DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Refer to: MOB:14

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MAY 13 1992

Kathryn T. Glynn
Chief, Office of Medicaid
Ohio Department of Human Services
30 East Broad Street
Columbus, Ohio 60603

Dear Ms. Glynn:

This letter is in response to your letter of April 15, 1992 in which you requested comments on proposed methods of verifying children's Medicaid eligibility in an effort to expand Medicaid coverage for habilitation services provided in the school setting. Specifically, you mentioned the possibility of using the provision governing EPSDT and\or information obtained from the Local Education Agencies (LEA) school lunch program.

Medicaid eligibility information is confidential and may not be freely exchanged: however, verification of probable Medicaid eligibles by Medicaid providers of services is permissible. In 1989, this office sent out CRSL 35-89 which addressed guidelines for State contracts with outside parties to confirm to providers a Medicaid recipient's eligibility. In writing these guidelines, the extent to which Medicaid eligibility information could be released was addressed. The guidelines specified, in part, that:

a. Medicaid agencies may contract with an outside party to furnish eligibility information; however, the outside party must be an agent of the State Medicaid agency and must enter into a contract with the State Medicaid agency;
b. No agent of the State Medicaid agency who disseminates eligibility verification information can bill on behalf of providers;
c. Agents of the State Medicaid agency must agree, in writing, not to use information for purposes other than to give Medicaid providers eligibility information. The eligibility information may be given only as a direct result of a provider inquiry on a specific individual; and
d. The agent may furnish eligibility data only to providers duly enrolled in the State's Title XIX program.

e. Under no circumstances may the agent release the entire Medicaid eligibility tape to a provider.

Schools may be providers of Medicaid services provided that they meet all of the criteria for participation and meet the provider definitions and standards under Federal and State laws and regulations and under the State plan. The schools may not, however, receive tapes of Medicaid eligible clients or direct certification of Medicaid eligibility. tf the school is a provider of Medicaid services, the school can verify eligibility of clients selecting them as their provider and of clients referred to them. The school may submit a name or a list of names of probable Medicaid eligibles to the Medicaid agency for verification.

In order for schools to be participating providers of services, they must meet all related provider qualifications in the State plan. However, Medicaid agencies cannot restrict providers of services to schools. You specifically indicated interest in the expansion of Medicaid coverage to habilitation services in the school setting as well as the provision of EPSDT services in me school setting. If by providing habilitation services in the school setting, you mean the provision of rehabilitation services by habilitation centers, then the school must meet the qualification for provision of these services under your State plan and 42 CFR 440.130(d).

As you are aware, EPSDT services include the administrative activities of outreach, informing, assistance with transportation, and scheduling appointments for services and examination, diagnosis, and treatment. Section 5230 of the State Medicaid Manual addresses coordination with related agencies and programs. Federal financial participation (FFP) is available to cover costs of public agencies for providing direct support to the Medicaid program in administering the EPSDT program. Agreements between the Medicaid agency and any other public agency must specify, in addition to the pat-ties, their intent and the date, items, such as: the services each party offers, the cooperative and collaborative relationships at the State level, the kinds of services provided by local counterparts, and the methods for early identification of individuals under twenty-one (21) needing health services, reciprocal referral, etcetera. Section 5122 A.3. of the State Medicaid Manual permits school health programs to be providers of EPSDT screening examinations: provided that the school health program assures that the services meet the minimum standarcs set by the Medicaid agency for these services.

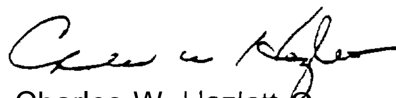
Section 5230 C. of the State Medicaid Manual specifically addresses ways for schools to relate to EPSDT and refers to a publication, EPSDT: A Guide for Education Programs. This publication addresses three possible ways for schools to participate in the EPSDT programs:

a. The school as an outreacher: Under this model, the school acts as an outreach agent for the EPSDT program. EPSDT outreach is a process of identifying eligible clients, informing them of services available, and recruiting them for participation in the program. This could be accomplished in conjunction with other outreach activities.
b. The school as a Screener: This model requires that schools serve under an agreement with the appropriate State and local agencies to provide screening for eligible children. In order for a school to qualify as a certified provider, the school must employ qualified health personnel as specified in Federal and State regulations and the State plan.
c. The school as a fuil range provider: Schools providing a full range of EPSDT services must operate under the terms of an agreement with the Medicaid agency. The school must be in a position to provide medicai diagnosis and treatment in addition to screening services. Services must meet all applicable Federal and State standards and must be under the direct authority or control of the school district.

