Table of Contents

State/Territory Name: District of Columbia

State Plan Amendment (SPA) #: 14-006

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CENTERS FOR MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

SWIFT #123120144016

SEP 08 2015

Claudia Schlosberg, J.D.
Senior Deputy Director/State Medicaid Director
Department of Health Care Finance
441 4th Street, N.W., Suite 900 South
Washington, D.C. 20001

Dear Ms. Schlosberg:

I am writing to inform you that we have reviewed the District of Columbia's State Plan Amendment (SPA) 14-006 entitled, Non Public Schools Reimbursement Methodology for School Based Health Services (SBHS). This amendment delineates a reimbursement methodology for SBHS in nonpublic school settings.

We are pleased to inform you that, after extensive review, this amendment is approved; its effective date is October 1, 2014.

A copy of the approved SPA pages and signed CMS-179 form are included under this cover.

If you have any further questions regarding this SPA, please contact Alice Robinson Penn at 215-861-4261 or by email at Alice.RobinsonPenn@cms.hhs.gov.

Sincerely,

[redacted]

Francis McCullough
Associate Regional Administrator

Enclosures

cc: M. Diane Fields, DHCF

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **14-006**	2. STATE District of Columbia
	3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act	
TO: Regional Administrator Centers for Medicare & Medicaid Services Department of Health and Human Services	4. PROPOSED EFFECTIVE DATE October 1, 2014	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION Sections 1905(a) and 1902(a)(23) of the Act 42 CFR 440.110 (various); 42 CFR 440.80	7. FEDERAL BUDGET IMPACT a. FFY 15 $ 5,300,000 b. FFY 16 $ 5,450,000
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19B, Part 1 pp. 20-26, 26.1 (new) and 26.2 (new)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* Attachment 4.19B, Part 1 pp. 20-26

10. SUBJECT OF AMENDMENT:
Nonpublic Schools Reimbursement Methodology for School Based Health Services

11. GOVERNOR'S REVIEW *(Check One)*
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Resolution Number: PR20-0772

12. SIGNATURE OF STATE AGENCY OFFICIAL [redacted]	16. RETURN TO Claudia Schlosberg, JD Senior Deputy Director/State Medicaid Director Department of Health Care Finance 441 4th Street, NW, 9th Floor, South Washington, DC 20002
13. TYPED NAME Claudia Schlosberg, JD	
14. TITLE Senior Deputy Director/ State Medicaid Director	
15. DATE SUBMITTED June12, 2014	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED June 12, 2014	18. DATE APPROVED SEP 08 2015
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL October 1, 2014	20. SIGNATURE OF REGIONAL OFFICIAL [redacted]
21. TYPED NAME Frances McCullough	22. TITLE Associate Regional Administrator

23. REMARKS

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

28. Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services

REIMBURSEMENT METHODOLOGY FOR SCHOOL BASED HEALTH SERVICES (SBHS)

EPSDT School based health services (SBHS) are delivered by District of Columbia Public Schools (DCPS) and Public Charter Schools (DCPCS), referred to as "providers" for Section 28.I of this Attachment, in DCPS and DCPCS school settings within the District of Columbia.

Providers who arrange for the delivery of SBHS services by a privately owned or operated entity meeting the definition of "Nonpublic special education school or program" as defined in D.C. Official Code § 38-2561.01, are referred to as "nonpublic programs". Nonpublic programs must be certified as "Full Approval Status" schools by the Office of the State Superintendent of Education (OSSE) in accordance with D.C. Official Code § 38-2561.07 and 5-A DCMR §§ 2800 *et seq.*, and shall be used when a provider is unable to provide free and appropriate public education to the beneficiary. A nonpublic program shall submit claims for SBHS to OSSE, and OSSE shall maintain enrollment with DHCF as the SBHS nonpublic program provider of record. Reimbursement to OSSE for SBHS delivered in nonpublic programs shall be subject to cost based reimbursement.

SBHS are defined in Supplement 1, Attachment 3.1-A pages 6, 6a and 6b and include the following Medicaid services:

1. Skilled Nursing Services
2. Psychological Evaluation Services
3. Behavioral Supports (Counseling Services)
4. Orientation and Mobility Services
5. Speech-Language Pathology Services
6. Audiology Services
7. Occupational Therapy Services
8. Physical Therapy Services
9. Specialized Transportation
10. Personal Care Services
11. Nutrition Services

I. Cost-Based Reimbursement for District of Columbia Public Schools (DCPS) and Public Charter Schools (DCPCS)

A. Direct Medical Payment Methodology

Providers are being paid on a cost basis for SBHS provided on or after October 1, 2009. Providers will be reimbursed interim rates for SBHS direct medical services per unit of

service at the lesser of the provider's billed charges or the statewide enterprise interim rate. On an annual basis, a District-specific cost reconciliation and cost settlement for all over and under payments will be processed based on a yearly filed CMS-approved cost report.

