limited number of services on a fixed per member per month basis and pays for all other services on a fee-for-service basis.

Medicaid Managed Care Enrollment

State efforts to enroll their Medicaid beneficiaries into managed care has dramatically increased over the past few years. States are facing fiscal pressure due to increasing Medicaid growth and state budget restrictions and are responding to these fiscal pressures by developing Medicaid managed care programs. The growth in managed care programs is the result of a desire of states to improve access to services while decreasing unnecessary care, enhancing the quality of care and containing health care costs.

Section 1915(b) and 1115 Waivers States can test new approaches to providing services to their Medicaid populations by obtaining waivers of statutory requirements and limitations from the Secretary of the Department of Health and Human Services. Section 1915(b) waivers permit states flexibility from the Federal Medicaid statutory and regulatory requirements that cannot be altered through the Medicaid state plan amendment process. In obtaining waivers of Medicaid program requirements, many states mandate managed care delivery systems to Medicaid beneficiaries. There are two types of waivers that states use to institute mandatory Medicaid managed care programs, section 1915 (b) waivers and section 1115 waivers.

(1) Section 1915 (b) Waivers

Section 1915(b) waivers provide limited waiver authority. Section 1915(b)(1) waivers permit variations from the Medicaid law to allow states to restrict the providers from whom a recipient receives Medicaid services. Furthermore, these waivers permit states to waive such Medicaid requirements as comparability of services (allowing different benefits to be provided to one group and not another) and statewideness (facilitating variations in the Medicaid program in different areas of the state). These waivers are limited in scope and flexibility. For example, 1915(b)(1) waivers do not allow states to:

modify the Medicaid benefit package;

restrict access to family planning providers; and

restrict access to FQHC services (although the state can restrict access to FQHCs).

One specific type of 1915(b) waiver is the 1915(b)(4) waiver. These are sometimes referred to as selected contract waivers. This waiver restricts the number of providers who can participate in the Medicaid program. For example, a state may choose to limit the providers who are permitted to provide mental health services through this waiver authority and only one provider may be available in a given geographic area.

Another type of waiver is the 1915(b)(3) waiver. This waiver, used in conjunction with other waiver types, permits states to use the savings from one waiver to provide non-Medicaid services. For example, if this waiver is in the area of mental health, savings may be used to provide recreational activities, parenting classes or family therapy if the parents are not Medicaid-eligible. Basic Medicaid services to Medicaid beneficiaries must have been provided before these additional services may be offered.

In general, most states request a combined 1915(b)(1) waiver, which restricts recipients to certain provider, and a 1915(b)(4) waiver, which restricts the providers that may participate in the Medicaid program. This is done to guarantee access while controlling costs. Federal approval of 1915(b) waivers is granted for a two year period and may be subsequently renewed for two year periods. States are required to provide HCFA with documentation on areas related to recipient

access to care, quality of care and the cost effectiveness of the waiver with each initial and renewal waiver application.

(2) Section 1115 Research and Demonstration Waivers

Section 1115 of the Act provides the Secretary of the Department of Health and Human Services with broad authority to authorize "experimental, pilot or demonstration project(s) which, in the judgement of the Secretary, are likely to assist in promoting the objectives of the Medicaid statute." The following lists common characteristics of 1115 waivers, some provisions states generally waive and what states cannot waive:

Common characteristics of Statewide 1115 health care reform waivers

the state expands its use of managed care through Federally or state qualified HMOs, partially capitated systems, primary care case managers or other entities;

savings are projected as one of the outcomes of increased managed care;

savings are expected to finance coverage to individuals previously ineligible for Medicaid, and

the demonstrations are expected to be budget neutral for the life of the project (generally 5 years). This means that the waiver does not cost the Federal government any more than if the state were operating under their Medicaid program **without** the waiver.

Among the Provisions States Can Waive Are:

statewide uniformity, or statewideness;

comparability requirements;

eligibility, permitting states to revise Medicaid eligibility standards and criteria;

the definition of qualified managed care organizations, permitting recipients to receive services through alternative delivery systems not recognized through existing Federal and state requirements, and

reimbursement, allowing reasonable alterations in Medicaid payment

requirements.

States **Cannot** Waive:

unnecessary utilization and access safeguards. Section 1902(a)(30) of the Act requires safeguards against unnecessary utilization of services as well as ensuring that payments are sufficient to enlist enough providers to make services as available as they are to the general population. Such safeguards must be maintained under these waiver programs;

quality assurance - states are expected to enhance quality assurance processes; and

EPSDT provisions. Under the terms and conditions of the 1115s, states must submit to HCFA their plans for ensuring that the full range of EPSDT services, including outreach and preventive care, are provided by plans participating in the demonstration as well as assurances that access to these services is not restricted by the demonstration. The plan should also address the coordination of medical and non-medical services.

States must submit to HCFA a description of their plan for receiving public input either before an 1115 demonstration is submitted or at the time the proposal is submitted. The public input process ensures that interested parties have an opportunity to review and comment on the proposal before HCFA review. After states submit their 1115 proposals, HCFA reviews and identifies issues and questions. States then respond in writing to the issues and questions identified by HCFA. HCFA and the states discuss the outstanding issues and negotiate a resolution. Terms and conditions are developed and the waivers are generally approved.

Many states, in formulating their waivers and moving Medicaid beneficiaries into mandatory managed care, generally do not include the disabled population and related "long term care services" in their waivers. In the future, many states intend to incorporate this population into the waiver, or formulate another waiver to deal specifically with this population and the difficult issues associated with moving them into managed care. **Therefore, many of the Medicaid-covered IDEA services, such as rehabilitation, are not included in the waiver and continue to be provided in the Medicaid fee-for-service program. As such, if these services are carved out of the waiver, schools, who traditionally provide Medicaid-covered services under an IEP or IFSP, can continue to provide**

them and bill the Medicaid program directly. However, primary and preventive services such as EPSDT screens, provided mainly in school-based clinics, are usually among the services provided under managed care plans in the waiver. Therefore, depending on the services provided by the school-based provider and the services covered (or carved-out) in the waiver, the role schools play in providing and/or coordinating services and receiving Medicaid reimbursement when states move Medicaid beneficiaries into managed care will vary.

Issues for School Health Providers and Medicaid Managed Care

The pursuit of Medicaid reimbursement for school health services is complicated by the recent growth in Medicaid managed care. A school provider who becomes accustomed to the Medicaid rules under the "traditional" Medicaid fee-for-service practice may find the system and accompanying requirements completely changed if a state decides to move its beneficiaries into Medicaid managed care. Because a state that mandatorily moves Medicaid beneficiaries into managed care does so under a waiver, there are no specific statutory requirements for states to establish relationships between school-based providers and managed care entities. HCFA policy is to strongly encourage states, upon submission and negotiation of their waivers, to promote relationships between the managed care entities and school-based providers. HCFA also encourages schools and school districts to get involved with the state and/or managed care entities during the formation of the waivers in order to establish relationships and ensure a place in the new health delivery system. In this manner, provision of medical services can be coordinated by the school-based providers and the managed care entities in order to ensure children receive necessary services and care is not duplicated.

There are many types of arrangements that states put in place under their waivers to promote and assure the coordination of care between managed care entities and school-based providers. Some states have instituted state laws which require coordination between managed care organizations and school-based health providers. In addition, some school-based health providers have developed formal arrangements, including legal contracts; protocols for referral and treatment; authorization for school based providers to provide services to managed care enrollees and bill Medicaid directly; and commitments to expedite the treatment of patients referred by school-based health providers. Some states, in their waivers, "carve-out" school-health services and reimburse those services under the "traditional" Medicaid fee-for-service program. However, as discussed earlier, most states carve-out Medicaid-covered IDEA services in their waivers, and place

the responsibility of primary and preventive services with the managed care entity. **While formulating such arrangements with MCOs often entails an administrative burden and can be a cumbersome process, schools and school-based health centers that serve Medicaid beneficiaries in states that move their beneficiaries into managed care must secure a role in the managed care system if they are to be reimbursed for the services provided to children.**

Examples of Relationships

States, managed care providers and school-based services providers have taken different approaches to ensure the coordination of services and information between schools and managed care entities. In order to give schools an idea of how coordination can be accomplished, the following examples describe how arrangements for providing services to Medicaid beneficiaries were achieved in these states.

OREGON

A 1991 Oregon state law requires prepaid managed care plans to contract with county health departments and other providers of services to children and adolescents. Contracts must cover immunizations, diagnosis and treatment of sexually transmitted diseases, and testing and treatment for communicable diseases. Under this state law, Medicaid managed care plans are required to reimburse school-based health centers for the provision of these services. Plans are also encouraged to contract with school-based health clinics for provision of other health care services, such as maternity case management, well-child care and prenatal care.

SAN FRANCISCO, CALIFORNIA

Balboa High School operates a primary care clinic, funded primarily by the San Francisco Department of Public Health, as an authorized Medi-Cal provider. Many of the school's students are enrolled with Kaiser Permanente, either privately or through the Medi-Cal program. Accordingly, Balboa has established an informal referral process with Kaiser. In this system, Balboa performs a basic triage function. That is, the school provides primary or acute care to Kaiser enrollees, referring them to Kaiser when care needs exceed the clinic's capabilities. In these situations, Balboa schedules Kaiser appointments to ensure continuity of care.

Balboa shares patient information with Kaiser only when referring students for emergency care, follow-up visits, or additional services not available at Balboa. Although the information exchange is informal, all patient information released by the clinic to places other than the San Francisco Department of Public Health requires specific patient release.

MASSACHUSETTS Under its 1915(b) waiver, Massachusetts includes coordination of care with school-based health centers as a requirement in each HMO contract. The school-based health centers operate according to a guideline of written quality standards and clinical protocols so that the managed care providers are assured that primary care services are delivered according to acceptable standards. The state includes this coordination as a part of the managed care

providers performance measures in order to ensure the two providers are coordinating the care provided to Medicaid beneficiaries.

RHODE ISLAND Under the Rhode Island 1115 waiver, RIte Care, all Medicaid-covered services under an IEP or IFSP under the IDEA are considered "out of plan" services and carved out of the waiver. As such, these services are provided in the school settings and billable to Medicaid under the fee-for-service reimbursement methodology. The state has three school-based clinics that provide a wide range of primary and preventive care services. The managed care contract is required to include these three school-based clinics in its network for delivery of RIte Care covered services available at the school-based clinic. The state retains the right to change the number of clinics included in the network during the term of the contract.

BALTIMORE, MARYLAND

The Baltimore City Health Department operates school-based health centers in middle and high schools to provide a range of primary and preventive care services to students. The school-based health centers are staffed by nurse practitioners or physician assistants, a community health nurse, a medical office assistant and a health aide. While nurse practitioners and physician assistants are the primary providers of clinical services, they work under written agreement with an adolescent medicine physician who is onsite part-time every week and accessible by phone at all times.

Many Maryland Medicaid beneficiaries in schools are enrolled in Medicaid managed care plans. The school-based health centers have a formal agreement with Total Health Care, a managed care plan operated by a federally qualified community health center. Reimbursement is made at Medicaid rates by Total Health Care for authorized services provided in school-based centers. There is no specific arrangement for reimbursement for services provided by the school-based provider by other Medicaid managed care plans.

The managed care provider is recognized as the medical home for the students. When a student has an acute medical need, the nurse practitioner at the school-based health clinic tries to arrange an appointment at Total Health Care, or with whichever managed care entity the child is enrolled in. If an appointment cannot be arranged the same day, Total Health Care authorizes the school-based health center to treat the student. The other managed care providers have the same choice of whether to authorize the school-based health center to treat the student.

