MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING GUIDE

May 2003

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TABLE OF CONTENTS

I. INTRODUCTION 1

II. MEDICAID IN THE SCHOOL SETTING 3

III. INTERAGENCY AGREEMENTS 5

A. GENERAL 5
B. ELEMENTS OF THE INTERAGENCY AGREEMENT 6

IV. PRINCIPLES OF ADMINISTRATIVE CLAIMING 7

A. GENERAL 7
B. OPERATIONAL PRINCIPLES 7
1. Proper and Efficient Administration 7
2. Capture 100 Percent of Time 8
3. Parallel Coding Structure: Medicaid and Non-Medicaid Codes for Each Activity 9
4. Duplicate Payments 9
5. Coordination of Activities 10
6. Performing Direct Services v. Administrative Activities 11
a. Case Management as Administration 11
b. Case Management as a Service 12
7. Allocable Share of Costs 12
8. Enhanced FFP Rates 14
a. Skilled Professional Medical Personnel (SPMP) School-Based Administrative Claiming 14
b. Claiming for Administration of Family Planning Services 16
9. Provider Participation in the Medicaid Program 16
10. Individualized Education Program (IEP) Activities 18
11. Review and Approval of Program and Codes by CMS 19
12. Free Care 20
C. ACTIVITY CODES: DESCRIPTIONS AND EXAMPLES 21
1. Introduction 21
CODE 1.a. NON-MEDICAID OUTREACH 23
CODE 1.b. MEDICAID OUTREACH 24
CODE 2.a. FACILITATING APPLICATION FOR NON-MEDICAID PROGRAMS 25
CODE 2.b. FACILITATING MEDICAID ELIGIBILITY DETERMINATION 25
CODE 3. SCHOOL-RELATED AND EDUCATIONAL ACTIVITIES 26
CODE 4. DIRECT MEDICAL SERVICES 27
CODE 5.a. TRANSPORTATION FOR NON-MEDICAID SERVICES 28
CODE 5.b. TRANSPORTATION-RELATED ACTIVITIES IN SUPPORT OF MEDICAID COVERED SERVICES 28
CODE 6.a. NON-MEDICAID TRANSLATION 29
CODE 6.b. TRANSLATION RELATED TO MEDICAID SERVICES 29
CODE 7.a. PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO NON-MEDICAL SERVICES 30
CODE 7.b. PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO MEDICAL SERVICES 31
CODE 8.a. NON-MEDICAL/NON-MEDICAID RELATED TRAINING 32
CODE 8.b. MEDICAL/MEDICAID RELATED TRAINING 32
CODE 9.a. REFERRAL, COORDINATION, AND MONITORING OF NON-MEDICAID SERVICES 33
CODE 9.b. REFERRAL, COORDINATION, AND MONITORING OF MEDICAID SERVICES 34

CODE 10. GENERAL ADMINISTRATION *35*

V. CLAIMING ISSUES 37

A. DOCUMENTATION 37
B. SAMPLING/TIME STUDIES 38
1. Sample Universe *39*
2. Sampling Plan Methodology *40*
3. Treatment of Summer Period *41*
4. Time Study Documentation *42*
5. Training for Staffing Time Study *43*
6. Monitoring Process *43*
C. OFFSET OF REVENUES 44
D. COST ALLOCATION PLANS 44
E. ADMINISTRATIVE CLAIMING IMPLEMENTATION PLAN 45
F. TIMELY FILING REQUIREMENTS 46
G. STATE LAW REQUIREMENTS 47
H. CONTINGENCY FEES 47
I. PROVIDER AGREEMENTS 48
J. THIRD PARTY LIABILITY (TPL)/MEDICAID AS PAYOR OF LAST RESORT/FREE CARE 48
K. TRANSPORTATION AS ADMINISTRATION 49

APPENDIX 50

A. MEDICAID 50
1. Medicaid's Role In School-Based Health Services Programs *50*
2. Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) *51*
a. EPSDT Screening 51
b. EPSDT Treatment 51
c. EPSDT Administrative Claiming 51
3. State Children's Health Insurance Program (SCHIP) *52*
B. INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA) 53
1. Purpose of IDEA *53*
2. Child Find *54*
3. Evaluation and Assessment Activities *54*
4. Individualized Education Program (IEP) *55*
a. Pre-IEP 56
b. Development of IEP 56
c. Review/Revision of IEP 56

MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING GUIDE

I. INTRODUCTION

The school setting provides a unique opportunity to enroll eligible children in the Medicaid program, and to assist children who are already enrolled in Medicaid to access the benefits available to them. Medicaid, a joint state-federal program, offers reimbursement for both the provision of covered medical services and for the costs of administrative activities, such as outreach, which support the Medicaid program.

The purpose of the Medicaid School-Based Administrative Claiming Guide (referred to hereafter as the Guide) is to inform schools, state Medicaid agencies, and other interested parties on the appropriate methods for claiming federal reimbursement for the costs of Medicaid administrative activities performed in the school setting.

Specifically, the purpose of this Guide is to:

- Help schools and school districts prepare appropriate claims for administrative costs under the Medicaid program;
- Ensure that the Medicaid program pays only for appropriate school-based administrative activities and that such activities are carried out effectively and efficiently;
- Protect the fiscal integrity of the Medicaid program by providing a clear articulation of the requirements for school-based administrative claiming;
- Help ensure consistency in the application of federal administrative claiming requirements across regions and states;
- Promote the flexibility afforded at the state/local level in the implementation of the Medicaid program;
- Assist in the implementation of operational and oversight functions, both at the federal and state levels; and
- Provide technical assistance for the intended audience.

Contemporary schools are engaged in a variety of activities that would not traditionally be thought of as education. In carrying out the mission of meeting the educational needs of their students, schools find themselves delivering many different services to students that help ensure that students come to school healthy and ready to learn and that students can benefit from instructional services.

Pursuant to requirements under the Individuals with Disabilities Education Act (IDEA) and section 504 of the Rehabilitation Act of 1973, schools deliver a broad range of "related services" (e.g., educational, social, and medical services) to students with disabilities that address their diverse needs. These include medical services that may be provided under the Medicaid program, such as physical therapy, occupational therapy, and mental health services, and transportation for the purpose of receiving medical services. Most schools conduct health screenings for all their students in such areas as vision and hearing. Many school districts employ school nurses to assist with the administration of medications and to assist students who become ill or injured. Some schools operate school-based clinics that provide direct medical services. More and more schools are engaged in Medicaid outreach activities to inform students and their families about the availability of Medicaid and the State Children's Health Insurance Program and to assist them in applying for these programs.

