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TO: John Schlitt, National Assembly on School-Based Health Care

FROM: Andy Schneider

RE: HCFA's "Free Care" and "Third Party Liability" Policies

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As requested, here is a brief analysis of HCFA's "free care" and "third party liability" (TPL) policies as they apply to SBHC billing for primary care services furnished to Medicaid-eligible children and adolescents. This memo reviews each of these policies, their legal bases, and their rationales, and it identifies some open issues on which clarification from HCFA would be helpful. The memo concludes with recommendations to NASBHC for improving the ability of SBHCs to bill state Medicaid programs for primary care services to Medicaid beneficiaries.

### **HCFA's "Free Care" Policy**

HCFA's "free care" policy is that federal Medicaid matching funds are not available for payments to a provider unless the provider has "the authority to charge" all patients for services rendered and uses this authority. As stated in *Medicaid and School Health: A Technical Assistance Guide* (August 1997), at p. 42, "If only Medicaid [beneficiaries] or their third parties are charged for the service, the care is free and Medicaid will not reimburse for the service." [www.hcfa.gov/medicaid/scbintro.htm](http://www.hcfa.gov/medicaid/scbintro.htm).

In the case of schools, HCFA has stated that the "free care" policy would not prevent payment for Medicaid-covered services to an SBHC if the SBHC:

- (1) establishes a sliding-scale fee schedule for its services,
- (2) determines whether every student served has any third-party coverage other than Medicaid, and
- (3) bills the student (the student's insurer, if any) for the cost of the services.

HCFA recognizes two exceptions to this "free care" policy:

- (1) Medicaid-covered services "provided under an IEP or IFSP;" and
- (2) Medicaid-covered services "provided by Title V".

In the case of each exception, the school is still required to “pursue any liable third party insurers for reimbursement.” (TPL is discussed at pp. 3-4 of this memo).

**Legal Basis for HCFA’s “Free Care” Policy.** In its August 1997 *Guide* setting forth its “free care” rule, HCFA cites no statutory or regulatory basis for the policy (Appendix I). In fact, neither the federal Medicaid statute nor HCFA’s own regulations state such a policy, much less a policy specific to SBHCs delivering primary care services. Similarly, there is no statutory or regulatory basis for the two exceptions that HCFA has carved out; HCFA has imputed the exceptions from statutory language identifying Medicaid as the first dollar payor for purposes of IDEA and Title V.

In short, it appears that HCFA has relied upon its inherent authority to administer the Medicaid program in order to craft its “free care” rule. It has chosen to use this authority in a manner that makes it difficult for SBHCs to bill Medicaid for covered primary care services delivered to Medicaid beneficiaries. In my view, HCFA could use its inherent authority to carve out another exception to the “free care” rule that allows states, at their option, to permit SBHCs to bill Medicaid for primary care services provided to Medicaid-eligible students without billing all students for all services.

**Rationale for HCFA’s “Free Care” Policy.** The rationale for HCFA’s “free care” rule is that federal Medicaid funds should not be used to pay for services that are furnished without charge. As a general matter, this is eminently reasonable. However, in the case of SBHCs, which provide primary care services to all students seeking care regardless of ability to pay and which generally do not bill the students, their parents, or any insurers or managed care plans for services rendered, this “free care” rule is problematic.

As HCFA itself acknowledges in its August 1997 *Guide* at p. 43, the effect of its “free care” rule is to establish a barrier for SBHCs in accessing Medicaid payments: “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 either [the IDEA or Title V exceptions].” HCFA pointedly notes that “many schools provide a wide range of health services which would *not* fall under either exception” (emphasis added).

**Open Issues in HCFA’s “Free Care” Policy.** The August 1997 *Guide*, combined with the absence of any statutory or regulatory guidance on the “free care” policy, leaves several important issues unresolved. In particular, there is considerable uncertainty in the field as to the scope of the Title V exception. In the absence of an SBHC-specific exception to HCFA’s “free care” policy, a broad Title V exception could be of great value to SBHCs seeking to participate in Medicaid as well as those state Medicaid agencies interested in using SBHCs to increase access to care for eligible children. HCFA clarification of the following questions – at either the Central or the Regional Office level – could frame such a broad Title V exception.

The August 1997 *Guide* states that Medicaid-covered services “provided by Title V” are exempt from the “free care” rule (p. 43). Which of the following meets this “provided by Title V” test?