The school-based health centers provide EPSDT services for those students enrolled in Total Health Care who have never been to their facility. These students are identified through a computer cross walk. EPSDT screenings are performed by Total Health Care for other enrolled students.

When services are provided at the school-based health centers, a bill for the services and a medical report are forwarded to Total Health Care which is responsible for reimbursing the school-based health center. If the school provides services to a student in another managed care entity, they are billed as well, but there is no formal agreement in place which ensures reimbursement. When scheduling appointments, Total Health Care gives priority to students referred by school-based health centers, and the school-based health centers are notified of

completed referrals. Under the state's 1115 waiver, which went into effect July 1, 1997, IDEA services are carved out of the waiver. Children are permitted to self-refer to school-based health centers, and the managed care providers must reimburse the school-based clinic based on established Medicaid rates.

BROOKLYN, NEW YORK

The Sunset Park Family Health Center Network of the Lutheran Medical Center operates a 12 site school-health program to provide medical, dental and psychological services to children in school districts 15 and 20 in southwest Brooklyn. Sunset Park started Health Care Plus, a managed care plan for Medicaid clients. The school-based health centers are the primary care providers for students enrolled in Sunset Park who choose them. Thus, the managed care entity itself runs the school-based health clinics. The Sunset Park sites are all electronically linked to facilitate the accessibility of information.

ST. PAUL, MINNESOTA

Health Start, a non-profit corporation, operates school-based health centers in six St. Paul high schools, serving over 3,000 students annually. Since approximately half of the students treated at these clinics are covered by Medicaid, Health Start has been a fee-for-service provider since its inception.

Minnesota has encouraged its managed care providers to coordinate with school-based health care centers. As a result, RamseyCare (the largest Medicaid managed care provider in Ramsey County, where St. Paul is located) and Health Start executed a contract making the school-based health centers primary care clinic providers and care coordinators for adolescents enrolled in RamseyCare. Under the contract, RamseyCare reimburses Health Start on a fee-for-service basis, using the Medicaid reimbursement rates plus 15%. Health Start also bills RamseyCare for EPSDT services provided to patients and for confidential services provided at the school-based health centers, such as mental health services.

The school-based health centers provide medical information to RamseyCare through their billing for services. In addition, RamseyCare must give prior authorization for all speciality services. In turn, RamseyCare notifies school primary care clinics whenever emergency room visits are used. In order to assure quality, Health Start clinics participate in RamseyCare quality assurance and utilization review programs.

In summary, schools need to work with their state Medicaid agencies, during the formation and implementation of their 1915(b) and 1115 waivers, in order to forge a role in the managed care arena and with managed care providers. Schools should aim to make formal arrangements with the managed care providers through contracts, which specifically lay out each entities' responsibility regarding services provided and reimbursement received. These arrangements will depend on the local configuration of the delivery of services to the populations served by both the school-based health providers and the managed care providers. The examples listed for coordination will be a guide depending on the distinct circumstances in

each state and locality. While HCFA encourages coordination between the state, school-based health providers and managed care providers, it is the responsibility of each party involved to form a relationship to ensure the provision and coordination of services provided to Medicaid eligible children.

RECOMMENDED RESOURCES/PUBLICATIONS

The following lists some recommended resources and publications that provide further information and insight into the relationship of schools to Medicaid managed care. In addition, specific information regarding Medicaid managed care enrollment
can be accessed via the Internet at <<www.hcfa.gov>>.

PUBLICATIONS

(1) *A Partnership for Quality and Access: School-Based Health Centers and Health Plans.*

The School Health Policy Initiative
Division of Adolescent Medicine
Department of Pediatrics
Montefiore Medical Center
111 East 210th Street
Bronx, New York 10456-2490
(718) 654-4190

(2) Hacker K. *Integrating School-Based Health Centers into Managed Care in Massachusetts, J. School Health, 66(9) November 1996, 317-321.*

RESOURCES

(1) The National Assembly on School-Based Health Care.

6728 Old McLean Village Drive
McLean, VA 22101-3906
(703) 556-0411

(2) Making the Grade, State and Local Partnerships to Establish School-Based Health Centers.

George Washington University
Suite 505
1350 Connecticut Ave., NW
Washington, D.C. 20036
(202) 466-3467

Website: <<www.gwu.edu\~mtg

With the Medicaid program funding an increasing amount of school-health services nationwide, schools, school districts, and LEAs have had to deal with the often challenging world of Medicaid payment. Federal Medicaid law provides the general framework regarding payment for covered services but states will also have specific guidelines regarding payment methodologies. This section details and explains the Federal Medicaid payment requirements, including the state plan process as it pertains to payment for school health services, Medicaid provider responsibilities, allowable payment methodologies, and necessary documentation.

Payment Requirements

When a Medicaid provider furnishes a covered service to a beneficiary, that provider normally files a claim for payment with the state Medicaid agency. Payment can be obtained either through prepaid arrangements, such as a capitated rate (as discussed in the section of guide on Medicaid Managed Care), or as a result of filed service claims, such as cost-based or fee-for-service arrangements. State Medicaid agencies will then file claims with HCFA for the FFP for medical services or the administrative expenditures made by the state.

Often states amend their state plans by submitting new language to HCFA in the form of state plan amendments (SPAs). Amendments are necessary when there is a significant change in the coverage or scope of services provided and/or a substantial change in the reimbursement methodology. When the change to the state plan is statewide and significant with respect to the methods and standards used in setting payment rates, public notice is also required.

The following are general principles dictated by Federal Medicaid law for payment of covered services under Medicaid state plans:

Flexibility, which generally means states have broad discretion to operate Medicaid programs within Federal guidelines;

Efficiency, economy and quality of care; which means striking a balance in payment amount such that payment is not excessive, but sufficient to ensure provision of high quality services and adequate access to care;

Reasonableness, which is a standard which individual states define; and

Allowable, reasonable and allocable cost reimbursement to public providers.
The specific principles of allowable, reasonable, and allocable cost reimbursement apply only when payment is based on the costs incurred for delivering the service or when an interagency agreement exists between the state and the LEA/school for administrative activities. The effect is that rates are limited to no more than actual cost of providing the service.

There are also several **specific state plan requirements** states must abide by as well. First, **for every service in the state plan, there exists a corresponding rate methodology**. Because school-health services are not a statutorily defined Medicaid service, individual services must be described individually in an

applicable coverage section of the state plan. If the services and provider information are already covered in a state plan, a new state plan amendment is not required. However, it may be desirable for the state to describe the schools' role as providers in a SPA to assure compliance with relevant Federal Medicaid rules. As such, the state Medicaid agency may create a new rate unique to the provision of school-based services.

Second, **the state plan must carefully describe the policy and methods used to set payment rates**. This means that the rates should be clear and well defined. The rates must be supported by information on elements such as: the factors used to create the rate; how each factor was determined (e.g., historical data, time study, etc.); and if the rate is subject to change, who makes the changes and how the change is made (e.g., yearly adjustments for inflation based on appropriate inflation index). The state Medicaid agency must maintain documentation of these payment rates to be made available to HCFA on request.

Third, **the actual payment rates must be adequate to obtain sufficient access to providers**. State agency payments must be sufficient to enlist enough providers so that services under the state plan are available to Medicaid beneficiaries at least to the extent that those services are available to the general population. This requirement, in effect, sets a minimum limit on the amount a provider may be reimbursed by Medicaid, ensuring that beneficiaries receive adequate access to Medicaid providers.

On the other hand, **there are also regulations on the maximum amount a provider may be reimbursed**. Upper limit requirements which apply to outpatient hospital and clinic services provide that Medicaid can not reimburse for the services any amount more than payment that would be made for those services under Medicare under comparable circumstances. Upper limits for non-hospital outpatient
facilities provide that the state may not pay more than prevailing charges in the locality for comparable circumstances. These limits apply when the outpatient hospital, clinic, or outpatient facility is the provider billing for the services. When the reimbursement system takes the form of a prepaid capitation plan, different upper limits apply. States must provide assurances that these upper limits are not violated by the state's proposed methodology.

<u>Establishing Payment Rates</u>
Rates for medical services are established by the state Medicaid agency and

described in the state plan. **Schools/LEAs may use the rates already established by the state in the state plan, or the state Medicaid agency may prefer to develop unique payment rates for school-based providers that more closely reflect the costs incurred by such providers, as long as those rates are consistent with efficiency, economy and quality of care. In creating a new rate, the state must use statistically accurate and valid data to justify the rate amounts.**

There are general rate principles that state Medicaid agencies, in conjunction with education entities, need to consider when developing rates. Payments must be reasonable and adequate to meet the costs incurred by efficiently and economically operated providers in conformity with state and Federal laws, regulations, and quality and safety standards. HCFA must approve these rates based on the assurances of the state that its findings for the particular settings and the adjustment of rates meet the requirements set in the regulations and applicable cost principles.

Most rate methodologies already include administrative overhead. It would not be appropriate for the school districts to add an administrative or processing fee to the amounts they pay, since that amount would not be for medical assistance. If some processing were required, the Medicaid agency could contract with the school districts to provide those administrative services, which would be reimbursed at the administrative rate (see section on Administrative Claiming).

The following is a discussion of three types of payment methodologies currently utilized by states for school health services:
(1) Bundled or Per Diem rate system. Bundled payments are fee-for-service rates for a grouping of separately covered Medicaid services under one rate. Under this methodology, each service component must be calculated separately to determine the overall payment level, and each service component must have a corresponding description in the services section of the state plan. If the payment methodology for each service is altered in any way from the current methodology in the state plan, a SPA is necessary. This grouped rate may not reasonably exceed the amount payable under the methodology applicable to other providers, since this could exclude providers who would be willing to furnish the service under the same terms as the school-based provider.

The bundled rate is usually utilized as one charge per child per school-day. If a child does not attend school on a given day, the Medicaid program may not be

billed for those services. Under the bundled methodology, the number of Medicaid eligibles may not be estimated for the purposes of billing. (Although if creating a rate according to actual cost, an estimate of eligibles receiving the services may be factored into the rate to obtain the cost of the services provided. However, this rate may then only be billed on a per child basis). Also, the bundled rates may not include elements other than the cost of covered services. Finally, if the bundled rates involve risk-based contracting, then the state must determine whether the entity meets requirements for Federal participation as a HMO or PHP.

Unless a state has obtained a waiver (discussed in more detail in the section in this guide on Managed Care), the schools may not require that a Medicaid recipient receive services from the school, as this violates freedom of choice requirements. Therefore, the rate cannot be based on the assumption that the beneficiaries will be obligated to use the school-based providers. Beneficiaries are permitted to use any qualified providers, even on the same day as they go to a school-based provider.

EXAMPLE State Y has found that the majority of students who receive Medicaid service A also receive Medicaid service B. Both of these services fall under the same recognized Medicaid coverage category. To simplify billing, the school has established a bundled rate to combine the cost of providing the two services. To ensure freedom of choice, the school also retains the flexibility to bill under a fee-for-service rate in the event a child does not receive both services on a given day. This bundled rate has been incorporated into the state plan, using the two current methodologies already in the plan for the two services. In the event the pattern of these services being provided together changes, the state has measures in place to adjust the rates accordingly.

(2) Per unit, or per service package**.** Per unit rates are utilized by schools to cut down on the administration and paperwork associated with billing directly every time a service is rendered for a Medicaid beneficiary. To establish a rate, schools/LEAs engage in extensive historical cost gathering using time studies, interviews, and cost reports. Once this information is collected, the costs to the provider (school/LEA) of furnishing individual services to the Medicaid population of children is established. Rates for services are developed that specify the methodology for each specific service and provider type or practitioner which is a component of the calculation and fully explain how the average per unit or per service package rate is determined.