Expenditures for direct school-based health services that are within the scope of Medicaid coverage and furnished to Medicaid eligible children may be claimed as "medical assistance" and are not within the scope of the administrative claims discussed in this guide. The CMS publication, "Medicaid and School Health: A Technical Assistance Guide," released in August 1997, contains guidance on Medicaid claims for direct medical services delivered in a school setting. Expenditures for administrative activities in support of these school-based services, including outreach and coordination, may be claimed as costs of administering the state Medicaid plan; these claims are the subject of this Guide. The Guide is intended to help schools, and other interested parties, better understand when Medicaid reimbursement can be obtained for the administrative costs of school-based health services and how to prepare and submit appropriate claims for federal financial participation (FFP).

At the national level, CMS reviews and assesses states' administrative claiming programs in accordance with applicable federal Medicaid law and regulations. CMS provides technical assistance to the state Medicaid agencies to ensure ongoing integrity of the administrative claiming process. The development and implementation of a school-based Medicaid administrative claiming program should be a collaborative process, as appropriate, involving the relevant entities: the schools, the state education and Medicaid agencies, and the federal government. Because each state Medicaid agency is responsible for the operation of its Medicaid program, it is important for the involved education agencies to work closely with the state Medicaid agency for policy and technical assistance. This collaboration will help to ensure compliance with administrative claiming requirements. State Medicaid Agencies are responsible for ensuring that applicable policies are applied uniformly throughout the state, and that claims are submitted to CMS in conformance with such requirements.

Because the Medicaid program provides significant state operational and programmatic flexibility under federal regulation and oversight, federal Medicaid requirements provide only a framework for state Medicaid programs. Since each state establishes and administers its Medicaid program within this framework, Medicaid programs vary considerably from state to state, and states regularly revise their own Medicaid programs. Therefore, while federal Medicaid requirements are administered by CMS and can be of assistance to schools, in order to determine specific state Medicaid program requirements, schools need to contact and work through their state Medicaid agency.

The Guide does not supersede any statutory or regulatory requirements. Rather, it clarifies and consolidates CMS' guidance on how to meet these statutory and regulatory requirements and explains the application of such requirements in the context of current practices. The Guide does not impose any

additional Medicaid provider requirements on schools as compared to Medicaid providers in other settings[1]. However, as discussed in the Guide, claiming for the costs of Medicaid-related administrative activities performed by school employees necessitates that schools implement a system to appropriately identify those activities and costs which are claimable under Medicaid, in accordance with federal requirements. These requirements were applicable prior to the issuance of the Guide and typically involve the participation of school employees in time studies used to develop and submit these Medicaid claims.

Both states and schools may realize after reading this Guide that some of their current methods for claiming administrative costs may not be allowable under the federal requirements. In those cases, CMS will work with the state(s) to develop acceptable administrative claiming procedures which will allow states and schools to go forward prospectively with proper and allowable claiming. CMS Regional Offices will work with the Medicaid state agencies currently participating in school-based administrative claiming to assess their programs and determine if changes are necessary to meet the statutory and regulatory requirements consistent with this guidance.

Throughout this Guide, the terms "school" and/or "school district" are used to represent all types of school related administrative claiming units (i.e., local education agencies (LEAs), consortia, etc.).

II. MEDICAID IN THE SCHOOL SETTING

Medicaid is a means-tested benefit program that provides health care coverage and medical services to millions of low-income children, pregnant women, families, persons with disabilities, and elderly citizens. Medicaid is financed jointly by the states and federal government, and is administered directly by states. Under broad federal guidelines, each state establishes a state Medicaid plan that outlines eligibility standards, provider requirements, payment methods, and benefit packages tailored to the needs of its citizens.

Medicaid is a critical source of health care coverage for children. The Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) provision is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. ESPDT services include periodic health screening, vision, dental, and hearing services. The Medicaid statute also requires that states provide any medically necessary health care services listed in section 1905(a) of the Social Security Act (the Act) to an EPSDT recipient even if the services are not available under the state's Medicaid plan to the rest of the Medicaid population. States are required to inform Medicaid eligibles under age 21 about the EPSDT benefit, set distinct periodicity schedules for screening, dental, vision and hearing services, and report EPSDT performance information annually to CMS. For more information about EPSDT, please refer to the CMS Medicaid website at www.cms.hhs.gov.

Many of the administrative activities discussed in the Guide that are claimable to Medicaid are those associated with and in support of the provision of medical services reimbursable under Medicaid. (See Section IV., Subsection C., Activity Codes 5.b., 6.b., 7.b., and 9.b.). The medical services reimbursable

[1] Throughout the Guide, schools and school districts are frequently referred to as "Medicaid providers" or "providers," which is how they are commonly known, despite the fact that in most cases they are more accurately defined as assignees of practitioner claims rather than actual providers.

under Medicaid that are provided in schools are: 1) medical services that are specified in a Medicaid eligible child's IEP; and 2) EPSDT-type primary and preventive services provided in schools where third party liability requirements are met. There are other administrative activities not associated with a covered Medicaid medical service which may be covered in schools. These include Medicaid outreach, facilitating Medicaid eligibility determinations, medical/Medicaid related training and general administration (See Activity Codes 1.b., 2.b., 8.b. and 10).

Schools can provide a wide range of health care and related services to their students, which may or may not be reimbursable under the Medicaid program. The services can be categorized as follows:

- IDEA-related health services. The Individuals with Disabilities Education Act (IDEA) was passed to "assure that all children with disabilities have available to them… a free appropriate public education which emphasizes special education and related services designed to meet their individual needs." The IDEA authorizes federal funding to states for medical services provided to children through a child's Individualized Education Program (IEP), including children that are covered under Medicaid. In 1988, section 1903(c) of the Act was amended to permit Medicaid payment for medical services provided to Medicaid eligible children under IDEA and included in the child's IEP.

- "Section 504"-related health services. Section 504 of the Rehabilitation Act of 1973 requires local school districts to provide or pay for certain services to make education accessible to handicapped children. These services may include health care services similar to those covered by IDEA and Medicaid. These services are typically described in a section 504 plan and are provided free of charge to eligible individuals.

- General health care services. These services are typically mandated by the school district or state and include health care screenings, vision exams, hearing tests, a scoliosis exam, etc., provided free of charge to all students. Services provided by the school nurse (e.g., attending to a child's sore throat, dispensing medicine) may also fall into this category. These general health care services often resemble EPSDT services.