Common to all of these models is the issue of confidentiality of information which identifies Medicaid eligible children and the appropriate safeguards which must be followed in order to ensure confidentiality.

If you have any questions or need additional information, please contact me at (312) 886-5354 or Candace L. Burlew of my staff at (312) 353-2322.

Sincerely,



Charles W. Hazlett
Associate Regional Administrator
Division of Medicaid

George V. Voinovich
Governor

Ohio Department of Human Services

30 East Broad Street. Columbus, Ohio 432664423

April 15, 199.2

Charles Hazlett
Health Care Financing Administration
135 W. Adams Street , 15th floor
Chicago, Illinois 60603

Dear Mr. Hazlett:

The purpose Of this letter is to identify possible methods of verifying children's Medicaid eligibility which would facilitate the expansion of Hedicaid coverage to habilitation services provided in school settings. Although the provision of EPSDT services in school settings is not yet occurring, we do envision moving in that direction. At this juncture, it would be helpful to develop a more clear understanding of the following concepts:

The use of EPSDT administration far outreach and follow-up.

The use of EPSDT administration for outreach and follow-up uhen the contract agency is also a provider.

The use of ADC eligibility information from the Free Lunch Program in schools and Medicaid billings.

AS I am sure you are well aware, Ohio and many states arworking toward providing better access to services for children. Hedicaid reimbursement plays a major role in ensuring that medical services are accessible to children. These initiatives will probably be financed with existing revenues from "non-Medicaid" agencies because the bottom Line is that most states, Including this one, do not have new revenues to keep pace with the expanded eligibility requirements, the medically necessary services requirements of EPSDT, the "look-alike" situation for FQHCs and a host of other requirements. The logical management step is to use existing funds, often budgeted for non-Uedicaid programs to help finance the care to kids.

An Equal Opportunity Employer

Although it is somewhat unnerving to see the growth of Hedicaid, there is the opportunity to use Medicaid funding to vertically integrate systems. of care and finance that often serve the same populations. For example, Medicaid can be instrumental in bringing together a mental health agency and a children's services board because it makes sense to develop a system that will accommodate the mental health needs of kids regardless of whether the kid first hits the "mental health" or "children's services" system. Medicaid funding can provide an incentive for the two systems of care to integrate so that a mentally ill child goes through one system *of care.* The same would be said for the school systems' education *of* the handicapped and *the* MR/DD's habilitation center programs. Hedicaid funding can be used as a major incentive that promotes integrated approaches to the delivery of care to kids. The more we are able to integrate systems of care the more closely we approach *the* "one stop shopping" service delivery concept.

As you consider the questions raised in this letter, I would request that you understand that fundamental to any system trying to deliver services to children who have Medicaid coverage is knowing who those children are. Kids do not go to school with identification that indicates their Medicaid eligibility. Medicaid eligibility is base level information needed for billing. This department is interested in facilitating a method for schools to obtain the base level of information necessary to begin the Medicaid billing process. We are acutely aware that should there be any insurance coverage of the service s), the third party payor would need to be billed. We understand that *the* "free and appropriate public education* (FAPE) provisions governing education programs do not govern the Medicaid program.

EPSDT Administration for Outreach and Follow-up

Section 5230 of the State Medicaid Manual identifies the importance of coordinating the provision of EPSDT services with other programs, including the coordination with programs offered by the Local Education Agency (LEA.) The first area *of* focus would be the use of the EPSDT provisions as a vehicle for authorizing a *contract* that would enable an LEA to act as an EPSDT "agent." Included in the "agent" activities would *be* outreach activities, health care coordination, coordination of services that *are* not health care via referral, and follow-up. In Ohio we have relied on County Departments *of* Human Services to perform such traditional EPSDT activities. We would anticipate that a CDHS could contract with another entity (an LEA) to perform all or some of the traditional EPSDT activities. It would be the state's intention to claim such activities as an administrative cost and we are exploring this possibility with an *LEA* in Cincinnati and the Hamilton County Department of Human Services. Although we believe this to be relatively straightforward and allowable, we are *interested* in any comments you might have regarding this initiative.