Often an interim rate based on sampling is established. In the event interim reimbursement is used, there must be a reconciliation or adjustment at some point in the future based on actual costs. To obtain actual costs, the state maintains eligibility data, proper accounting for services, types of services, types of facilities,

types of practitioners/providers, with cost reports at the end of the cost reporting periods. These cost reports may result in upward or downward adjustment in the succeeding rate-setting period and there must be a mechanism for making these changes. In addition, as with any other rate, upper limit payment requirements must be satisfied when applicable.

Also, the requirement for the payment methodology are that the state per unit rate methodology will be multiplied by the actual number of recipients receiving services. The state should not estimate the number of recipients used in establishing the per unit rate unless the rate is an interim one which the state will adjust at a set time to reflect the actual services furnished to individual recipients.

In the event the per unit rate takes the form of a prepaid capitation plan, both risk contracts and non-risk contracts are subject to upper limit requirements based on what the services would have cost on a fee-for-service basis.

(3) Unique payment mechanisms. States and school districts are encouraged to use the flexibility inherent in the Federal Medicaid regulations to come up with new and innovative payment methodologies allowable under applicable requirements.

The Role of Medicaid Providers

In order to receive reimbursement for school-health services, there must be a provider agreement between the state and the actual provider of services (see the Coverage section of this guide for more information regarding provider qualifications). The

provider agreement, along with any contractual arrangement between the state and the school/LEA or between schools and providers, governs how and by whom Medicaid is billed for services and to whom reimbursement may be made. Payment is generally made only to the provider of services.

If a school/LEA enrolls as a Medicaid provider, it may receive reimbursement directly for Medicaid-covered services provided to eligible beneficiaries. It is important to note that provider status also includes the responsibilities of ensuring that claims are processed expediently, that all liable third parties are billed, that all free care issues are addressed, and that all necessary documents are kept in the event of an audit.

Billing for Medicaid reimbursement sometimes requires more administrative work than schools have the time and personnel to invest. As a result, schools as providers sometimes share the billing requirements with LEAs or with the state

Medicaid agency, or schools may contract with an independent billing agency to handle billing. Regardless, billing is not reimbursable as a separate service; rather, it is considered part of the rate for medical services. Many schools hire contractors to develop systems for billing for Medicaid services. However, schools may not bill the Medicaid agency for services of contract employees at rates higher than they are paid, or for mark-ups which pay a "factoring" agent, such as a percentage of the funds recovered by the school district, are not allowable. Furthermore, while these contractors can provide valuable advice, schools should first consider contacting their state Medicaid agency, the Department of Education, and HCFA Central and Regional offices, for free technical assistance in developing a school-based services program. State Medicaid agencies can distribute provider manuals and assist schools with other necessary information and development regarding the state's billing requirements for school health services.

Under the timely claims processing provisions, state Medicaid agencies require that providers submit all claims no later than 12 months from the date of service (some states may allow even less time for providers to bill). This is an important consideration before retroactive billing is attempted by the school or school district. Once the claims of the providers are received by the state, the state agency then has additional time (generally two years) to submit those claims to HCFA. Provider agreements must be in place at the time the claims are submitted, Medicaid provider qualifications must be met at the time the services are furnished, and requirements for billing third parties must be satisfied at the time the claims are submitted for FFP (see the section of the guide on Third Party Liability and Free Care for more information). Furthermore, there is no authority for the state to enroll providers and to pay for services furnished during prior periods before the provider agreement was in effect.

Documentation

A school, as a provider, must keep organized and confidential records that details client specific information regarding all specific services provided for each individual recipient of services and retain those records for review. In addition, all of the screening elements of an EPSDT screening must be documented as it is not sufficient to indicate just one of the elements. Relevant documentation includes the dates of service, who provided the service, where the service was provided, any required medical documentation related to the diagnosis or medical condition of the recipient, length of time required for service if relevant, and third party billing information. This information will be necessary in the event of an audit and will

also be helpful in the event it is necessary to adjust the rates in the future.

One of the barriers to schools claiming Medicaid reimbursement for Medicaid covered services is the issue of billing for these services. While the reimbursement section of this guide explains how states determine reimbursement rates for covered
services provided and innovative methods in how states can claim reimbursement for school-health services, this section explains other requirements for billing of Medicaid services, such as the issue of "free care" and third party liability requirements as it pertains to school-based services. The issue of Medicaid billing is especially problematic because schools are not well acquainted with operating as medical service providers or the specific Medicaid requirements associated with seeking reimbursement for Medicaid-covered services. The requirements that Medicaid does not reimburse for free care (the free care policy) and that payment must be sought from any liable third party before Medicaid can make payment (third party liability) are two separate principles for Medicaid billing that are distinct and often confused.

Free Care An important requirement related to billing for Medicaid covered school-based services is the issue of "free care." From the outset of the Medicaid program, a principle basic to public assistance has applied to Title XIX, in that

Medicaid funds may not be used to pay for services that are available without charge to everyone in the community. Free care, or services provided without charge, are services for which there is no beneficiary liability and for which there is no Medicaid liability.

In applying the free care principle to determine whether medical services are provided free of charge and, thus, there is no payment liability to Medicaid, a determination must be made whether both Medicaid and non-Medicaid beneficiaries are charged for the service. Providers of Medicaid services must have the authority to charge for their services and utilize this authority, before Medicaid will make payment. If only Medicaid recipients or their third parties are charged for the service, the care is free and Medicaid will not reimburse for the service.

Schools may employ certain methods to ensure the care is not considered free, allowing Medicaid to be billed. The services would not be considered free if the following conditions are met. The provider:

(1) Establishes a fee schedule for the services provided (it could be sliding scale to accommodate individuals with low income);
(2) Ascertains whether every individual served by the provider has any third-party benefits, and
(3) Bills the beneficiary and/or any third parties for reimbursable services.

Exceptions to Free Care

For purposes of the provision of school-based health services, there are two exceptions to the free care rule, described below.

(1) IDEA. Section 1903(c) of the Act prohibits the Secretary from refusing to pay or otherwise limiting payment for services provided to children with disabilities which are funded under the IDEA under an IEP or IFSP. Under these circumstances, Medicaid is the primary payer to the Department of Education. As such, Medicaid-covered services provided under an IEP or IFSP are exempt from the free care rule. This means that school providers may bill Medicaid for Medicaid-covered services provided to children under IDEA even though they may be provided to non-Medicaid eligible children for free. However, as discussed in more detail below, the requirements to bill all liable third parties for services still apply. Therefore, although the services would be exempt from the free care rule, the school would still have to pursue any liable third party insurers for

reimbursement.

(2) Title V. Another exception to the free care policy which relates to school-based health services includes services provided by Title V of the Social Security Act. Title V of the Act is the Maternal and Child Health Services Block Grant, which provides a lump sum of funds to states for the provision of health services and related activities to mothers, children and adolescents for the reduction of infant mortality, preventable diseases, and access for to necessary health services.

Federal Medicaid regulations at 42 CFR 431.615 define Title V grantees as agencies, institutions, or organizations that receive Federal funding for part or all of
the cost of providing maternal and child health services, services to children with special health care needs, maternal and infant care projects, children and youth projects and projects for the dental health of children under Title V of the Act. Schools may be able to qualify for funding under Title V as grantees, whether they contract with health providers or are a provider themselves. Medicaid regulations specify requirements for cooperative agreements and arrangements between Title V grantees and state Medicaid agencies. Medicaid-covered services provided by Title V are exempt from both the free care rule and the policy of Medicaid as the payer of last resort in that Medicaid will pay before Title V for Medicaid-covered services. Again, although the services would be exempt from the free care rule, the school would still have to pursue any other liable third party insurers for reimbursement before billing Medicaid.

Impact of Free Care on School-Based Health Services

This policy on free care somewhat limits the ability of schools to bill Medicaid for covered services provided to Medicaid eligibles unless the school charges all students for the services provided or meets one of the exceptions above. For example, many schools have a school nurse on staff to provide necessary health services to all students without charging them for the care provided. However, the school cannot charge the Medicaid program for the services of the school nurse, if she furnishes care to all students (not solely Medicaid eligibles) without also charging non-Medicaid students. While there are exceptions to this free care requirement for Title V and Medicaid-covered services provided under the scope of an IEP or IFSP under IDEA, many schools provide a wide range of health services which would not fall under either exception.

Third Party Liability (TPL)

A third party is any individual, entity or program that is or may be liable to pay all or part of the costs for medical assistance for Medicaid-covered services furnished under the state plan (42 CFR 433.136). Under Medicaid law and regulations, Medicaid is generally the payer of last resort. The Congress intended that Medicaid, as a public assistance program, pay for health care only after a beneficiary's other health care resources have been exhausted.

State Medicaid agencies are required to take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the state plan (section 1902(a)(25) of the Act and implementing regulations at 42 CFR 433.138) . Such measures, include specific requirements to identify and recover payments from liable third parties. States are required to integrate pursuit of TPL payments with mechanized claims processing and information retrieval systems used to administer Medicaid programs. Furthermore, states must require Medicaid applicants to assign to the state their rights to medical support and third-party payments as a condition of Medicaid eligibility. Applicants for Medicaid must cooperate in identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

Payment of Claims

There are specific requirements in the Federal Medicaid statute and regulations regarding the payment of claims by the state Medicaid agency if it is determined that TPL exists. If the state Medicaid agency finds that TPL exists and that the third party will pay within a reasonable time, the agency must pay only the amount, if any, by which the allowable Medicaid claim exceeds the amount of the third party liability (42 CFR 433.139). However, the agency cannot withhold payment if TPL or the amount of such liability cannot be determined or if the third party payment will not be available within a reasonable period of time.

If TPL exists but does not cover the specific Medicaid services provided, the provider would have to furnish documentation to the state Medicaid agency that although TPL generally exists for the beneficiary, there is no coverage for the services provided. After such documentation is given, the provider would not have to continually pursue TPL for the services provided which are not covered. Thus, the claim is submitted to the state and would be paid. The provider would need to

establish annually thereafter that coverage for those non-covered services has not changed. Many services covered by states under their Medicaid programs are not covered by liable third parties of Medicaid beneficiaries. As such, the provider would not need to pursue TPL every time the service was furnished as long as it was demonstrated such coverage is not available by otherwise liable third parties.

If the probable existence of third party liability cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, the agency must pay the full amount allowed under the agency's payment schedule. However, if the state Medicaid agency learns of the existence of a liable third party after a claim is paid, the agency must seek recovery of reimbursement within 60 days after the end of the month in which payment is made
unless the agency has a waiver of this requirement.

There are two methods states must utilize if probable TPL is established at the time the claim is submitted to the state Medicaid agency. Generally, states are required to use the cost avoidance method. There are some exceptions to using the cost avoidance method whereby the state uses the pay and chase method.

Cost Avoidance

Federal regulations at 42 CFR 433.139(b)(1) concerning the cost avoidance requirements state, "if the state Medicaid agency establishes the probable existence of third party liability at the time the claim is filed, it rejects the claim and returns to
the provider for determination of the amount of liability. The establishment of third
party liability takes place when the state receives confirmation from the provider or a third party resource indicating the extent of the third party liability. When the amount of liability is determined, the state pays the claim to the extent that payment
allowed under their payment schedule exceeds the amount of third party's payment."

The cost avoidance method of payment of claims is considered to be cost-effective because the state saves administratively from using fewer Medicaid resources and dollars to pursue third party payment. Furthermore, this ensures that the liable third party is pursued for payment before Medicaid pays the claim so that Medicaid dollars are not outstanding while waiting for third party reimbursement to materialize.