Federal matching funds under Medicaid are available for the cost of administrative activities that directly support efforts to identify and enroll potential eligibles into Medicaid and that directly support the provision of medical services covered under the state Medicaid plan. To the extent that school employees perform administrative activities that are in support of the state Medicaid plan, federal reimbursement may be available. However, Medicaid third party liability rules and CMS's free care policy limit the ability of schools to bill Medicaid for some of these health services and associated administrative costs.

- Third party liability requirements preclude Medicaid from paying for Medicaid coverable services provided to Medicaid beneficiaries if another third party (e.g., other third party health insurer or other federal or state program) is legally liable and responsible for providing and paying for the services.

- The "free care" principle precludes Medicaid from paying for the costs of Medicaid-coverable services and activities which are generally available to all students without charge, and for which no other sources for reimbursement are pursued.

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- Third party liability requirements preclude Medicaid from paying for Medicaid coverable services provided to Medicaid beneficiaries if another third party (e.g., other third party health insurer or other federal or state program) is legally liable and responsible for providing and paying for the services.

- The "free care" principle precludes Medicaid from paying for the costs of Medicaid-coverable services and activities which are generally available to all students without charge, and for which no other sources for reimbursement are pursued.

These policies preclude Medicaid reimbursement for either "Section 504" services or general health care services because schools are legally liable and responsible for providing and paying for these services and activities. CMS's free care policy also precludes Medicaid reimbursement because these services and activities are provided free of charge to all students. To the extent that health care service are not Medicaid reimbursable under these policies, associated administrative costs also may not be claimed. In order for Medicaid payments to be made available for either Section 504 services or general health care services, the school providers must do the following:

1) establish a fee for each service that is available;
2) collect third party insurance information from all those served (Medicaid and non-Medicaid); and
3) bill other responsible third party insurers.

While schools are legally liable to provide IDEA-related health services at no cost to eligible students, Medicaid reimbursement is available for these services because section 1903(c) of the Act requires Medicaid to be primary to the U.S. Department of Education for payment of the health-related services provided under IDEA. Medicaid covers services included in an IEP under the following conditions:

- The services are medically necessary and included in a Medicaid covered category (speech therapy, physical therapy, etc.);
- All other federal and state Medicaid regulations are followed, including those for provider qualifications, comparability of services and the amount, duration and scope provisions;
- The services are included in the state's plan or available under EPSDT; and
- The medical service must be provided to a Medicaid eligible student.

We recognize that Medicaid TPL rules and the free care provision serve to limit the ability of schools to bill Medicaid for covered services and associated administrative costs provided to Medicaid-eligible children. While there are exceptions to these policies for Medicaid services provided to children with disabilities pursuant to an IEP under IDEA, many schools provide a range of services that would not fall under these exceptions, including services provided by school nurses and school psychologists.

III. INTERAGENCY AGREEMENTS

A. General

Any school district or local entity that receives payments for Medicaid administrative activities being performed in the school setting is acting as an agent for the state Medicaid agency. Such activities may be paid under Medicaid only if they are necessary for the proper and efficient administration of the Medicaid state plan. An interagency agreement, which describes and defines the relationships between the state Medicaid agency, the state Department of Education and/or the school district or local entity conducting the activities, must be in place in order to claim federal matching funds.

The state Medicaid agency is the only entity that may submit claims to CMS to receive FFP for allowable Medicaid costs. This requirement necessitates that every participating agency be covered, either directly or indirectly, through an interagency agreement, but there is no need for duplicative or

overlapping agreements. For example, a school district may enter into an interagency agreement with the state Medicaid agency. However, an individual school is not required to be party to the interagency agreement if its employees are all part of the school district, and that school district is party to the interagency agreement with the state Medicaid agency.

In a state that recognizes consortia arrangements for purposes of Medicaid administrative claiming, an interagency agreement must be in place between the local agency representing the consortia, for example the "lead" school district, and the state Medicaid agency. A consortium is an entity that represents a collection of local education agencies (LEAs), or school districts, as appropriate. Also, the state Medicaid agency will define the terms for participation in a consortium, and should be notified of any changes in the membership or status of an approved consortium.

Interagency agreements may only exist between governmental (i.e., public) entities and cannot extend to private contractors or consultants. If a school district hires a private consultant to manage its administrative claims, the contract between the school district and the private consultant would be considered outside the scope of the interagency agreement.

Interagency agreements must be in accordance with state law. That is, states must consider their own civil statutes relative to interagency agreements, and their status as a single state agency for the Medicaid program as defined at 42 CFR 431.10. Consideration must also be given to state contracting requirements. For example, some state laws do not allow interagency agreements to have effective dates prior to the date that all parties to the agreement have signed the agreement.

B. Elements of the Interagency Agreement

The interagency agreement must include:

- Mutual objectives of the agreement;
- Responsibilities of all the parties to the agreement;
- Activities or services each party to the agreement offers and under what circumstances;
- Cooperative and collaborative relationships at the state and local levels;
- Specific administrative claiming time study activity codes which have been approved by CMS, by reference or inclusion;
- Specific methodology which has been approved by CMS for computation of the claim, by reference or inclusion;
- Methods for reimbursement, exchange of reports and documentation, and liaison between the parties, including designation of state and local liaison staff.

The interagency agreement should address the Medicaid administrative claiming process, identify the services the state Medicaid agency will provide for the local entity, including any related reimbursement

and funding mechanisms, and define oversight activities and responsibilities. All participation requirements the state Medicaid agency determines to be mandatory for ensuring a valid process should be detailed in the agreement. Maintenance of records, participation in audits, designation of local project coordinators, training timetables and criteria, and submission of fiscal information are all important elements of the interagency agreement. Also, the specific methodology, which may include a standardized claim form, the mechanism for filing the claim, and the approved time study codes for use by the local entity, are valid agreement elements.

Although prior approval by CMS of the interagency agreement is not required, state Medicaid agencies are encouraged to consult CMS during the development of their model interagency agreements for Medicaid administrative claiming. CMS has the authority to review interagency agreements to ensure that activities are in support of the proper and efficient administration of the state plan.

IV. PRINCIPLES OF ADMINISTRATIVE CLAIMING

A. General

School or school district employees may perform administrative activities that directly support the Medicaid program. Some or all of the costs of these administrative activities may be reimbursable under Medicaid; however, an appropriate claiming mechanism must be used. The time study is the primary mechanism for identifying and categorizing Medicaid administrative activities performed by school or school district employees. The time study also serves as the basis for developing claims for the costs of administrative activities that may be properly reimbursed under Medicaid. (See also Section V., B.).

The time study, including the activity codes, should represent the actual duties and responsibilities of participating school or school district employees, consistent with the operational principles discussed below. Section IV. of the Guide provides examples of appropriate activity codes. These activity codes may be adopted for use by states, school districts, and schools as the basis for time studies that would be used to allocate administrative costs for purposes of making claims under the Medicaid program.