B. Interim Payments

The units of service are defined by each Health Insurance Portability and Accountability Act (HIPAA) compliant current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Direct medical services may be encounter-based or in 15-minute unit increments. The interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and cost settlement for that period.

C. Data Capture for the Cost of Providing Health-Related Services

Data capture for the cost of providing health-related services will be accomplished utilizing the following data sources:

- Total direct and indirect costs, less any federal payments for these costs, will be captured utilizing the following data sources:

  a. School Based Health Services CMS-approved Cost Report received from schools
  b. Random Moment Time Study (RMTS) Activity Code 1200 (Direct Medical Services) and Activity Code 3100 (General Administration):
     i. Direct medical RMTS percentage
  c. School District specific IEP Medicaid Eligibility Rates (MER)

D. Data Sources and Cost Finding Steps

The cost report identifies SBHS costs by the following cost pools: 1) Medical costs; 2) Personal care costs; and, 3) Transportation costs. Change in the number of cost pools is determined during the CMS approval of the cost report and RMTS. The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1) Allowable Costs:

Direct costs for direct medical services include unallocated payroll and other costs that can be charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the description of covered Medicaid services delivered by DCPS and DCPCS, excluding transportation personnel. Other direct costs include costs

directly related to the approved direct services personnel for the delivery of medical services, such as medically-related purchased services, supplies and materials. These direct costs will be calculated on a Medicaid provider-specific level and reduced for any federal payments for these costs, resulting in adjusted direct costs. Allowable provider costs related to Direct Medical Services include: 1) Salaries; 2) Benefits; 3) Medically-related purchased or contracted services; and, 4) Medically-related supplies and materials.

The cost report contains the scope of cost and methods of cost allocation that have been approved by the CMS. Costs are obtained from the audited Trial Balance and supporting General Ledger, Journals, and source documents. They are also reported on an accrual basis.

Indirect Costs: Indirect costs are determined by applying the DCPS and DCPCS specific unrestricted indirect costs rate to their adjusted direct costs. District of Columbia Public Schools and Public Charter Schools use predetermined fixed rates for indirect costs. The District of Columbia Public Schools, Office of the Chief Financial Officer, in cooperation with the United States Department of Education (ED), developed an indirect cost plan to be used by DCPS and DCPCS. Pursuant to the authorization in 34 CFR § 75.561(b), DCPS and DCPCS approves unrestricted indirect cost rates for schools, which are also considered the cognizant agencies. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

Indirect Cost Rate:

a. Apply the District of Columbia Public Schools and Public Charter Schools Unrestricted Indirect Cost Rate (UICR) applicable for the dates of service in the rate year.
b. The DCPS and DCPCS UICR is the unrestricted indirect cost rate calculated by the District of Columbia Public Schools, Office of the Chief Financial Officer.

2) Time Study: A time study that incorporates CMS-approved methodology is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. This time study methodology will utilize two mutually exclusive cost pools representing individuals performing Direct Medical Services. A sufficient number of personnel for each cost pool will be sampled to ensure time study results that will have a confidence level of at least 95 percent (95%) with a precision of plus or minus five percent (5%) overall. The Direct Medical Service time study percentage is applied against the Direct

Medical Service cost pool. Results will be District-wide so every school will have the same time study percentages.

a. Direct Medical RMTS Percentage
   i. Direct Medical Cost Pool: Apply the Direct Medical Service percentage from the Random Moment Time Study (Activity Code 1200). The direct medical service costs and time study results must be aligned to assure appropriate cost allocation.
   ii. Personal Care Service Cost Pool: Apply the PCS percentage from the Random Moment Time Study. The Personal Care Service costs and time study results must be aligned to assure appropriate cost allocation.

b. General Administrative Percentage Allocation
   i. Direct Medical Cost Pool: Apply the General Administrative time applicable to the Direct Medical Services percentage from the Random Moment Time Study (Activity Code 3100). The Direct Medical Services costs and time study results must be aligned to assure appropriate cost allocation.
   ii. Personal Care Service Cost Pool: Apply the General Administrative time applicable to Personal Care Service percentage from the Random Moment Time Study (Activity Code 3100). The Personal Care Service costs and time study results must be aligned to assure appropriate cost allocation.