- 1.) The SBHC is sponsored by the state or local Title V agency.
- 2.) The SBHC is sponsored by a school or by a nonprofit entity, but the majority (50 percent or more) of its operating budget comes from the state Title V program in the form of a grant or contract.
- 3.) The SBHC is sponsored by a school or nonprofit entity, its revenues come from a variety of sources, including a grant or contract it receives from the state Title V agency for the provision of a specified set of services (e.g., immunizations). May the SBHC bill Medicaid for the Title V-specific services (e.g., immunizations) without billing all patients for all services? May the SBHC bill Medicaid for other Medicaid-covered services that it provides to children who are eligible for Medicaid and Title V without billing all patients for all services?
- 4.) The SBHC is sponsored by a school or nonprofit entity, and it receives no Title V funding. However, under the state's Title V program, some of the children it treats are eligible for Title V services. May the SBHC bill Medicaid for the Medicaid-covered services it furnishes to Title V-eligible children who are also eligible for Medicaid without billing all patients for all services?
- 5.) The SBHC is sponsored by a school or nonprofit entity, and it receives no Title V funding. However, under the state's Title V program, the SBHC is designated as a "safety net" provider with a policy of treating all children regardless of source of payment. May the SBHC bill Medicaid for the Medicaid-covered services it furnishes to Medicaid-eligible children without billing all patients for all services?

### **HCFA's "Third Party Liability" (TPL) Policy**

Unlike the State Children's Health Insurance Program (CHIP), Medicaid does not deny eligibility to children who have private health insurance coverage. Children and adolescents qualify for Medicaid based on their age and their family income (and in some states, resources). If Medicaid-eligible children also happen to have coverage as dependents under one or both parents' private health insurance policies, this coverage is viewed not as a disqualifying event but as a liable "third party" that should pay for covered services before Medicaid pays. Accordingly, the federal Medicaid statute requires state Medicaid agencies to take "all reasonable measures" to determine the legal liability of third parties (including health insurers and managed care plans) to pay for care and services covered under the state Medicaid program.

HCFA's August 1997 Guide interprets this TPL policy in the context of "schools" (not just SBHCs). The general rule is that schools, like other Medicaid providers, must bill a beneficiary's health insurer first, before billing Medicaid. This practice is known as "cost avoidance," a reference to the purpose of helping Medicaid avoid paying the costs of covered services for which other insurers are responsible. However, in the case of "preventive pediatric care services," a different policy applies: "pay and chase." This means that, in the case of these 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." (Appendix II).

This “preventive pediatric care services” exception to the general TPL “cost avoidance” rule is of particular importance to SBHCs furnishing primary care to children and adolescents. The August 1997 *Guide* at p. 46 notes that HCFA’s *State Medicaid Manual* “includes a list of diagnosis codes that, at a minimum, states are required to pay and chase,” including preventive medicine visits and screening and preventive treatment for infectious and communicable diseases. (Appendix III). Of particular importance to SBHCs is the August 1997 *Guide*’s statement that “States are given discretion to define the list [of preventive pediatric service diagnoses] more broadly. For instance, states should pay and chase for additional diagnoses whenever using the cost avoidance method would discourage provider participation.” Clearly, the use of the cost avoidance method has discouraged many SBHCs from participating in Medicaid, so states could easily justify the designation of additional “pay and chase” diagnoses for SBHCs.

**Legal Basis for HCFA’s “TPL” Policy.** In contrast to HCFA’s “free care” policy, there is actually a statutory basis for “TPL” policy. The problem is that HCFA’s interpretation of the statute in the context of SBHC services is highly restrictive and makes life unnecessarily difficult for SBHCs.

Section 1902(a)(25) of the Social Security Act requires state Medicaid agencies to “take all *reasonable* measures to ascertain the legal liability of third parties (including health insurers...) to pay for care and services available under [the state Medicaid program]...” (emphasis added). The statute goes on to specify that in the case of “preventive pediatric care (including early and periodic screening and diagnosis services under section 1905(a)(4)(B)) covered under the [state Medicaid program],” the State “shall” make payment for the services “without regard to the liability of a third party for payment for such services” and “seek reimbursement from such third party ... where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery.”

**Rationale for HCFA’s “TPL” Policy.** In HCFA’s view, “Medicaid is generally the payer of last resort. 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.” (August 1997 *Guide* at p. 43). As a general matter, this is unassailable. But it is not an absolute policy. Otherwise, Congress by statute would have required that state Medicaid agencies make “every possible effort” to determine third party liability rather than take “all reasonable measures.” Similarly, Congress would have mandated cost avoidance in all cases, rather than carving out an exception for “preventive pediatric care (including EPSDT services).”