The activity codes listed in Section IV. may be modified by states to reflect activities unique to a local environment. Additional activity codes may also be acceptable, to the extent that they are in accordance with the operational principles discussed below. Similarly, certain activity codes and/or the examples included under particular activity codes may not be applicable to some school-based administrative claiming programs. While flexibility is afforded in the design and application of the activity codes, adherence to the following principles is required for claiming purposes.

B. Operational Principles

1. Proper and Efficient Administration

According to the Medicaid statute at section 1903(a)(7) of the Act and the implementing regulations at 42 CFR 430.1 and 42 CFR 431.15, for the cost of any activities to be allowable and reimbursable under Medicaid, the activities must be "found necessary by the Secretary for the proper and efficient administration of the plan" (referring to the Medicaid state plan). In addition, OMB Circular A-87,

which contains the cost principles for state, local and Indian tribal governments for the administration of federal awards, states that, "Governmental units are responsible for the efficient and effective administration of federal awards." Under these provisions, costs must be reasonable and necessary for the operation of the governmental unit or the performance of the federal award.

The principle of being necessary for the proper and efficient administration of the Medicaid state plan must be applied in developing time study activity codes. For example, outreach activities would be considered to be in support of the Medicaid program if they were in regard to explaining Medicaid requirements. By contrast, outreach with respect to explaining the requirements of education programs or other programs' requirements would not be in support of the Medicaid program and must be accounted for separately.

2. Capture 100 Percent of Time

In order to ascertain the portion of time and activities that are related to administering the Medicaid program, states must develop an allocation methodology that is approved by the U.S. Department of Health and Human Services. The approved allocation methodology, which may use random moment sampling (RMS), contemporaneous time sheets, or other quantifiable measures of employee effort, is often referred to as a time study. The time study must incorporate a comprehensive list of the activities performed by staff whose costs are to be claimed under Medicaid. That is, the time study must reflect **all** of the time and activities (whether allowable or unallowable under Medicaid) performed by employees participating in the Medicaid administrative claiming program. The time study mechanism must entail careful documentation of all work performed by certain school staff over a set period of time and is used to identify, measure and allocate the school staff time that is devoted to Medicaid reimbursable activities.

In order to ensure that the time study reflects all of the activities performed by the time study participants, CMS, the state, and the school districts should work together to establish the master list of activities by program. CMS and the state would then determine which of the activities in each program are allowable Medicaid administrative activities.

If a portion of a sampled employee's time is also billed as direct medical services, then the administrative time study results should be compared to the time coded to direct medical services (for example, Code 4 in Section IV., C.) to determine the actual amount of hours billed directly. The results should be within a reasonable tolerance or else the time study may effectively result in duplicate payments being made.

In order to ensure that all of the time study participants are appropriately reflected in the time study, the staff classifications and associated supporting documentation (such as position descriptions) for time study participants should also be reviewed and considered in developing the time study activity codes. This will also ensure that the unique responsibilities and functions performed by the participants, as well as the special factors and programs applicable to the participating schools or school districts, are accounted for and included in the time study codes. As these codes are formulated, they should be compared against the staff classifications and supporting position descriptions to ensure that all functions being performed are identified and incorporated into the codes. (See also Section V., A. on documentation.)

3. Parallel Coding Structure: Medicaid and Non-Medicaid Codes for Each Activity

The time study activity codes must capture all of the activities performed by the time study participants, as indicated by Principle 2., and distinguish Medicaid activities from similar activities that are not Medicaid reimbursable. For example, a school employee who provides referrals for both Medicaid and non-Medicaid programs would need to appropriately allocate his or her time between these programs. This can be accomplished through the use of "parallel" time study activity codes. In the above example, the time study would include an activity code such as "Medicaid referral and coordination" and a parallel code such as "Non-Medicaid referral and coordination" (see Codes 9.a. and 9.b. in Section IV., C.). Using a parallel coding structure ensures that the time study captures 100 percent of the time spent on referrals and allocates it to the appropriate program. As noted in Section V., B., 5., all staff in the sample universe should be trained on proper coding procedures, including reporting activities under the parallel codes, before sampling begins.

4. Duplicate Payments

Federal, state and local governmental resources should be expended in the most cost-effective manner possible. In determining the administrative costs that are reimbursable under Medicaid, duplicate payments are **not** allowable. That is, states may not claim FFP for the costs of allowable administrative activities that have been or should have been reimbursed through an alternative mechanism or funding source. The state must provide assurances to CMS of non-duplication through its administrative claims and the claiming process. 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 may dispute CMS's position on what is a duplicate payment through appeal of any disallowance to the Departmental Appeals Board (DAB).

Examples of activities for which the costs may not be claimable as Medicaid administration due to the potential for duplicate payments:

- Activities that are integral parts or extensions of direct medical services, such as patient follow-up, patient assessment, patient education, or counseling. In addition, the cost of any consultations between medical professionals that may occur is already reflected in the payment rate for medical assistance services and may not be claimed separately as an administrative cost.

- An activity that has been, or will be, paid for as a medical assistance service (or as a service of another (non-Medicaid) program) (See Section IV., B., Principle 6. on performing direct services vs. administrative activities).

- An activity that has been, or will be, paid for as a Medicaid administrative cost.

- An activity that is included as part of a managed care rate and is reimbursed by the managed care organization.

It is important to distinguish between duplicate payments for the same activity and the inefficient use of resources, which may result in the unnecessary performance of an activity more than once.

Coordination of activities is intended to mitigate the duplicate performance of services or administrative activities, and is discussed in Principle 5., Coordination of Activities.

There are many situations in which a Medicaid-eligible child with special needs receives IEP services from the school, and well-child, primary, preventive and acute care services from a managed care organization (MCO). (MCO services can be provided at a school-based, school-linked clinic, a doctor's office, or elsewhere.) In those situations where the same Medicaid-eligible child receives IEP services from both a school and an MCO, there must be a concerted effort to ensure that Medicaid is not paying for the same services twice, once to the MCO and again to the school.

As appropriate, the mechanism under which managed care rates are set and adjusted should address the activities and services being furnished in the school setting.

5. Coordination of Activities

In addition to avoiding duplicate payments, as discussed above in Principle 4., duplicate performance of activities should also be avoided. Under Principle 1., allowable administrative activities must be necessary "for the proper and efficient administration of the [Medicaid] state plan," as well as for the operation of all governmental programs. Therefore, it is important in the design of school-based administrative claiming programs that the school not perform activities that are already being offered or should be provided by other entities, or through other programs. As appropriate, this calls for close coordination between the schools, the state Medicaid agency, state education agencies, providers, community and non-profit organizations, and other entities related to the activities performed.