3) IEP Medicaid Eligibility Rate (MER): A District-wide MER will be established that will be applied to all participating schools. When applied, this MER will discount the cost pool expenditures by the percentage of IEP Medicaid students.

The names and birthdates of students with a health-related IEP will be identified from the December 1 Count Report and matched against the Medicaid eligibility file to determine the percentage of those that are eligible for Medicaid. The numerator of the rate will be the students with an IEP that are eligible for Medicaid, and the denominator will be the total number of students with an IEP.

E. Specialized Transportation Services Payment Methodology

Providers are paid on a cost basis for effective dates of service on or after October 1, 2009. Providers will be reimbursed interim rates for SBHS Specialized Transportation services at the lesser of the provider's billed charges or the District-wide interim rate. Federal matching funds will be available for interim rates paid by the District. On an annual basis a cost reconciliation and cost settlement will be processed for all over and under payments.

Transportation to and from school may be claimed as a Medicaid service when the following conditions are met:

1) Transportation is specifically listed in the IEP as a required service;
2) The child requiring transportation in a vehicle with personnel specifically trained to serve the needs of an individual with a disability;
3) A medical service is provided on the day that specialized transportation is billed; and
4) The service billed only represents a one-way trip.

Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with special education reduced by any federal payments for these costs, resulting in adjusted costs for transportation. The cost identified on the cost report includes the following:

1) Bus Drivers
2) Attendants
3) Mechanics
4) Substitute Drivers
5) Fuel
6) Repairs & Maintenance
7) Rentals
8) Contract Use Cost
9) Depreciation

The source of these costs will be the audited Trial Balance and supporting General Ledger, Journals and source documents kept at DCPS and DCPCS. Costs are reported on an accrual basis.

Special education transportation costs include those adapted for wheelchair lifts and other special modifications which are necessary to equip a school bus in order to transport children with disabilities.

F. Certification of Funds Process

Each provider certifies on an annual basis an amount equal to each interim rate times the units of service reimbursed during the previous federal fiscal quarter. In addition, each provider certifies on an annual basis through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and non-federal share.

Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

G. Annual Cost Report Process

Each provider will complete an annual cost report for all school based health services delivered during the previous state fiscal year covering October 1 through September 30. The cost report is due on or before June 30 of the year following the reporting period. The primary purposes of the cost report are to:

1) Document the provider's total CMS-approved, Medicaid allowable scope of costs for delivering school based health services, including direct costs and indirect costs, based on CMS-approved cost allocation methodology procedures; and
2) Reconcile its interim payments to its total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures.

The annual SBHS Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual SBHS Cost Reports are subject to a desk review by the Department of Health Care Finance (DHCF) or its designee.

H. Cost Reconciliation Process

The cost reconciliation process must be completed within fifteen (15) months of the end of the cost report submission date. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the provider's Medicaid interim payments for school based health services delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in cost reconciliation.

For the purposes of cost reconciliation, the District may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

I. Cost Settlement Process

For services delivered for a period covering October 1 through September 30, the annual SBHS Cost Report is due on or before June 30 of the following year, with the cost reconciliation and settlement process completed within fifteen months of the cost report filing.

If a provider's interim payments exceed the actual, certified costs of the provider for school based health services to Medicaid beneficiaries, the provider will return an amount equal to the overpayment.

If actual certified costs of a provider for school based health services exceed the interim Medicaid payments, DHCF will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment within 30-days of final cost settlement.

DHCF shall issue a notice of settlement that denotes the amount due to or from the provider.

II. Cost-Based Reimbursement for SBHS Delivered in Nonpublic programs on Behalf of OSSE

A. General Provisions

1) In accordance with the requirements of Supplement 3 of Attachment 3.1-B, pp. 5-5b and 5-A DCMR §§ 2803.6, 2803.10, and 2854.2, DHCF will reimburse OSSE for expenditures incurred when paying for the delivery of SBHS to D.C. Medicaid enrollees covered under the Individuals with Disabilities Education Act (IDEA) who attend nonpublic special education schools that maintain "Full Approval Status" certification. Reimbursement for SBHS delivered in nonpublic programs shall be retrospective and subject to an annual cost reporting and reconciliation process.

2) Reimbursement under this Section shall be limited to payments resulting from placement in nonpublic programs, pursuant to D.C. Official Code § 38-2561.03 (Supp. 2010).