Federal regulations at 42 CFR 433.139(e) permit states to obtain a waiver of cost avoidance method of payment of claims and instead use the pay and chase method. To do so, the state has to demonstrate that the pay and chase method is as cost effective as the cost avoidance method.

"Pay and Chase

Using the "pay and chase" method, the state Medicaid agency pays the claims submitted by providers and then seeks reimbursement from the liable third parties. Reimbursement must be sought unless it is determined that recovery of reimbursement would not be cost effective in accordance with threshold amounts that have been established by the state. If the probable existence of a third party cannot be established or third party benefits are not available to pay the beneficiary's medical expenses at the time the claim was filed, the state will pay the full amount allowed under their payment schedule. If the existence of a third party is determined after the claim is paid, or benefits become available from a third party after the claim is paid, recovery for reimbursement is sought to the limit of legal liability within 60 days from the end of the month in which the existence of the third party is determined.

There are specific circumstances in which states are required to use the pay and chase method of payment, even though there is a probable or known third party at the time the claim is filed. One circumstance impacting school-based health services where states are required to pay and chase involves claims for Medicaid beneficiaries obtaining prenatal and preventive pediatric services. Another way to use the pay and chase method without this exception is through a cost avoidance waiver.

Prenatal and Preventive Pediatric Services

States must use pay and chase when the claim is for prenatal services or preventive pediatric services (some of these services include EPSDT services) that are covered in the state plan. The intent of this requirement is to alleviate the administrative burden associated with third party liability efforts so as not to discourage participation in the Medicaid program by physicians and other providers of these types of services, since beneficiaries in need of such services already often have difficulty finding providers in many communities. The State Medicaid Manual (SMM), which is gives guidance to states on how to implement Federal regulations and requirements in their state Medicaid programs, includes a list of diagnosis codes that, at a minimum, states are required to pay and chase.

Diagnoses included in this list are for immunizations, screening tests for congenital disorders, well child visits, preventive medicine visits, preventive dental care, and screening and preventive treatment for infectious and communicable diseases. States are given discretion to define the list more broadly. For instance, states should pay and chase for additional diagnoses whenever using the cost avoidance method would discourage provider participation. Although states are not mandated to pay and chase all EPSDT services, HCFA allows flexibility to permit states to pay and chase a range of Medicaid covered services provided to Medicaid recipients in schools using the rationale of not discouraging provider participation.

Although states are permitted to use pay and chase for more pediatric preventive care services than those specified in the SMM, many states choose not to because it undermines the collection of TPL recoupments if there is existence of a probable third party payer. Schools, as providers, should check with their state Medicaid agency to determine its policy on paying and chasing school-based services claims for more than the required diagnoses stated in the SMM.

States are also required to pay and chase rather that use the cost avoidance method in situations in which there is a third party derived from a non-custodial parent under a court order to provide medical support. This requirement would impact schools providing Medicaid-covered services to these children.

Exceptions to Medicaid as the Payer of Last Resort

There are exceptions to the provisions of Medicaid as the payer of last resort which allow Medicaid to be the primary payer to another Federal or Federally funded program for services covered under Medicaid when specifically required by Federal law, and only after other liable third party payments have been established. One such exception is Title V as mentioned earlier in the discussion of free care. In addition, section 1903(c) of the Act permits an exception to the TPL requirements in that, for Medicaid-covered services listed on a Medicaid eligible child's IEP/IFSP, Medicaid will pay primary to IDEA. **This means that Medicaid will pay prior to DOE for Medicaid-covered services listed in a child's IEP/IFSP.**

Although the Medicaid program pays first to DOE for covered IDEA services, these services are still subject to the TPL requirements applicable to any other services furnished under the state Medicaid program. In other words, this exception does not provide any exemption from pursuing <u>OTHER</u> liable third party payers, such as private insurance. Medicaid is still secondary to all

other sources of payment. Neither IDEA nor Medicaid was changed in any way by Congress that would relieve the Medicaid program of actively pursuing any liability of third parties, including private insurance, in order to minimize Medicaid outlays.

Impact of the TPL Requirements on School Providers

IDEA requires a school/school district to provide a free and appropriate education to every eligible child. The Medicaid statute was amended by Congress in order to facilitate payment for the health-related services under the IDEA. However, as stated above, although Medicaid pays primary to DOE, it still pays secondary to any liable third parties. IDEA statutory and regulatory provisions on health-related services do not create exceptions to Medicaid requirements and procedures, or expand the scope of Medicaid responsibility or coverage. Therefore, schools or their health practitioners who seek to bill the Medicaid program for reimbursement for health services must meet Federal and state Medicaid provider qualifications including requirements to bill third parties.

In addition, schools must abide by the payment of claims provisions at 42 CFR 433.139 where liable third parties are involved. This means that, as a Medicaid provider, schools may be required to bill the beneficiary's health insurance first before billing Medicaid to determine the extent of the insurer's payment liability. If, under Medicaid, the services meet one of the regulatory exceptions or the state has obtained a waiver of the cost avoidance requirements, the state may pay in full and seek recovery of reimbursement from the liable insurer. This removes the administrative burden of seeking TPL for services from the school provider and places it on the state Medicaid agency. For preventive pediatric care services, the school provider may bill the state Medicaid agency, which will pay the claim, and the state will seek reimbursement from a liable third party. However, unless the state interprets the typical treatment services under the scope of an IEP or IFSP such as the speech or physical therapy, to fall under the preventive pediatric services exception to the cost avoidance method of payment of claims, the school provider will have to pursue any liable third parties before billing Medicaid.

Because under IDEA children are entitled to a free and appropriate public education, whether a school would actually choose to bill private insurers for services covered under an IEP or IFSP would depend on the school's policies regarding health insurance billing and the potential for an associated cost to the family. Under Federal education policy on the use of parents' insurance proceeds, the requirements that a free and appropriate public education be provided without

charge or without cost means that DOE may not compel parents to file an insurance claim when filing the claim would pose a realistic threat that the parents of children with disabilities would suffer a financial loss not incurred by similarly situated parents of other children.[2] As such, private insurance of parents could not be billed for IDEA services, unless the parents agreed to such a cost. Because the TPL provisions requires Medicaid to pay after private insurance, Medicaid could not be billed for these services either. Medicaid does not have an interest under its third party liability requirements concerning which person, organization or agency pays the third party's liability. Thus, if the state education agency elects to pay the third party's liability through its own funds, that is permissible under the Medicaid statute. For example, if a particular service, such as physical therapy, is billed at $50 and any private insurance coverage is available to meet $40 of that payment, then Medicaid's payment is the difference between the Medicaid payment rate and third party payment, assuming the Medicaid rate is higher. The state education agency may elect to meet the $40 liability. If, however, Medicaid erroneously paid the $50 in the first instance and later discovered the beneficiary had private insurance coverage, the Medicaid agency must pursue recovery from the third party. If the state or LEA assumes the liability of the third party, Medicaid payment could be made minus the amount assumed on behalf of the third party payer.

In order to simplify billing, schools in some states, such as Alabama, contract out the billing process. In other states, such as Michigan and Texas, schools use billing agents. In Oregon, over 60% of the schools' medical providers contract with a billing agency. Washington, Wisconsin and Indiana use billing contractors in some cases.

We acknowledge that these requirements and policies regarding third party liability and free care are problematic for school-based providers. Schools typically do not have the staff, experience or equipment to run an efficient billing operation.

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[2] "Medicaid Coverage of Health-Related Services for Children Receiving Special Education: An Examination of Federal Policies", November 1991, p. 9. Financial losses include, but are not limited to the following: 1) a decrease in available lifetime coverage or any other benefit under an insurance policy; 2) an increase in premiums under an insurance policy; or 3) an out-of-pocket expense, such as the payment of a deductible amount incurred in filing a claim (45 Federal Register 86390, December 30, 1980).

HCFA
has considered alternatives to these requirements but as yet, no changes have been made. Therefore, schools will have to learn and abide by these requirements in order to bill the Medicaid program and receive reimbursement for Medicaid covered services provided.

Title XIX of the Act provides for the availability of FFP for states' claims for administrative expenditures that are found to be necessary by the Secretary for proper and efficient administration of the Medicaid state plan. Schools and school districts may perform activities that support administration of the Medicaid state plan, and FFP for the cost of such activities may be claimed as Medicaid administration under certain conditions. Medicaid-reimbursable related activities performed by schools districts and schools may include items such as Medicaid outreach, eligibility intake, information and referral, coordination and monitoring of health services, and interagency coordination. FFP for states' claims for Medicaid administration expenditures is available at the rate of 50 percent.

The statutory, regulatory and administrative requirements for the performing of claiming for administrative activities differ from those for providing and claiming for medical assistance services. For example, reimbursement requirements pertaining to the provision of medical services such as provider qualifications, comparability, freedom of choice of providers, statewideness and free care are not relevant to claiming for administration. Under administrative claiming, schools and school districts may perform certain Medicaid administrative functions without having to meet provider requirements. This obviates the need to document and submit individual claims for services rendered. However, schools and school districts do need to be aware that when providing <u>both</u> administrative claims and medical services, the medical service requirements must still be met. Furthermore, when claiming under both aspects of the Medicaid program, some activities that may be claimed as administration may not be allowable as separate medical

services claims once the school or school district becomes a Medicaid provider.

Guiding Principles of Administrative Claiming

In determining whether or not an activity qualifies for administrative FFP, the focus is on the state plan. If the activity in question is performed in support of the eligibility determination process, or in support of any service covered under the state plan (such as a prior authorization determination, transportation to medical providers, assistance in completing the application of eligibility, state oversight in connection with ensuring the quality of services provided, marketing (such as hotlines, school bus posters, distribution of pamphlets) etc.), the activities necessary to administer such functions may be eligible for FFP. However, an activity unrelated to the Medicaid program, even if performed in the best interest of the beneficiary, is generally not allowable (such as assistance in locating suitable housing, assistance in locating a free food pantry, or baby-sitting which enables the mother to attend classes at the local community college). The supported activity must be in the approved Medicaid state plan for its related administrative costs to be eligible for Federal matching funds under the Medicaid program. The following are some additional guiding principles applicable for determining the allowability of administrative claims:

(1) No Duplicate Payments- In determining allowable administrative costs, the basic principle is that duplicate payments are **not** allowable. That is, payments for allowable administrative activities must not duplicate payments that have been or should have been included and paid as part of a rate for services, part of a capitation rate, or through some other state or Federal program. Furthermore, in no case should a program or claiming unit in a local jurisdiction be reimbursed more than the actual cost of that program or claiming unit, including state, local, and Federal funds. The state would need to provide and maintain appropriate documentation and assurances that claims to HCFA for administrative activities are not duplicative of other claims or payments.

(2) Accurate Submission of Claims and Contracting- It is the state's responsibility to present Local Governmental Agency's (LGA) claims in readily reviewable form to HCFA for review, and after HCFA's approval, to submit those approved claims on the appropriate Form HCFA-64.

(3) Provision of Technical Assistance- It is HCFA's responsibility to provide the state with any technical assistance required to develop and establish a system for making administrative claims under Medicaid for allowable activities. Such

technical assistance could relate to resolution of claims for prior periods, claims during a transition period and for prospective claims. HCFA is available to provide guidance and all necessary approvals at each step in these processes, and to review and approve allowable claims and expedite (for the resolution and transition periods only) the payment to the state of those allowable claims.