States must ensure that appropriate coordination occurs among providers. States can include these kinds of assurances in the language implementing their Medicaid managed care contracts. In addition, since schools are required under IDEA to provide services listed in a child's IEP, many Medicaid managed care contracts contain provisions that specifically exclude these services from the capitation rate paid to cover the costs of providing other medical services to Medicaid eligible children.

The following are examples of activities that should be coordinated:

- Activities performed by an MCO for Medicaid enrollees, such as case management functions. To avoid duplication of these functions by school personnel, coordination mechanisms should be established between the school and appropriate entities, such as the MCO and state Medicaid agency.

- Payment rate setting mechanism. State Medicaid agencies and schools need to coordinate with respect to their activities, payments to providers, third party payers, and rate setting mechanisms in order to ensure that duplicate payments are not made and that medical services and administrative activities are provided as efficiently and effectively as possible. For example, MCO payment rates may need to be adjusted to reflect the activities and services being furnished in the school setting.

- An activity that is provided/conducted by another governmental component. For example, it is not necessary for EPSDT educational materials, such as pamphlets and flyers, which have already been developed by the state Medicaid agency, to also be developed by schools. It would be inefficient in

the allocation of Medicaid program and school resources to do so. In order to avoid this, school districts/schools should coordinate and consult with the state Medicaid agency to determine the appropriate activities related to EPSDT and to determine the availability of existing materials.

6. Performing Direct Services v. Administrative Activities

School employees often perform both direct services (e.g., medical, vocational or social services, teaching) and administrative activities (e.g., outreach or care coordination). The time study and activity codes must capture and clearly distinguish direct services from administrative activities. Typically, direct services have different funding sources, claiming mechanisms, and documentation requirements related to each program or type of activity, and therefore they should not be claimed as an administrative expense. Because the time study must capture 100 percent of the time (See Principle 2., above) spent by school employees, activity codes are designed to reflect all administrative activities and direct services that may be performed in the school, only some of which are reimbursable under Medicaid. The time study methodology should identify the costs of medical and other direct services and ensure that those costs are not included in the claims for Medicaid administrative activities.

The activity codes used in the time study must distinguish between different types of activities and direct services, as well as their respective funding sources. For example, as indicated in the model activity code system in subsection C., Medicaid program outreach would be reported under Code 1.b., education program outreach under Code 1.a., Medicaid services under Code 4., and educational services under Code 3.

As indicated in Principle 4., payments for allowable Medicaid administrative activities must not duplicate payments that have been, or should have been, included as part of a **direct** medical service, capitation rate, or through some other state or federal program (as specified in OMB Circular A-87). It is the state's responsibility to ensure there is no duplication in a claim prior to submitting the claim to CMS.

Activities that are considered integral to, or an extension of, the specified covered service are included in the rate set for the direct service, and therefore they should not be claimed as an administrative expense. For example, when a school provides a medical service, the practitioner should not bill separately for the cost of a referral as an administrative expense. These activities are properly paid for as part of the medical service and reimbursed at the federal medical assistance percentage (FMAP). Nor may these activities be claimed as an additional cost through administrative case management, which is defined below.

a. Case Management as Administration

The State Medicaid Manual (SMM) Section 4302 identifies certain activities that may be properly claimed as **administrative** case management. An allowable administrative cost must be directly related to a Medicaid state plan or waiver service, and be necessary for the "proper and efficient administration of the state plan."

Some examples of administrative case management services addressed at SMM Section 4302.2 (G)(2), are:

- Medicaid eligibility determinations and redeterminations;
- Medicaid intake processing;
- Medicaid preadmission screening for inpatient care;
- Prior authorization for Medicaid services;
- Utilization review; and
- Medicaid outreach.

As indicated in the SMM, CMS may make determinations regarding whether or not other activities are necessary for the proper and efficient administration of the state plan. Examples of activities that are performed in a school-based setting may be found in the time study activity codes included elsewhere in this Guide.

While some case management activities may fall within the scope of both administrative and targeted case management, a state may not claim the same costs both as targeted case management and administrative case management, per the duplicate payment provision discussed above.

b. Case Management as a Service

Sections 1905(a)(19) and 1915(g)(2) of the Act (42 U.S.C. 1396d(a)(19) and 42 U.S.C. 1396n(g)(2), respectively) define case management as services which will assist an individual eligible under the state plan in gaining access to needed medical, social, educational, and other services. Case management services are referred to as targeted case management (TCM) services when the services are not furnished in accordance with requirements pertaining to statewideness or comparability. TCM services are included in state Medicaid programs as an optional service. This flexibility enables states to target case management services to specific classes of individuals and/or to individuals residing in specified areas. If a child is receiving TCM services through the school or through another provider, extra care must be taken to ensure that there is no duplication of services, or payment. All TCM services would be reported under Activity Code 4., Direct Medical Services, in Section IV., C. CMS intends to issue further guidance on TCM in the future.

7. Allocable Share of Costs

Since many school-based medical activities are provided both to Medicaid and non-Medicaid eligible students, the costs applicable to these activities must be allocated to both groups. This allocation of costs involves the determination and application of the proportional share of Medicaid students to the total number of students. Development of the proportional Medicaid share, which is sometimes referred to as the Medicaid eligibility rate, Medicaid percentage, allocable share or discount rate, should relate to and be based on the claiming unit (the entity submitting the claim). For example, claims may be developed on the basis of an individual school, a school district, or a specific unit of government, such as a county or statewide, as determined by the claiming unit. The proportional Medicaid share is then applied to the total costs of a specific activity for which the school district is submitting claims for FFP. This process is necessary to ensure that only the costs related to Medicaid eligible children are claimed to Medicaid. (Note that not all activities are subject to the proportional Medicaid share; activities such as outreach and facilitating eligibility determinations are not discounted.)

Through the use of time studies that contain specific activity codes, the cost of school personnel are distributed to certain activities (time study codes) to determine the administrative cost allocable to the Medicaid program. The universe of activity codes used in the time study as a group must capture the following categories of costs:

(1) **Unallowable** - the activity is unallowable as administration under the Medicaid program;

(2) **100% Medicaid Share** - the activity is solely attributable to the Medicaid program and as such is not subject to the application of the Medicaid share percentage (this is sometimes referred to as "not discounted");

(3) **Proportional Medicaid Share** - the activity is allowable as administration under the Medicaid program, but the allocable share of costs must be determined by applying the percentage of the Medicaid eligible population for each school or school district included in the time study; or

(4) **Reallocated Activities** - those activities which are reallocated across other codes based on the percentage of time spent on allowable/unallowable administrative activities.