The Use of EPSDT Administration When the Agency is also a Provider Service

The second situation is probably less straightforward since it recognizes the multiple roles a public entity performs. It would appear to us that an entity could operate in both an administrative capacity, performing EPSDT administration (case management) and a provider capacity, providing counseling, day treatment or some other therapy. In this situation it would seem counterproductive to not use information, including valid Medicaid identification numbers, to perform "program" services and to bill for such services.

We are interested in this second version of using EPSDT administration because it is a very logical next step, for an agency that has other resources i.e., counselors, physical therapists etc. at its disposal. I would suggest that in many respects our (federal and state) regulations have a "Norman Rockwell" type of perspective. That is we have regulation9 for physician (and clinics) that treat the.patient, public agencies that do social work and refer patients to physicians, and third party payors who pay for the services. The reality of the situation, particularly for kids, is that many public entities perform all three tasks and do not fit into just one of our discrete ways of categorizing entities. An LEA has an obligation much like a third party payor which includes a fiscal responsibility to provide or pay for services related to a child's Individualized Education Plan (IEP). The school system acts in a physician/clinic capacity when it provides many of these services through its employees or persons under contract. The LEA also has an administrative/case management role in trying to assure that many services required by the child are provided elsewhere in the community.

We need to look for flexible ways to use the regulations since many public system9 of care do not fit cleanly into a single regulator+ category. For example, I am not aware of a regulation that would prohibit a provider of medical services from providing EPSDT administration. Absent such a regulation and given the all encompassing definition for EPSDT (whatever is determined to be medically necessary,) I have some difficulty understanding why a school system could not do both function9 - EPSDT administration and service delivery.

ADC Eligibility Information From the School Lunch Program

Under this scenario the LEA would use identifying information from children who are eiigible for the free lunch program; this information, which was originally generated by the County Department of Human Services (CDHS), allow9 the schools to determine who is eligible for the free lunch program. The school lunch program information would be generated back to the CDHS to verify Medicaid eligibility and to obtain an accurate Medicaid identification number. The automatic certification to LEAS of client food stamp and/or AFDC eligibility is permissable under 4s CFR 205.50 (a)(1)(C). This regulation provides for the disclosure of information connected with the administration of any other Federal or federally assisted program.

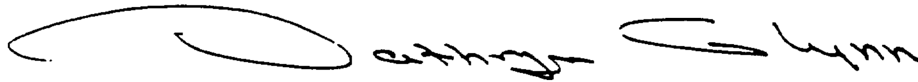
it's interesting to note that one reason Ohio uses automatic certification of eligibility for the free lunch program is that reliance upon application9 completed by the parents resulted in 55-60% of eligible kids not taking advantage of the program. Either the parent(s) would not complete the application or the application would not be returned by the child. A direct certification by the state nearly double9 the number of kid9 that can be fed. The same opportunity exists for the provision of health care.

Although direct certification of a Medicaid eligibility by the state to the LEA's would be the most administratively streamlined way of doing business and worth working toward, a second best alternative would be to use the existing information for the free lunch program to match against the Medicaid eligibility files of the county Department of Human Services and verify Medicaid eligibility. We would suggest that this verification comports with 42 CFR 431.306(d) and 42 CFR 431.302(b) and (c) since the information is being used to verify eligibility and is directly related to the administration of the state plan.

Summary

This department is interested in facilitating an exchange of Hedicaid information specific to kids. Absent a statewide certification of Hedicaid eligibility to government entities serving kids, we are interested in the possibility of using the provision governing EPSDT and/or verification of Medicaid eligibility using the information from the LEA's school lunch program. Any insight you can provide regarding these concerns is appreciated.

Sincerely,



Kathryn T. Glynn
Chief, Office of Hedicaid

KTG/FXB/cam

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