(4) Relation to the State Plan - Activities for which administrative claims are made must directly relate and support the Medicaid state plan or waiver services. Allowable administrative costs do not include gaining access to or coordinating non-Medicaid services even if such services are health-related. However, the cost of gaining access to or coordinating non-Medicaid services may be claimable as targeted case management services if applicable state plan requirements for such services are met. The Secretary, rather than the state, is the final arbiter of which activities fall under the proper and efficient administration of the state plan. HCFA exercises the Secretary's authority to make these determinations, and has consistently held that allowable claims under this authority must be directly related to the administration of the state Medicaid program.

(5) Relation to Medical Services - Expenses cannot be claimed as administration if they are an integral part or extension of a direct medical or remedial service, such as patient follow-up, patient assessment, patient education, counseling, development of the medical portion of an IEP or IFSP, or other physician extender activities. Such services are properly paid for as part of the payment made for the medical or remedial services. Because Medicaid providers have agreed to accept service payment as payment in full, such providers may not claim an additional cost as administrative costs under the state plan.

(6) Not for General Health Initiatives - Administrative claims may not include funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns, unless the campaign is explicitly for the purpose of assisting Medicaid-eligible individuals to access the Medicaid program. Similarly, activities directed toward services not included under the Medicaid program, although such services may be valuable to Medicaid beneficiaries, are not necessary for the administration of the Medicaid program, and are therefore not administrative costs.

(7) Operating Costs - Administrative claims may not include the operating costs of an agency whose purpose is other than the administration of the Medicaid program. If a government agency such as a school district, directs some fraction of its efforts

exclusively to Medicaid claimable administrative services and can accurately identify that fraction, it may claim an appropriate portion of its operating costs to support that function if all other criteria for administrative claiming are satisfied. For direct providers of services, administrative claims may not include overhead costs of operating a provider facility, such as the supervision and training of providers. Moreover, additional claims for activities reimbursable under the medical assistance rate may not be submitted as administrative expenses, much like a physician may not submit claims for expenses incurred when a nurse calls to remind a patient of an appointment; as the expense is considered in the rate for the medical service provided.

General Administrative Services

There is much flexibility in what services may be properly claimed as administrative, and some activities can be billed as either medical services or administration. **Typical activities that can be claimed as administrative costs by schools or LEAs are:**

Medicaid eligibility determinations and redeterminations;

Medicaid outreach:
(1) activities to inform or persuade beneficiaries to enter into care through the Medicaid system;
(2) activities to inform or persuade potential beneficiaries to apply for Medicaid;
(3) LEAs may only conduct outreach to the populations served by their school districts, i.e., students and their parents or guardians.

EPSDT administrative activities/case management activities, such as informing all program eligibles about the EPSDT benefit:
(1) providing or arranging for the provision of EPSDT screening services;
(2) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment;
(3) assisting families in identifying and choosing Medicaid providers;
(4) conducting follow-up to ensure children receive needed diagnosis and treatment; and

activities related to obtaining third party liability.

As described earlier, how these activities are claimed depends on the specifics of the services themselves, whether any interagency agreements are in place governing these activities, and in some cases, how the state prefers to provide the activities. For example, if a state pays for case management as a medical service claim, case management services provided to the same population may not then claimed to HCFA as an administrative cost. Again, this is because when a school becomes a Medicaid provider, general overhead expenses become part of the rate for the particular service provided.

Percentage of Allowable Activities

When claiming for allowable administrative activities that are performed with respect to a population consisting of both Medicaid-eligibles and non-eligibles, payment may only be made for the percentage of time actually attributable to the Medicaid-eligible individuals. This distinction is applicable when the school or school district performing the service is performing the same service to non-Medicaid-eligible children. Often, time coding systems are used for the purpose of identifying the percentage. States ensure that state and local agency time coding systems used to determine Medicaid utilization are designed to appropriately distinguish allowable administrative costs from non-allowable expenses. These time coding systems must also be approved by HCFA prior to state and local implementation and must meet the simplicity of administration requirements under the Act.

Because distinctions are necessary between medical services claims and administrative services claims, school districts must establish a mechanism to identify students receiving services that could be considered under either category. For example, schools providing targeted case management services to children as a medical service must ensure that a method is established to preclude duplicate billing as administration. When submitting claims for similar administrative case management services. (See the Case Management section for more specific information regarding this issue).

Once administrative activities are identified, costs must be included in a cost allocation plan that is submitted by the state Medicaid agency, approved by HCFA, and supported by a system which has the capability to properly identify and isolate the costs which are directly related to the support of the Medicaid program from all other costs incurred by the agency. Cost allocation plans distinguish between direct and indirect costs, and must abide by the cost allocation principles described in the Office of Management and Budget Circular A-87 which requires that costs

be “necessary and reasonable” and “allocable” to the Medicaid program. States often negotiate contracts with local school districts, or the state’s DOE for the provision of Medicaid administrative services prior to submitting a formal plan to HCFA. However, administrative claims reimbursement is subject only to the terms negotiated in the final approved submission by the state Medicaid agency.
The FFP rate for state administrative expenditures is generally 50%. An enhanced FFP rate of 75% is available for skilled professional medical personnel. These skilled medical professional staff must have appropriate credentials as skilled medical professionals, and the activity performed must require their level of training and credentialing (which are specified at 42 CFR 432.506).

Since the inception of the Medicaid program, states have been required to arrange for transportation of beneficiaries to and from necessary medical care, recognizing that unless needy individuals can actually get to providers of services, the goals of a state Medicaid program in providing necessary medical services are inhibited at the start. Federal Medicaid regulations at 42 CFR 431.53 incorporate this requirement by stipulating that a state plan must "specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers and describe the methods that the agency will use to meet this requirement." The Medicaid program's requirements for transportation emanates from several statutory authorities. Title XIX laws and regulations specify mandated medical services and optional medical services, as well as necessary administrative requirements which must be met under a state's Medicaid plan. Although states are required to provide non-emergency transportation to their Medicaid beneficiaries, states can cover transportation in two ways, or using a combination of both of these two methods. Transportation costs can be covered as an optional medical service or as an administrative expense. Depending on whether a state covers transportation as an administrative expense or an optional medical service, different requirements apply.

Transportation as an Optional Medical Service

Aside from the specified mandated medical services and the administrative requirements, Federal Medicaid law and implementing regulations also provide for optional medical services. These optional services are either specified in the Act, or authorized by the Secretary under section 1905(a)(25) of the Act which specifies "any other medical care or remedial care recognized by state law and specified by the Secretary." Transportation has been included under the latter authority since the beginning of Title XIX and implemented at Federal regulations at 42 CFR 440.170(a). This regulatory authority defines the coverage of transportation services which includes "expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient." States that choose to cover transportation as an optional medical service would receive FFP at the medical services or FMAP rate.

In order for transportation to be an optional medical service, it must be provided by

a vendor to whom direct payment can be made by the state Medicaid agency. In general, FFP is not available for direct reimbursement to the beneficiary of the services except under certain limited conditions. As is the case for all services provided under the Medicaid program, in covering transportation as an optional medical service, the freedom of choice principles apply. The beneficiary must have the freedom to choose among all qualified providers unless the state is granted a freedom of choice waiver.

Transportation as an Administrative Expense

States may also choose to cover transportation as an administrative expense, and thus receive FFP at the 50% administrative rate. The state has more flexibility in covering transportation under this method. Arrangements may include the use of vendors, or other transportation alternatives, such as direct reimbursement to the beneficiary in the form of vouchers or tokens, or cash reimbursement for needed transportation with supporting documentation (e.g., a receipt). Furthermore, the freedom of choice principles do not apply, which allows the state to restrict the providers from which a beneficiary can obtain transportation or the type of transportation provided.

Whether transportation is covered as an administrative expense or an optional medical service, generally Federal Medicaid law authorizes Medicaid payment only where transportation is otherwise not available. Thus, the state is obligated to utilize all available sources of free transportation services (such as relatives, friends and otherwise available school transportation) before authorizing Medicaid payment. Furthermore, the Federal Medicaid requirement that states administer their Medicaid programs properly and efficiently requires the state to use the least costly means, appropriate with the medical condition of the beneficiary, when multiple methods exist.

Medicaid Coverage of Transportation to School-Based Health Services

As a general rule, Medicaid funds are not available for reimbursing the transportation of Medicaid recipients to school even though Medicaid-covered school-based health services may be provided in the school during part of the day. This is because education is the primary purpose of attending school, while any medical services rendered are secondary. Moreover, transportation to school is provided free of charge to all students attending school, and HCFA policy generally prohibits the use of Medicaid funds for services provided at no charge (see the section of the guide on Free Care for more information on HFCA's free care policy).

There is an exception to the exclusion of Medicaid reimbursement for transportation to onsite school-based services which applies for children receiving services under IDEA. Section 1903(c) of the Act provides that HCFA may not "prohibit or restrict payment ... for medical assistance for covered services ... because such services are included in the child's IEP or IFSP." **Therefore, the Medicaid program can pay for transportation to school based services for children under IDEA when both of the following conditions are met:**

1) The child receives transportation to obtain a Medicaid-covered service (other than transportation), and

2) Both the Medicaid-covered service and the need for transportation are included in the child's IEP or IFSP.

On any day the above two conditions are met, Medicaid payment for transportation to and from the school is available. HCFA policy is that this applies whether the state covers transportation as an administrative expense or an optional medical service.

However, depending on which method in which the state covers transportation (administrative expense or optional medical service), different requirements apply for reimbursement for children under IDEA receiving Medicaid-covered school-based services. If the state covers transportation as an optional medical service, the statute and regulations on reimbursement for Medicaid services apply, which means the provider of transportation is reimbursed based on the transportation reimbursement methodology stipulated in the state plan (please see the section of the guide on Reimbursement for more detailed information on these requirements).

Alternatively, if a state covers transportation as an administrative expense, the Medicaid reimbursement rules for services do not apply. Instead, the principles for administrative service reimbursement must be followed. Federal cost principles are contained in Office of Management and Budget (OMB) Circular A-87 for determining allowable costs of programs administered by state and local governments. Under OMB Circular A-87, costs must be "necessary and reasonable" and "allocable" to the Medicaid program for Medicaid payment to be available. Allocation of costs may be required in accordance with principles of OMB circular A-87 to ensure that the Medicaid program only pays for that portion

of transportation that would be necessary for the medical service. As such, the Medicaid program would not be replacing the cost burdens of school transportation allocable to states and local governments, but only paying for the portion of the transportation that could be allocated to the Medicaid service received. Cost allocation plans must be approved by HCFA.

States are allowed flexibility in determining the method when formulating their cost allocation plans for reimbursing transportation to school-based services as an administrative expense. One example of a cost allocation plan is according to time units. Under a time unit method of cost allocation, if a student with an IEP receives a Medicaid-covered service on school premises during the school day, the percentage of time spent receiving a Medicaid-covered service would be the same percentage reimbursed from the total cost of transportation to and from school. That is, if 60 percent of the day for a child covered under IDEA was for education, 20 percent for medical services and 20 percent for other activities, Medicaid would pay only 20 percent of the cost of transportation because that is the portion properly allocated to the receipt of the Medicaid-covered service.

Furthermore, if the child receives a Medicaid-covered IDEA service at an off-site facility during the school day, the cost of transportation from the school to the facility and back to the school would be reimbursable in full by Medicaid whether the state covers transportation as a service or as an administrative expense. However, in that situation, no cost of transportation to and from the child's home and school would be reimbursable. If a beneficiary does not receive a Medicaid covered service during the school day, transportation to and from school is not reimbursable for that day. Finally, although Medicaid pays primary to DOE for Medicaid-covered services in a child's IEP or IFSP, all other liable third parties of the beneficiary should be billed primary to Medicaid for the provision of transportation services.