OMB Circular A-87 states that, "a cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective **in accordance with relative benefits received**" (emphasis added). To establish the proportional Medicaid share, the number of Medicaid eligible students must be determined for each school/school district or governmental unit that is submitting a claim. This number serves as the numerator in a fraction, with the denominator being the total number of students in the same entity. This fractional value is then applied to the total costs applicable to the proportional Medicaid share time codes to determine the costs applicable to Medicaid administrative activities. Note that the number of Medicaid eligibles and the total number of students must be identified for the same time period. For example, total enrollment at the opening of school in August, compared with Medicaid enrollment in November, may not be used.

$$\textbf{Medicaid Costs} = \frac{[\ \textbf{Total Number of Medicaid Students}\ ]}{[\ \textbf{Total Number of Students}\ ]} \times \textbf{Costs to be allocated}$$

The number of Medicaid eligible students must be obtained from or verified with the state Medicaid agency. This may be done through a matching of school/school district enrollment data to Medicaid eligibility files or other comparable methods. Children who are deemed presumptively eligible for Medicaid are included in the number of Medicaid eligible students.

In the following example, administrative claims are developed on a school district basis. The purpose of applying a proportional Medicaid share is to determine the amount to be allocated between Medicaid and non-Medicaid students. The following example establishes how much of the costs related to the activity should be allocated to Medicaid. The amount of federal financial participation is then determined based on the activity costs that are allocable to Medicaid.

EXAMPLE OF MEDICAID SHARE

Gross Claimable Amount = $1,500

Number of Medicaid Students in District = 1,000

Number of Total Students in District = 5,000

Activity = Referral, Coordination, and Monitoring of Medicaid Services
(Proportional Medicaid /50 Percent Federal Financial Participation)

Medicaid Share Factor: Number of Medicaid Students/Total Students = 1,000/5,000 = 20 percent

Gross Claimable Amount	$1,500
Medicaid Share Rate (20 percent)	X .20
	$300
FFP Rate (50 percent)	X .50
Net Claimable Amount	**$150**

For example, an administrative activity may involve: "Referring students for necessary medical health, mental health, or substance abuse services covered by Medicaid." While the activity may be intended to benefit only Medicaid students, medical referrals would affect services provided to both Medicaid and non-Medicaid students. That is, both groups would benefit from the activity and therefore the costs associated with such referral activities must be allocated accordingly.

The allocation of costs applies to activities that are performed with respect to a population of children that includes Medicaid and non Medicaid-eligible children, such as referral and monitoring of services. Specifically, children with an IEP may have medical (Medicaid covered) services included in their IEPs. Some of these children may be eligible for Medicaid and some may not. When the IEP coordinator performs administrative activities such as referral and monitoring of services for such children, they typically may not know who is and who is not eligible for Medicaid. For that reason, a Medicaid percentage is applied to the time spent o n this activity to determine the proportion of the time that is allowable as a Medicaid administrative activity.

For outreach activities that are performed to identify potentially Medicaid eligible students and enroll them in the Medicaid program, schools do not need to determine which of these students are later determined eligible or which students apply for the program. Discounting is not applicable for this type of activity.

8. Enhanced FFP Rates

a. Claiming for Skilled Professional Medical Personnel (SPMP)

In order to claim at the enhanced rate of 75 percent for Skilled Professional Medical Personnel (SPMP) activities, SPMPs must have completed a two-year program leading to an academic degree or certificate in a medically-related program **and** the activity itself must require the use of their professional training

and expertise. Although there are employees in schools who have the qualifications needed to be considered an SPMP, CMS has determined that their advanced skills and training are **not** necessary in order to perform the types of administrative activities that take place in school settings. Therefore, effective January 1, 2003, FFP is no longer available at the enhanced rate of 75 percent for the costs of activities performed by school-based SPMPs (see State Medicaid Director letter dated November 21, 2002).

Under this policy, the availability of the 75 percent FFP rate for the costs of SPMP activities performed in the school setting is determined by when the SPMP activities were performed. Specifically, for potential SPMP activities performed prior to January 1, 2003, the 75 percent FFP rate may be available for the associated administrative costs, as long as the requirements for claiming at the enhanced rate are met. For SPMP activities performed on or after January 1, 2003, the 75 percent FFP rate would not be available for the associated administrative costs. The particular quarterly expenditure report on which a state submits claims for the costs of SPMP activities performed in the school setting is not relevant for determining whether the 75 percent FFP rate is available. That is, expenditure reports for quarters beginning on or after January 1, 2003 may contain claims at the 75 percent FFP rate for the costs of school-based SPMP activities performed prior to January 1, 2003. However, claims for FFP at the 75 percent rate contained in such expenditure reports would not be available if the SPMP activities were performed on or after January 1, 2003.

Administrative activities provided in schools may include: outreach, facilitating eligibility determination, program planning and coordination, training, and referral, coordination and monitoring of services. Since school employees without the advanced training of an SPMP are able to perform administrative activities, performance of these activities does not require the use of an SPMP. SPMPs in the school setting do not need to use their expertise to perform such administrative activities, and therefore should not claim at the enhanced FFP rate. Activities that do require individuals with advanced medical skills and training are likely provided as part of a medical service, and as such are not reimbursable as administrative costs under the Medicaid program.

While it is sometimes difficult to properly differentiate between administrative activities and medical services, this distinction is critical in understanding and applying Medicaid policy regarding the role of SPMPs in schools. Many of the direct medical services that IDEA students require are therapies that are needed on a continuing basis. In such cases, the medical provider, as part of providing the medical service, may need to develop a medical plan of care for the child. The medical plan of care is developed as part of the medical service being provided to the child, and may not be considered an administrative activity for purposes of claiming for the associated costs under Medicaid. Therefore, even if the therapists are qualified as SPMPs, most of the activities they conduct related to the therapy will be reimbursed through the services rate, while any unrelated administrative activities not included in the services rate may be claimed at the non-enhanced 50 percent rate.