A close reading of the August 1997 *Guide*, and especially the text set forth in Appendix II, suggests that HCFA was not focusing on SBHCs delivering primary care when it developed the *Guide*. Instead, HCFA’s concern appears to have been services such as speech therapy or physical therapy furnished by schools to children under IEPs and IFSPs. The policy considerations with respect to these services differ substantially from those relating to access to primary care services for children not under IEPs or IFSPs.

## **Recommendations**

In its August, 1997 *Guide*, HCFA expressly acknowledged 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. HCFA has considered alternatives to these requirements but as yet, no changes have been made.” (p. 49).

It is now well over 3 years since this *Guide* was written, and, judging from the Regional meetings NASBHC facilitated in March, HCFA has still not developed alternatives to address the issues facing SBHCs that deliver primary care services to Medicaid-eligible children. There is now a new Administration that has expressed its interest in making HCFA more responsive. I would therefore recommend that NASBHC pursue the following policy clarifications with HCFA:

- Work with states Medicaid and Title V agencies to seek HCFA clarification, ideally in the form of a State Medicaid Director (SMD) letter, of the questions listed at page 3 regarding the Title V exception to HCFA’s “free care” policy.
- Depending upon HCFA’s willingness to clarify the Title V exception to address SBHC concerns, seek a statutory exemption from HCFA’s “free care” policy for SBHCs providing primary care services.
- With respect to TPL “cost avoidance” requirements, work with interested states and HCFA Regional Offices to tailor the statutory “preventive pediatric care” exception to the billing codes used by SBHCs
- If the statutory “preventive pediatric care” exception proves not to be sufficiently broad to accommodate all SBHC billing codes, seek a statutory change to broaden the exception to include primary care services provided by SBHCs.

I recognize that these recommendations will not address the problems faced by SBHCs in states that are not supportive of SBHCs or that do not want to facilitate participation by SBHCs in Medicaid. I do not believe it is realistic to expect either Congress or HCFA to require or even encourage states to be supportive of SBHCs. However, I do believe that there is sufficient flexibility in the current Medicaid statute to allow HCFA to enable states, at their option, to minimize the “free care” and “TPL” policy barriers to SBHC participation in Medicaid.

## APPENDIX I

HCFA articulates its “free care” policy in *Medicaid and School Health: A Technical Assistance Guide* (August 1997), [www.hcfa.gov/medicaid/scbintro.htm](http://www.hcfa.gov/medicaid/scbintro.htm), as follows:

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 [sic] 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 free 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. ...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...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. ...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 liable third party insurers for reimbursement before billing Medicaid.

## APPENDIX II

HCFA articulates its “third party liability” (TPL) policy as it affects schools in *Medicaid and School Health: A Technical Assistance Guide* (August 1997), [www.hcfa.gov/medicaid/scbintro.htm](http://www.hcfa.gov/medicaid/scbintro.htm), at p. 48:

“...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.”

## APPENDIX III

Excerpt from HCFA's *State Medicaid Manual*, Part 03, Section 3904.4, relating to the scope of "pay and chase" for preventive pediatric care,  
[www.hcfa.gov/pubforms/45\\_smm/sm\\_03\\_3\\_3900\\_to\\_3910.15.htm#\\_toc490897594](http://www.hcfa.gov/pubforms/45_smm/sm_03_3_3900_to_3910.15.htm#_toc490897594)

"B. Prenatal and Preventive Pediatric Care – You must pay and chase in situations where the claim is for prenatal care for pregnant women or preventive pediatric services (including EPSDT services) that are covered under the State plan. The intent of this requirement is to alleviate the administrative burden associated with TPL 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 have difficulty finding providers in many communities....

The following exhibits are provided as guidelines for determining certain claims for which you must use the pay and chase method....The second exhibit includes diagnosis codes related to preventive pediatric care. These diagnosis codes were selected since it would be impractical to identify every procedure code which could relate to prenatal and preventive pediatric care. In order to identify prenatal claims which must be paid and chased, use the appropriate procedure codes related to these diagnoses. These guidelines define the terms prenatal and preventive pediatric care narrowly. You have the option of defining these terms more broadly. For example, the definition of prenatal care may be expanded to include preexisting conditions which are likely to affect the pregnancy."

Exhibit 2: "Preventive pediatric care is defined as screening and diagnostic services to identify congenital physical or mental disorders, routine examinations performed in the absence of complaints, and screening or treatment designed to avert various infectious and communicable diseases from ever occurring in children under age 21. This includes 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."

The following ICD-9-CM Diagnosis Codes are listed: VO1, VO2, VO3-VO6, VO7, V20, V70.0, V72.0-.3, V73-V75, V77.0-.7, V78.1-.3, V79.2-.3, V79.8, V82.3-.4