Therefore, while Medicaid coverage for transportation to school-based services is generally not allowable, there is an exception in the Medicaid statute which permits Medicaid coverage of transportation for children under IDEA only when receiving a Medicaid-covered service, and only when both the covered service and the transportation are listed in the IEP/IFSP. Depending on what method in which a state covers transportation, the reimbursement to transportation providers varies.

Case management is an activity which assists individuals eligible for Medicaid in

gaining and coordinating access to necessary care and services appropriate to the needs of an individual. Coordination is essential to preventing duplication of services while maximizing children's access to needed services. Schools can play an important case management role in identifying children's health problems and are well situated to provide a linkage among the family, health services, and social services, since they have access to the majority of children and adolescents in the country on a daily basis. Among other activities, case management can be used to assist families in identifying and choosing providers, scheduling appointments, accessing transportation, maintaining records, helping families to maintain contact with providers, and conducting follow-ups to ensure that children receive needed diagnosis and treatment.

States set their own specific provider qualifications, within broad Federal guidelines, as well as licensing or certification requirements and limitations. The qualifications established for the providers of case management services must be reasonably related to the case management services they are to perform. Any individual or organization, including schools or school districts, which meets the established provider qualifications and which undertakes to provide case management services may enroll as a Medicaid provider.

Case management takes many forms. In establishing a unique Medicaid program, each state has the flexibility to provide case management type services in any or all of the following ways:

as an administrative activity necessary for the proper and efficient administration of a State's Medicaid plan;

as a medical service under the authority of section 1905(a)(19) of the Act;

as an integral and inseparable part of a Medicaid covered service included in a state's approved Medicaid state plan;

in connection with the implementation of a primary care case management system under section 1915(b) of the Act;

as a service which can be provided under a home and community based services waiver under the authority of section 1915(c), (d), or (e) of the Act; and

as an optional targeted case management service under a state's Medicaid plan.

FFP for case management services may come from either administrative matching funds, or from medical assistance matching funds, depending on how the case management service is characterized. In some instances, the case management is appropriately reimbursed from either source. In cases where an activity may qualify as either a medical service or an administrative activity, states have the latitude to classify the function in either category. This decision should be made prior to claiming FFP because of the different rules that apply to each type of function under the Medicaid program.

Differences in how case management is claimed will affect the requirements for obtaining reimbursement. For example, while forms of documentation such as time studies, random moment sampling and cost allocation plans may be appropriate for claiming administrative FFP for activities in support of the state plan, these modes of documentation are not acceptable as a sole basis for Federal participation in the costs of Medicaid services. Medical service match requires an identifiable charge related to an identifiable service provided to a recipient. Furthermore, states cannot restrict provider participation, e.g., schools/school districts, or recipient participation, if these case management costs are claimed as medical assistance costs. Once the reimbursement is obtained, the funds are distributed according to any agreements between the school and the state Medicaid agency. In some instances, schools receive the Federal matching funds, and it is then up to the school to determine how Medicaid funds will be used to enhance current services.

Under section 1915(g)(2) of the Act, case management services are beneficiary-based activities, which have their purpose in the linking of eligible individuals with the most appropriate providers of care and services, regardless of the funding source of the care and services. Case management performed as an administrative activity however, is primarily concerned with the proper and efficient administration of the Medicaid program.

The determining factor in ascertaining whether a case management activity could qualify for administrative FFP is its relationship to the functioning of the Medicaid state plan. If the activity has a direct link with the appropriate operation or utilization of the Medicaid plan, it is considered necessary for the proper and efficient administration of the Medicaid program.

The following discussion clarifies the particular situations in which case management services may be furnished under Medicaid and highlights those program issues which typically arise when efforts are made to bring school-based providers into the Medicaid program.

Administrative Case Management

Case management can be provided as an activity found necessary for the proper and efficient administration of a state's Medicaid plan. This type of case management includes such activities as Medicaid utilization review, prior authorization for medical services or supplies, and Medicaid preadmission screening. Case management provided in this fashion must be limited to activities directly related to the administration of the Medicaid program and may not be used to help a person gain access to items and services outside Medicaid (such as special education services), even though these services may be necessary to the well-being of the person.

The state may restrict the providers of administrative case management. For example, case management activities in general administrative support of the state may be performed by employees of the state Medicaid agency. Case management activities may also be performed by a designee of the Medicaid agency. The designee could be another state agency such as Title V, the Health Department, or an entity with which the Medicaid agency has a contractual agreement. Such administrative case management, when limited to coordination of access to Medicaid funded medical services (42 CFR 441.61 and 441.62) may be found necessary for the proper and efficient administration of the state plan. Payment made for administrative case management services is made at the rate determined under section 1903(a) of the Act (that is, the 50 percent administrative match or if appropriate, one of the premium match rates provided in that section). With regard to any allowable administrative claim, payment may only be made for the percentage of time spent which is actually attributable to Medicaid-eligible individuals.

Because allowable administrative claims must be directly related to the administration of the Medicaid program and because the majority of services provided by schools will most likely be covered under medical service matching funds, most schools and school districts will play a very small part in administrative claiming.

Case Management as a Medical Service

Section 1905(r) of the Act requires states to provide any services included in section 1905(a) of the Act, when medical necessity for the service is shown by an EPSDT screen, whether or not such services are covered under the state plan. Care coordination, including aspects of case management, has always been an integral component of the EPSDT program. The purpose of case management in the EPSDT program is to assist children in arranging and obtaining health and related services in their communities. Since EPSDT screening, diagnosis, and treatment activities are frequently not conducted at one time or in one place, case management is critical to ensure that a child receives appropriate services on a timely basis. Schools provide an ideal setting for EPSDT case management services, as they are often the first to be aware of the specific medical needs of a child.

Case management may be used to reach out beyond the bounds of the Medicaid program to coordinate access to a broad range of services, regardless of the funding for the services to which access is gained. As an example, case management services could be used to help an adolescent with an abusive, alcoholic parent gain access to Alateen. Alateen is not a covered Medicaid service. However, a case manager could help the child gain access to the organization and its meetings.

Payment for case management services furnished under section 1905(a)(19) of the Act is as medical service at the FMAP rate. Claims should be fully documented for case management as a medical service. Claims should also include date of service, name of recipient, name of provider agency, name of the person providing the service, nature, extent or units of service, and place of service.

Lastly, we would note that states may elect the case management benefit under section 1905(a)(19) of the Act as a distinct state plan benefit, available to all recipients, regardless of the EPSDT program. However, at this time, we are unaware of any states who have elected this option.

Case Management Under Medicaid Waivers

With the inception of managed care and the increasing popularity of implementing Medicaid waivers, case management services have become an important element in service delivery. However, managed care settings can present unique complications in the provision of case management services by schools. In authorizing states to offer case management services, Congress recognized the

potential for duplicate payments, due to the same or similar services provided to children under both the managed care plans and the schools or school districts. As a result, under Federal law, Medicaid case management services may not duplicate payments by other programs to public agencies or private entities for the same purpose. Only in mutual collaboration can the provision of case management services be of a high quality and efficient and economic for all entities involved.

To diminish the threat of duplication, there are several approaches a school or school district can take. One approach would be for the state to request that school-related health services be exempt from the applicable managed care waiver. Although this approach allows schools to continue in their service provision without having to operate through a managed care organization, there still must be some coordination between the managed care entity and the school to establish the responsibilities of each.

The different types of waivers under which case management services are provided are discussed below.

(1)Freedom of Choice Waivers, Section 1915(b) - Freedom of Choice waivers authorized by section 1915(b) of the Social Security Act allow a state to request that the Secretary waive the freedom of choice requirements, in order to implement a primary care case management system (as described in 42 CFR 431.55(c)). (Please refer to the Managed Care section of the guide for more information on these types of waivers).

(2)Home and Community-Based Services (HCBS) Waivers, Section 1915(c) - Under section 1915(c) of the Act, states may request waivers of certain Federal requirements which impede the development of Medicaid financed community-based treatment alternatives. Federal regulations permit HCBS waiver programs to serve the elderly and disabled, the physically disabled, the developmentally disabled, or the mentally retarded or mentally ill. Section 1915(c) programs may also be targeted to individuals with a specific illness or condition, such as technology-dependent children or individuals with AIDS. Types of requirements that may be waived are statewideness, comparability, and community income and resource rules.

Case management is one of the many services that may be provided under a 1915(c) home and community-based waiver. In order to provide case management, the state must define it as part of a waiver request, and identify the

qualifications of the providers. Under such a waiver, case management services must be provided under a written plan of care which is subject to the approval of the state Medicaid agency. Schools should contact the state Medicaid agency if they are interested in developing case management services under a HCBS waiver, or to see if such a waiver is already implemented in the state.

(3)Research and Demonstration Waivers - Research and Demonstration Waivers are waivers granted under section 1115 of the Act. Depending on the structure of the 1115 waiver, case management services may be one of the many services offered to the 1115 population. Please see the managed care section the guide for more information on 1115 waivers.

Targeted Case Management

Most medical services providers routinely perform case management type services to some degree. As a result, case management services such as reminder calls for appointments, treatment plans, some referral costs, and patient education, are often provided as a component of a Medicaid-covered medical service. These case management services are not usually billed separately. However, when a distinct population is in need of more substantial case management services than typically provided by a physician, these activities may be covered as independent services.

In 1986, Congress recognized case management as a separate and distinct medical service eligible for reimbursement at the FMAP rate. Since then, Targeted Case Management services, often referred to as TCM, have been utilized to cover services which assist the individual in gaining access to needed medical, social, and educational services provided under a state's Medicaid program. Under TCM, states can waive the statewideness and comparability requirements. Therefore, under TCM, the state can target individuals by different criteria such as age, degree of disability, illness, or condition.

TCM must be provided to the targeted group of high risk individuals identified and characterized in the state plan. There is no limit to the number or size of target groups to whom a state may provide case management services. The target group may be the state's entire Medicaid population, or may focus on groups such as individuals with AIDS or HIV related disorders, pregnant women and infants up to age one, and developmentally disabled persons as defined by the state. Some states have approved TCM programs for children with disabilities, and for children under an IEP or IFSP. Geographically, states can also provide TCM on a less-than-statewide basis.

The receipt of case management services must be at the option of the individuals included in the target population. A beneficiary cannot be forced to receive case management services for which he or she might be eligible. Similarly, the state plan may not restrict the service choices of the individual. If a Medicaid beneficiary chooses to use a Medicaid-covered service, then the case manager must help the individual access that particular service. Providers also share in some protections. TCM cannot place restrictions on qualified providers (eligible individuals must be free to receive case management services from any qualified provider of TCM services) except for the chronically mentally ill (CMI) and the developmental disabled (DD). Still, in these instances the state can define "reasonable provider,"which in effect limits the pool of providers. If the state does intend to restrict providers for the CMI or DD population in this manner, it must indicate this in the state plan. CMI and DD individuals still retain free choice of any providers the state determines as qualified.

When case management services, as defined in section 1915(g)(2) of the Act, are also mandated under Early Intervention in IDEA, and furnished to an eligible individual (that is, a Medicaid eligible child who is included in the target group specified by the state in its approved Medicaid state plan) by a Medicaid participating provider, Medicaid may properly make payment for these services. This is because of section 1903(c) of the Act, which provides that HCFA may not "prohibit or restrict payment for medical assistance for covered services because such services are included in an IEP or IFSP." Therefore, as long as all other Federal requirements are met, FFP may be available for case management services, furnished under the authority of either section 1905(a)(19) or section 1915(g) of the Act, when these services are provided under IDEA.