In summary, school-based Medicaid administrative activities may not be claimed at the enhanced FFP rate for SPMPs because performance of these activities does not require the professional education and training necessary for the claiming of SPMP costs. Therefore, effective January 1, 2003, federal financial participation is no longer available at the enhanced rate of 75 percent for the costs of activities performed by school-based SPMPs.

b. Claiming for Administration of Family Planning Services

The enhanced family planning matching rate of 90 percent is available under Medicaid only for the "offering, arranging **and** furnishing" of family planning services (section 1903(a)(5) of the Act, emphasis added). This enhanced rate is available to personnel who administer as well as directly provide certain family planning services and supplies (42 CFR 432.50(b)(5) as referenced by 42 CFR 433.15(b)(2)). Schools that offer and/or arrange for family planning services, but do not actually furnish such services, may claim administrative activities related to covered Medicaid family planning services at the 50 percent administrative match, but not at the enhanced 90 percent FFP matching rate. This type of administrative activity would be reported under Code 9.b., "Referral, Coordination, and Monitoring of Medicaid Services." Payment for some or all of the costs of family planning services may also be available under Medicaid as a direct service. These costs are not allowable as administrative expenditures and would be reported under time study Code 4., "Direct Medical Services."

9. Provider Participation in the Medicaid Program

Administrative activities performed in support of medical services that are not coverable or reimbursable under the Medicaid program would not be allowable as Medicaid administration. In order for a medical service to be reimbursable, the provider furnishing such services must be participating in the Medicaid program and bill Medicaid for the service. If the provider is not participating or chooses not to bill Medicaid for the service, then the service cannot be reimbursed and the administrative expenditures related to the service are also not allowable. In order for the medical services to be reimbursable under the Medicaid state plan the following requirements must be met:

- The medical services must be furnished to a Medicaid eligible individual.
- The medical services must be included in the state's Medicaid state plan or available and required through the EPSDT program.
- The medical service is not provided free of charge to non-Medicaid individuals.
- The provider must furnish services as a participating provider in the Medicaid program, with a provider agreement and a Medicaid provider identification number, or must furnish such services as a provider for Medicaid enrollees of a Medicaid MCO.

Examples of this principle are:

Example 1. A school is a participating Medicaid provider. The school provides and bills for medical services listed in Medicaid eligible children's IEPs that are covered under the state's Medicaid state plan. Expenditures for administrative activities related to school children's services that are provided by the school as a Medicaid participating provider are allowable. Such activities would be reported under the appropriate Medicaid activity code.

Example 2. A school is not a Medicaid participating provider. Even though it provides medical services, the school does not bill for any direct medical services, including those listed in an IEP. The school provides medical-related IEP services to a Medicaid eligible child with

special education needs. In this example, the costs of the related administrative activities would not be allowable under the Medicaid program. Such activities would be reported under the appropriate non-Medicaid activity code.

Example 3. The school is not a participating provider. The school program refers Medicaid eligible children to participating Medicaid providers in the community. If the school performs administrative activities related to the services that are billed to Medicaid by community providers, the costs of such activities are allowable under the Medicaid program. Such activities would be reported under the appropriate Medicaid related activity code.

Example 4. Regardless of whether a school participates in the Medicaid program or not, school children's services referred to community providers that do not participate in Medicaid are not billed to Medicaid. In this case, the costs of administrative activities related to such medical services would not be allowable under Medicaid. Such activities would be reported under the appropriate non-Medicaid activity code.

A school or school district does not have to be a participating Medicaid provider in order to claim FFP for referring students to a covered medical service in the community. As long as the provider who renders such services participates in Medicaid and the service itself is Medicaid reimbursable, the school can receive FFP for the administrative costs related to making the referrals. In this case, the two activities – referral and provision of the service – are not linked for administrative billing purposes, as long as the referral is made to a participating Medicaid provider. CMS will pay for referrals to Medicaid-covered services regardless of whether the service was provided, but states must have a system in place for ensuring and documenting that students are actually receiving services.

It is not always administratively efficient for the schools to verify for each referral whether a provider is participating in the Medicaid program. The state and school may develop a mechanism/methodology to address this. For example, the state/school could apply a proportional "provider participation rate" in order to represent the percentage of referrals to participating providers. This provider participation rate can be used by schools in lieu of having to ascertain on a case basis whether the referral is to a participating provider. Such provider participation rates could be developed using a methodology similar to that used in establishing proportional Medicaid shares (see Principle 7. on allocable share of costs) and could be utilized for billing purposes. Note, the provider participation rate would be applied in conjunction with the proportional Medicaid share, as in the following example.

Example. There are ten providers in the school district to whom schools refer children for medical services covered by the Medicaid program. Only nine of these ten providers actually participate in the Medicaid program; therefore, the "provider participation rate" is 90 percent (9 out of 10). The provider participation rate would be multiplied by the proportional Medicaid share to determine the proportion of referral activity costs that are Medicaid related. In this case, if the proportional Medicaid share is 50 percent, and the "provider participation rate" is 90 percent, then 45 percent (50 percent multiplied by 90 percent) would represent the percentage of time/costs that are Medicaid related. The state could use this 45 percent amount rather than having to verify provider participation for every referral.

If a state and schools elect to use a provider participation rate, they must ensure that administrative claims are linked to services rendered by participating Medicaid providers. Schools and Medicaid agencies may also decide to work together to develop directories of participating providers that both entities can reference.

10. Individualized Education Program (IEP) Activities

Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) amended section 1903(c) of the Act (42 U.S.C. 1396b(c)) to permit Medicaid payment for services provided to children under the Individuals with Disabilities Education Act (IDEA) through an Individualized Education Program (IEP). IDEA provisions require school staff to perform a number of education-related activities that can generally be characterized as child find, evaluation (initial) and reevaluation, and development of an IEP (See also Appendix).

The IEP/IDEA related activities conducted by school staff are briefly described below:

> "Child Find." All children with disabilities residing in the state who are in need of special education and related services must be identified, located, and evaluated.
>
> "Initial Evaluations and Reevaluation." Before special education and related services are provided, an initial evaluation must be conducted by the state educational agency, another state agency or LEA in order to determine whether a child has a disability, and their special/specific educational needs. A re-evaluation would be a determination as to whether the child continues to be disabled, and regarding the continuing educational needs of the child.
>
> "Individualized Education Program (IEP)." IEPs are addressed in the Appendix to the Guide.

Schools are conducting the activities listed above for the purpose of fulfilling education-related mandates under the IDEA; as such, the associated costs of these activities are not allowable as administrative costs under the Medicaid program. In developing and reporting under the time study activity codes, these education-related activities must be clearly identified and distinguished as non-Medicaid activities. In general, these activities could be reported under model time study Codes 1.a., 2.a., and 3. in subsection C.

It is important to distinguish child find activities from Medicaid outreach for the purposes of claiming FFP under Medicaid. In accordance with the IDEA statute, schools conduct child find activities to identify children with disabilities who need special education and related services. Regardless of whether the child find activities result in finding eligible children for whom an IEP is developed, the child find costs are not allowed under Medicaid as administration. This type of outreach can be distinguished from outreach to identify children who might be eligible for Medicaid; such Medicaid outreach activities are allowable.