3) Reimbursement for services delivered during the course of an Extended School Year (ESY) shall not be covered.

4) Effective October 1, 2014, DC pays nonpublic providers for school based services based costs which is determined based on a reconciliation of a CMS-approved cost report. OSSE shall submit the CMS-approved cost report in accordance with (II)(B). DHCF will audit cost reports, and use nonpublic schools' invoices, described in (II)(B)(1), to tie the costs of services claimed on the cost reports. Services included on invoices must be based on services documented on each student's IEP.

B. Documentation Standards, Cost Reporting, and Record Maintenance

1) OSSE shall ensure that each nonpublic program submits all Medicaid related documentation along with each invoice which shall include costs for services delivered to a Medicaid beneficiary. Invoices submitted to OSSE must provide specific itemization of services and costs, including but not limited to the type of service, the frequency of each service, the unit of service, the total units of services, the costs of services per hour or per day, and total costs of services. Services included on invoices must be based on services

documented on each student's IEP, and must clearly identify the medical services and educational services.

2) OSSE will complete an annual cost report for all SBHS delivered during the previous District fiscal year covering October 1 through September 30. The cost report template shall be approved by CMS.

3) OSSE shall use the accrual method of accounting and prepare the cost report in accordance with the requirements of this section, generally accepted accounting principles, and program instructions.

4) The cost report is due to DHCF, or its designee, on or before June 30 of the year following the reporting period, and includes a "certification of funds statement" to be completed, certifying the OSSE's actual, incurred costs/expenditures.

5) OSSE must maintain financial records and data sufficient to support an appropriate determination of allowable costs based upon the amounts reflected in the cost report. For purposes of this section, financial records include the general ledger, books of original entry, transaction documents, statistical data, and any other original document pertaining to the determination of costs covered under this Section.

6) OSSE must maintain adequate administrative records supporting its certification of nonpublic programs and the nonpublic programs' assurances that SBHS will be delivered by qualified health care professionals determined to be licensed practitioners of the healing arts, as set forth in 42 C.F.R. §§ 440.60, 440.110, 440.130, and 440.167, the District of Columbia Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*) and implementing rules.

7) OSSE must maintain the records that are pertinent to each cost report for a period of not less than seven (7) years after the date on which the cost report is filed with DHCF. If the records relate to a cost reporting period that is under currently audit or appeal, the records also must be retained until the conclusion of the audit or appeal.

8) All records and other pertinent information are subject to periodic verification and review by DHCF, or its designee.

9) All filed SBHS Cost Reports are subject to an audit or desk review by DHCF, or its designee.

C. Appeals and Reconciliation

1) At the conclusion of any required audit, OSSE shall receive an audited cost report that will include a description and the reason for each audit adjustment.

2) Within thirty (30) days of receiving the audited cost report, if OSSE disagrees with the audited cost report, then OSSE may request an administrative review of the audited cost report by sending a written request for administrative review to the Office of Rates, Reimbursement and Financial Analysis, Office of the Director, Department of Health Care Finance, 441 4th Street, NW, Suite 900 S, Washington, D.C. 20001.

3) The written request for administrative review shall include an identification of the specific audit adjustment to be reviewed, an explanation of why OSSE views the calculation to be in error, the requested relief, and supporting documentation.

4) DHCF shall mail a formal response to OSSE no later than forty-five (45) days from the date of receipt of the written request for administrative review.

D. Program Integrity

1) Reimbursement available under Section 28.II excludes room and board, tuition and other educational costs.

2) OSSE shall be prohibited from reporting expenditures that coincide with services delivered in nonpublic programs that hold probationary or provisional certification. DHCF, or its designee, shall reserve the right to request documentation to support compliance with this requirement.

3) OSSE shall not submit costs associated with initial Psychological Evaluations pursuant to Supplement 1 of Attachment 3.1-A, pp. 6-6b and Supplement 6 of Attachment 3.16 pp. 5-5b for SBHS eligibility under this section. The sending LEA incurs the cost of an initial Psychological Evaluation based on its obligation to place a beneficiary in an appropriate nonpublic program setting. LEAs incurring expenditures for initial Psychological Evaluations should incorporate those amounts into the RMTS methodology outlined in Section 28.I.

4) OSSE shall ensure it maintains accurate records of the National Provider Identification numbers for all SBHS rendering providers who deliver services in nonpublic programs.

5) OSSE shall ensure access to all related SBHS.