Coverage of TCM remains an option to individual states. However, if a state does choose to cover TCM, the state must submit a SPA specifying the target group, the geographic area to be served, the service to be furnished, provider qualifications, and the arrangement under which providers will be paid. If these elements differ for subgroups, the state must submit separate amendments. When obtaining reimbursement, information that will be requested or documented by the state for claim submissions or case records of TCM include: date of service, name of the recipient, name of the provider agency, name of the person providing the service, nature and extent or units of service, and place of service delivery. In addition, providers must maintain case records which indicate all contacts with and on behalf of beneficiaries.

Because TCM activities are often confused with medical services or allowable administrative expenses, the following is a list of frequently misunderstood services that are **not** acceptable TCM services:

assessment costs for determining the individual's need for a physical or psychological examination or evaluation;

the provision of any medical treatment or service;

discharge planning from an institution (this is already required as a condition of payment of a hospital, IMD and ICF/MR - however TCM is an allowable activity within the last 30 days of institutionalization);

administrative activities such as eligibility determination, screening, intake, outreach and utilization review;

formal advocacy and developing new provider resources;

payment for the cost of the administration of other services or programs to which a recipient is referred. (e.g., education services, juvenile programs);

general administrative expenses of the Medicaid program; and

"prior authorization" of services.

In both the administration of the state plan and provision of Medicaid services, Medicaid law and regulations stipulate that preserving confidentiality of beneficiaries is of utmost importance. In addition, the confidentiality provisions of the Federal Family Education Rights and Privacy Act prohibit a computer match of Education and Medicaid data bases (except for the purposes of determining eligibility in which case DOE can submit information which can be matched to Medicaid information). While both the Medicaid confidentiality requirements and the DOE confidentiality requirements are in place as a safeguard to beneficiaries' privacy, these requirements can pose a barrier in the provision of Medicaid-covered school-based health services. This section explains the Medicaid confidentiality requirements, in addition to providing examples of how the provision of Medicaid-covered school-based health services has been achieved within these requirements.

Administration of the Plan

Section 1902(a)(7) of the Act requires that state Medicaid plans "provide safeguards which restrict the use and disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan." Therefore, disclosure of information concerning applicants and beneficiaries must be limited to purposes directly connected with the administration of the state Medicaid plan, which includes the delivery of medical services.

Purposes related to plan administration include establishing eligibility; determining the amount of medical assistance; providing services for recipients; and conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan (42 CFR 431.302). Therefore, release in permitted of information necessary for a provider to know which services, if any, Medicaid will pay for, and to what extent the provider should bill Medicare or other third-parties before billing Medicaid.

EPSDT

Because Medicaid law requires states to provide or arrange for the provision of EPSDT services, these services are considered activities directly connected with the administration of the plan. Activities such as outreach, informing, assistance with transportation, and scheduling appoints for services are also activities directly related to state plan administration.

The disclosure of medical information is privileged and may only be released with the patient's or in the case of children, parent or guardian's permission. Section 5320 of the SMM provides for the circumstances under which Medicaid information may be released, without the consent of the individual, to EPSDT providers and under interagency agreements relating to EPSDT. When the school is a qualified Medicaid provider, information regarding Medicaid eligibility may be collected by the school at the time a child registers for classes, or prior to receiving services.

An agency or provider with a written interagency agreement to perform EPSDT services that include outreach and/or assistance with transportation or scheduling appointments is considered an extension or arm of the Medicaid agency. Without his/her consent, an individual's name, address, medical assistance number, and related information may be furnished to such an agency or provider that meets specified confidentiality requirements as follows:

the entity must have criteria that specify the conditions for release and use of information about applicants and beneficiaries that are at least as restrictive as the standards applicable to the state itself;

Information access is restricted to persons or agency representatives subject to legal sanctions or standards of confidentiality at least comparable to those of the Medicaid agency;

The release of names of applicants and beneficiaries which may be used by outside sources is prohibited, and

Written permission is obtained from a family or individual before responding to a request for information from an outside source.

Standards of Confidentiality

Federal Medicaid regulations regarding confidentiality require that those receiving released recipient information must have standards of confidentiality comparable to those of the state Medicaid agency itself. This requirement is an additional condition for the release of information. However, a provider is not entitled to additional information simply because it is bound by contract and administrative regulations to protect confidentiality.

Releases of Information

Every exchange of information outside a discrete organizational entity or agency is considered a release. HCFA cannot authorize releases of recipient information unless there is a specific and direct connection to a Medicaid-covered service. To permit release of additional information to providers, there must be some basis to assure that the release meets the statutory and regulatory requirement of serving a purpose directly related to state plan administration. In addition, the entity receiving the Medicaid information may not release the information except as permitted by the SMM.

The beneficiary's consent is not necessary for releases which are not in response to outside requests but are, instead, essential to plan administration or service delivery. The requirement for recipient consent applies to requests for information from an outside source, not releases which are essential to ordinary program operations. Such consent was given at the time of application for Medicaid.

A school, as a Medicaid provider, may receive only the following information in reply to a query regarding a Medicaid-eligible:

Beneficiary's name;

Beneficiary's medical assistance identification number;

Beneficiary's Medicare health insurance claim number;

Social security number (if the individual agreed to the release of information when signing the application for assistance);

Date of birth;

Indication that the individual is eligible for the date or range of dates queried;

The scope of services for which the beneficiary is eligible;

Third party insurers, including policy number and type of coverage;

Service prior authorization requirements;
Copay amounts to be satisfied;

Lock-in/lockout restriction on the recipient record;

Unit or dollar limits and the portions/amounts;

Capitation plan enrollments, and

Names and telephone numbers of primary care physicians or case managers if the beneficiary is in a primary care case management plan.

Accessing Data

Providers may access the Medicaid eligibility information only by entering the beneficiary's Medicaid identification number or two or more of the following data elements: (1) beneficiary's full name, including middle initial; (2) beneficiary's date of birth, and (3) beneficiary's social security number; and by entering date or

dates of service(s).

Dates of Released Information

Requests for release of information to providers must include the date or a span of dates of service. This date (or dates) cannot be more than 12 months prior to the date of query. There is no known valid purpose connected to plan administration which can justify release of information over 12 months prior to the date of the inquiry. Provider claims must be submitted no later than 12 months from the date the service was provided. Assuming that a provider inquiry is related to a claim which the provider intends to file (which should be the only reason it makes an inquiry), eligibility information over 12 months old would therefore not be relevant.

Confidentiality and School-Based Services

Schools cannot receive a list of children who are Medicaid beneficiaries or eligibles, as the Medicaid Agency may not submit lists of eligibles to other agencies. In order to compile such a list, the school or school system must first submit to the Medicaid Agency a list of children receiving services for Medicaid Agency confirmation. The Medicaid Agency may then run lists from an education agency against its own files with replies to Education only for those children found to be already eligible for Medicaid.

State Examples

Several Medicaid agencies and school systems have solved the confidentiality problem in specific ways as discussed below.

THE DISTRICT OF COLUMBIA

The District of Columbia, in its new managed care program through an 1115 waiver for children and youth with special health care needs, asks the parent or guardian to sign permission for release of records at the time of enrolling in the managed care program.

MASSACHUSETTS

In Massachusetts, for students receiving special education services, as the student's IEP is being developed, some schools attempt to receive parental permission to bill Medicaid and the child's Medicaid identification number. Massachusetts sends a mailing to the parents explaining that parental permission is required for the schools to bill Medicaid. Most parents give consent.

NEW YORK

New York's application for medical assistance is an example of how one state has solved the problem of confidentiality. The eligibility form has been revised to give permission for release of information. The form permits the release of any information regarding the educational

records necessary for claiming Medicaid reimbursement for health-related educational services.

School-based health care is an efficient method in providing necessary medical care to Medicaid-eligible children and youth. From HCFA's standpoint, schools present a valuable opportunity to provide medical services to beneficiaries in a setting with ideal access. For schools, the Medicaid program presents an opportunity for funding medical services provided to children both under and apart from the IDEA.

As noted throughout the guide, collaboration between schools and the Medicaid program is a difficult process. Although the Federal requirements for the Medicaid program apply in all states, because Medicaid is a joint Federal/state program, each state program has its own unique characteristics. Under broad Federal guidelines, each state not only develops its own requirements but also designs and develops its own system for providing medical services to Medicaid-eligible children. While this guide attempts to explain the Federal requirements associated with obtaining Medicaid funding for school-based services, the state is the primary source for specific information on its Medicaid requirements for school-based services. HCFA encourages schools, school districts and LEAs to work collaboratively with the State Medicaid Agency, for the provision of Medicaid-covered services to

eligible children.

Definitions

Amount, Duration and Scope (42 CFR 440.230) - Extent of coverage of services available in the state as stipulated under the state plan. The amount, duration and scope of services in a state Medicaid plan must be sufficient to achieve their purpose.

Capitation Payment - A method of paying participating providers (generally managed care organizations) a fixed amount per member per month for each beneficiary assigned to or enrolled with the provider. For these payments, the provider is obligated to provide or arrange for a defined range of health services to these members.

Code of Federal Regulations (CFR) - The Federal regulations of the Medicaid program derive from Title XIX of the Social Security Act, found primarily under Public Health, Volume 42.

Comparability - Requires states, subject to certain exceptions or potential waivers, to cover the same amount, duration and scope of a service to beneficiaries within an eligibility group and to all beneficiaries in certain eligibility groups.

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) - Mandatory Medicaid benefit for children under the age of 21 which at a minimum, must include screening services, vision services, dental services, hearing services and other necessary diagnostic and treatment services within the Medicaid statute whether or not the services are generally included

under the state's Medicaid plan.

Federal Financial Participation (FFP) - The amount of Federal money a state receives for expenditures under its Medicaid program. For most administrative expenditures, states receive FFP at a rate of 50%. For medical assistance percentages (that is, payment for the cost of medical care and services) states receive FFP at a rate referred to as the Federal Medical Assistance Percentage (FMAP). The FMAP is determined by a formula which compares the state's per capita income level with the national average for per capita income (ranging from 50% - 83%).

Freedom of Choice - The Medicaid statute and regulations stipulate that recipients may obtain services from any qualified Medicaid provider that undertakes to provide services to them. A state may obtain a waiver of this requirement.

Health Care Financing Administration (HCFA) - Federal Agency responsible for the oversight and administration of the nation's two main public health programs, Medicare and Medicaid. HCFA administers the Medicare and Medicaid programs through 10 Regional Offices located throughout the country. States deal with the HCFA Regional Offices assigned to their state regarding any policy and operational questions. The Regional Offices, if necessary, will often involve Medicaid staff in HCFA's Central Office in Baltimore on issues of importance that arise on the administration of their states' Medicaid programs.

Health Maintenance Organization (HMO) - An entity that contracts on a prepaid, capitated risk basis to provide comprehensive health services to beneficiaries.

Individuals with Disabilities Education Act (IDEA) - Formally called the Education of the Handicapped Act, it contains two parts: Part B of IDEA was designed to ensure that school-aged children with special education needs receive a free, appropriate public education. Under Part B, schools must prepare and Individualized Education Plan (IEP) as appropriate for a child which specifies all of the special education and "related (health) services" needed by the child. Part H of IDEA, provides for early intervention programs that include all of the available developmental services needed by a toddler or infant and the development of an Individualized Family Education Plan (IFSP). Medicaid can potentially pay for some of the health-related services in and IEP and IFSP as discussed in this guide.

Office of Management and Budget (OMB) Circular A-87 - Federal government publication which contains the cost principles for determining allowable costs of programs administered by the states and local governments. It requires that costs be "necessary and reasonable" and "allocable" to the Medicaid program to ensure Medicaid does not supplant other allocable programs and only pays for the portion of the service that is appropriate.

Managed Care Organization (MCO) - An entity that combines the health care delivery and financing of services. The entity is generally paid a prepaid, capitated premium and assumes financial risk for the services to be provided to or arranged for enrolled beneficiaries. MCO models included fully-capitated, partially capitated and primary care case management.

Medical Necessity - A term used to refer to the appropriateness of medical intervention and treatment for certain medical conditions. There is no Federal Medicaid definition of medical necessity. States determine medical necessity for the purposes of making coverage decisions under their own individual Medicaid programs. In order for FFP to be available, Medicaid services must be medically necessary.

State Medicaid Agency - The organization in each state directly responsible for the administration of the Medicaid program. Each state must designate a "single state agency" for purposes of accountability to HCFA, even though a number of states (and local) agencies may help the program and/or function as medical providers.

State Medicaid Manual (SMM) - Manual issued by HCFA used to assist states in implementing specific requirements in their Medicaid programs.

State Plan - Document between the states and Federal government which details the scope of the Medicaid program in the state by listing the services offered, any applicable requirements and limitations and the payment rates for those services. The state plan consists of preprinted material that covers the basic requirements, and individualized content that reflects the characteristics of the particular state Medicaid program. The state plan is submitted by the state and subject to approval from HCFA.

State Plan Amendment (SPA) - States may, at any time, submit amendments to their State Plan in order to change the coverage of services or the payment rates for covered services. The amendments are reviewed and processed according to specific statutory timelines by the Regional Offices with consultation and review by Central Office staff, if necessary.

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Hartford, CT 06106
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Fax: 203-951-9544

REGION II - NEW YORK
HCFA - New York Regional Office
26 Federal Plaza, Room 3811
New York, NY 10278
212-264-2775

NEW YORK
Department of Social Services
40 North Pearl Street
Albany, NY 12237
518-474-2482
Fax: 518-473-6210

NEW JERSEY
Division of Medical Assistance and Health Services
CN-712, 7 Quakerbridge Plaza
Trenton, NJ 08625
609-588-2600
Fax: 609-588-3583

PUERTO RICO
Medicaid
Office of the Economic Assistance to the
Medically Indigent
Department of Health
G.P.O Box 70184
809-765-1230
Fax: 809-766-2240

VIRGIN ISLANDS
Bureau of Health Insurance and Medical Assistance
Department of Health
210-3A Altona, Suite 302
Frostco Center
Charlotte Amalie, VI 00802
809-774-4624
Fax: 809-774-4918

REGION III - PHILADELPHIA
HCFA - Philadelphia Regional Office
3535 Market St., Room 3100
Philadelphia, PA 19104
215-596-4515

PENNSYLVANIA
Medical Assistance Programs
Department of Public Welfare
Room 515
P.O. Box 2675
Harrisburg, PA 17105-2675
717-787-1870
Fax: 717-787-4639

MARYLAND
Department of Mental Health and Hygiene
Herbert R. O'Connor Bldg.
201 W. Preston St, 5th Floor
Baltimore, MD 21201
410-225-6505
Fax: 410-225-6489

DELAWARE
Department of Health and Social Services
1901 North Dupont Highway
New Castle, DE 19720
302-577-4901
Fax: 302-577-4899

VIRGINIA
Department of Medical Assistance Services
600 East Broad St., Suite 1300
Richmond, VA 23219
804-786-7933
Fax: 804-371-4981

WEST VIRGINIA
Bureau for Medical Services
Department of Health and
Human Resources
7012 McCorkle Ave SE
Charleston, WV 25304
304-926-1700
Fax: 304-926-1776

WASHINGTON D.C.
Department of Human Services
2100 ML King, Jr., Ave., S.E., Suite 302
Washington D.C. 20020
202-727-0735
Fax: 202-610-3209

REGION IV - ATLANTA
HCFA - Atlanta Regional Office
101 Marietta St.
Atlanta, GA 30323
404-331-0065

KENTUCKY
Department for Medicaid Services
Third Floor
275 East Main St.
Frankfort, KY 40621
502-564-4321
Fax: 502-564-3232

TENNESSEE
Medicaid Operations
Department of Finance and Administration
729 Church St.
Nashville, TN 37247-6501
615-741-0213
Fax: 615-741-0882

NORTH CAROLINA
Division of Medical Assistance
Department of Human Resources
1985 Umstead Drive
P.O. Box 29529
Raleigh, NC 27626-0529
919-733-2060

SOUTH CAROLINA
Department of Health and Human Services
P.O. Box 8206
Columbia, SC 29202-8206
803-253-6100
Fax: 803-253-4137

Fax: 919-733-6608

GEORGIA
Department of Medical Assistance
2 Peachtree St, NW
27th Floor, Suite 100
Atlanta, GA 30303-3159
404-656-4479
Fax: 404-651-6880

MISSISSIPPI
Division of Medicaid
Office of the Governor
Suite 801, Robert E. Lee Bldg.
239 N. Lamar St.
Jackson, MS 39201-1399
601-359-6056
Fax: 601-359-6048

ALABAMA
Alabama Medicaid Agency
501 Dexter Ave.
P.O. Box 5624
Montgomery, AL 36103-5624
205-242-5600
Fax: 205-242-5097

FLORIDA
Agency for Health Care Administration
P.O. Box 13000
Tallahassee, FL 32317-3000
904-488-3560
Fax: 904-488-2520

REGION V - CHICAGO
HCFA - Chicago Regional Office
105 W. Adams St.
Chicago, IL 60603-6201
312-353-8720

OHIO
Office of Medicaid
Department of Human Services
30 E. Broad St., 31st Floor
Columbus, OH 43266-0423
614-644-0140
Fax: 614-752-3986

MICHIGAN
Department of Social Services
P.O. Box 30037
Lansing, MI 48909
517-335-5001
Fax: 517-335-5007

INDIANA
Medicaid Policy and Planning
Family and Social Services Administration
Room W382
402 W. Washington St.
Indianapolis, IN 46204-2739
317-233-4455
Fax: 317-232-7382

ILLINOIS
Division of Public Aid
201 S. Grand St., East, 3rd Floor
Springfield, Il 62762
217-782-2570
Fax: 217-524-7232

WISCONSIN

MINNESOTA

Department of Health and Social Services
1 West Wilson St., Room 250
Madison, WI 53701
608-266-2522
Fax 608-266-1096

Department of Human Services
444 Lafayette Rd., 6th Floor
St. Paul, MN 55155-3852
612-297-3374
Fax: 612-297-3230

REGION VI - DALLAS

HCFA - Dallas Regional Office
1200 Main Tower Bldg., Room 2000
Dallas, TX 75202
214-767-4461

LOUISIANA

Bureau of Health Services Financing
Department of Health and Hospitals
P.O. Box 91030
Baton Rouge, LA 70821-9030
504-342-3890
Fax: 504-342-3893

ARKANSAS

Division of Medical Services
Department of Human Services
P.O. Box 1437, Slot 1100
Little Rock, AR 72203-1437
501-682-8292
Fax: 501-682-8013

TEXAS

Health and Human Services Commission
P.O. Box 13247
Austin, TX 78711
512-424-6517
Fax: 512-424-6585

OKLAHOMA

Health Care Authority
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK 73105
405-530-3439
Fax: 405-530-3470

NEW MEXICO

Medical Assistance Division
Human Services Department
P.O. Box 2348
Santa Fe, NM 87504-2348
505-827-3106
Fax: 505-827-3185

REGION VII - KANSAS CITY

HCFA - Kansas City Regional Office
New Federal Office Bldg.
601 E. 12th St., Room 235
Kansas City, MS 64106
816-426-3406 Ext. 3318

MISSOURI

Division of Medical Services
Department of Social Services
615 Howerton Court

IOWA

Division of Medical Services
Department of Human Services
Hoover State Office Bldg., 5th Floor

P.O. Box 6500
Jefferson City, MO 65102-6500
314-751-6922
Fax: 314-751-6564

Des Moines, IA 50319
515-281-8794
Fax: 515-281-4597

NEBRASKA

Medical Services Division
Department of Social Services
301 Centennial Mall South, 5th Floor
Lincoln, NE 68509-5026
402-471-9718
Fax: 402-471-9092

KANSAS

Department of Social and Rehabilitation Services
Docking State Office Bldg.
Room 628 South
915 Harrison St.
Topeka, KS 66612
913-296-3981
Fax: 913-296-4813

REGION VIII - DENVER

HCFA - Denver Regional Office
Federal Office Bldg.
1961 Stout St., Room 576
Denver, CO 80294-5358
303-844-4024 ext. 381

COLORADO

Health and Medical Services
Department of Health Care Policy and Financing
1575 Sherman St., 4th Floor
Denver, CO 80203-1714
303-866-6092
Fax: 303-866-2803

UTAH

Division of Health Care Financing
Department of Health
P.O. Box 16700
Salt Lake City, UT 84116-0700
801-538-6406
Fax: 801-538-6099

WYOMING

Division of Health Care Financing
Department of Health
6101 Yellowstone Rd.
Cheyenne, WY 82002
307-777-7531
Fax: 307-777-6964

SOUTH DAKOTA

Medical Services
Department of Social Services
Richard F. Kneip Bldg.
700 Governors Drive
Pierre, SD 57501-2291
605-773-3495
Fax: 605-773-6834

NORTH DAKOTA

Department of Human Services
600 E. Boulevard Ave.
Bismarck, ND 58505-0261
701-328-2321
Fax: 701-328-2359

MONTANA

Department of Social and Rehabilitation Services
P.O. Box 4210
111 N. Sanders
Helena, MT 59604-4210
406-444-4540

Fax: 406-444-1861

REGION IX - SAN FRANCISCO

HCFA - San Francisco Regional Office
75 Hawthorne St., 5th Floor
San Francisco, CA 94105
415-744-3579

CALIFORNIA

Medical Care Services

Department of Health Services
714 P St., Room 1253
Sacramento, CA 95814
916-657-1425
Fax: 916-657-1156

ARIZONA

Arizona Health Cost Containment System (AHCCS)
801 E. Jefferson St.
Phoenix, AZ 85034
602-271-4422 ext. 4053
Fax: 602-252-6536

NEVADA

Welfare Division
Department of Human Resources
2527 N. Carson St.
Carson City, NV 89710
702-687-4867
Fax: 702-687-5080

HAWAII

Department of Human Services, Med-QUEST
P.O. Box 339
Honolulu, HI 96809-0339
808-586-5391
Fax: 808-586-5389

GUAM

Dept. Of Public Health and Social Services
P.O. Box 2816
Agana, GU 96910
011-671-734-7269
Fax: 011-671-734-5910

AMERICAN SAMOA

Department of Health
LBJ Tropical Medical Center
Pago Pago, AS 96799
011-684-633-4590
Fax: 011-684-633-1869

REGION X - SEATTLE

HCFA - Seattle Regional Office
2201 6th Ave
Mail Stop RX-40
Seattle, WA 98121
206-615-2400

WASHINGTON

Department of Social and Health Services
P.O. Box 45080
Olympia, WA 98504-5080
206-753-1777
Fax: 206-586-5874

OREGON

Department of Human Resources
500 Summer St., NE
Human Resources Bldg., 3rd Floor
Salem, OR 97310-1015
503-945-5881
Fax: 503-373-7823

IDAHO

Division of Welfare Administrative Office
Department of Health and Welfare
Towers Bldg., 2nd Floor
P.O. Box 83720
Boise, ID 83720-0036
208-334-5747
Fax: 208-334-0657

ALASKA

Department of Health and Social Services
P.O. Box 110660
Juneau, AK 99811-0660
907-465-3355
Fax: 907-465-2204