Various education-related statutes obligate schools to furnish or make payment for services provided in the school setting for which Medicaid payment is not available. While section 1903(c) of the Social Security Act clarifies that Medicaid payment is available for medical services contained in a child's IEP established under the IDEA (so long as the child is eligible and the services are otherwise reimbursable

under Medicaid), no other education-related statutes obligate Medicaid payment. For example, section 504 of the Rehabilitation Act of 1973 requires local school districts to provide or pay for certain services to make education accessible to handicapped children; these services are described in a section 504 plan. The 1903(c) exception is very specific and does not extend to services provided pursuant to a section 504 plan. Because education agencies are required to pay for section 504 services, and there is no provision to make the education agencies secondary to Medicaid, federal Medicaid funds are not available for these services.

IDEA is described further in the Appendix to the Guide.

11. Review and Approval of Program and Codes by CMS

CMS reviews claims made by state Medicaid agencies, particularly in situations involving the establishment of a new program in a state such as a school-based administrative claiming program, in order to determine the allowability of such claims for federal matching funds. Furthermore, as discussed below and in Section V., D. on Cost Allocation Plans, the Division of Cost Allocation (DCA) in the U.S. Department of Health and Human Services (DHHS) (in coordination and consultation with CMS) is required to approve public assistance cost allocation plans (CAPs). The CAPs must incorporate, by reference, the time study and cost allocation methodology adopted by the state Medicaid agency for schools to develop and document claims submitted to the state. States must submit amendments to cost allocation plans and have them approved before they begin operating under them. Therefore, states should consult with CMS as early as possible in the development of their school-based administrative claiming programs in order to have such programs and the associated time study codes reviewed and approved by CMS prior to submission for federal matching to CMS and prior to submitting their CAP amendments to DCA. This will help ensure that such amendments are approved on a timely basis and that subsequent claims are in accordance with federal requirements, and to mitigate the amount of unallowable claims.

Federal regulations (42 CFR 433.34) require that under the Medicaid state plan, the single state agency have an approved public assistance cost allocation plan on file with DHHS that meets certain regulatory requirements (Subpart E of 45 CFR part 95). As indicated in Subpart E of 45 CFR part 95 and referenced in OMB Circular A-87, Attachment D, a state's public assistance CAP is an official document which describes the procedures that states use in identifying, measuring and allocating state agency costs incurred in support of all programs administered or supervised by the state agency, such as TANF, Medicaid, Food Stamps, Child Support Enforcement, adoption assistance, and Foster Care and Social Service Block Grant.

Furthermore, there are certain items that must be in the public assistance CAP which a state Medicaid agency must submit before providing FFP to school districts for administrative claiming, if it chooses to use schools to provide such services. The public assistance CAP must make explicit reference to the methodologies, claiming mechanisms, interagency agreements, and other relevant issues pertinent to the allocation of costs and submission of claims by the LEAs, school districts, and schools. Depending on the nature of the referenced time study and costing methodology, they may have to be amended to comply with documentation requirements. States should consult with the CMS Regional Office in the development of time study and allocation methodologies used for their school-based administrative claiming programs.

The required elements of public assistance CAPs are further discussed in the Cost Allocation Plan section of the Guide (Section V., D.), as is the review and approval process for such plans.

12. Free Care

The "free care" principle precludes Medicaid from paying for the costs of Medicaid-coverable services and activities which are generally available to all students without charge, and for which no other sources for reimbursement are pursued. Thus, Medicaid cannot reimburse for routine school-based vision and hearing screenings or other primary and preventive services provided free of charge to all students. In order for Medicaid payment to be available for these services, the provider must:

1) establish a fee for each service that is available;
2) collect third party insurance information from all those served (Medicaid and non-Medicaid); and
3) bill other responsible third party insurers.

Federal legislation provides for exceptions to the above-stated policy with regard to services provided under IDEA, the Women, Infants and Children's (WIC) program and services provided by title V grantees. Thus, Medicaid will pay before the education agency, the WIC program, or title V for Medicaid coverable services provided by those programs to Medicaid eligible children. This is true whether or not the IDEA, WIC or title V provider also charges non-Medicaid beneficiaries of these services. With respect to the title V exception, Medicaid will only reimburse for Medicaid-covered services provided to Medicaid beneficiaries to the extent that title V funds are used or available to the title V provider to provide the services. To the extent that the provider receives other, non-title V funds to provide the services, the title V exception from free care and third party liability does not apply.

The exceptions to the free care and payor of last resort principles are specified in Medicaid statute:

> Section 1902(a)(11)(B) of the Act (42 U.S.C. 1396a(a)(11)(B)), which provides for Medicaid to pay for Medicaid coverable services provided by a Title V grantee in the state.
>
> Section 1903(c) of the Act (42 U.S.C. 1396b(c)), which allows Medicaid to pay for coverable Medicaid services for children that are included in an IEP or Individualized Family Service Plan (IFSP) under the IDEA.

Medicaid will **not** pay for "EPSDT-type" primary and preventive care services not specified in a child's IEP, if the same service is provided free of charge to non-Medicaid children in the school. For example, the services of a school nurse who attends to a Medicaid child's sore throat, sprained ankle, or other acute medical problem **cannot** be reimbursed by Medicaid if similar services provided by the nurse to non-Medicaid children are not billed. Also, Medicaid coverable medical services that are provided to Medicaid children under a "section 504 plan" in order to make education accessible to these children with disabilities, are not reimbursed by Medicaid. It is the responsibility of the education agency to provide these services, and other third-party payors are not generally billed for these services. Costs of related administrative activities for these services are also not allowable under Medicaid.

Medical services specified in a child's IEP, and administrative activities provided in support of those services are treated differently from the other EPSDT-type primary and preventive services or "section 504 plan" services discussed above. Medicaid, as required by 1903(c) of the Act, will pay for IEP-specified medical services and related administrative costs provided to Medicaid children, even though non-Medicaid children are generally not billed for them.

This Guide does not change existing third party liability (TPL) requirements for IEP services. Medicaid is primary payor to the education agency for services included in an IEP, but is secondary to any other payor. Medicaid TPL provisions for pursuing all other sources of liability are still required by statute (section 1902(a)(25)(E) of the Act, 42 U.S.C. 1396a(a)(25)(E)) and recovery is sought if there is a liable third party (See also Section VI., J.).

> Example: A screening is provided free of charge to all students. Medicaid would not pay for the screen since it falls under the free care provision. However, the screening may lead to the discovery of a needed service included in a Medicaid enrolled child's IEP. In such a case, Medicaid could pay for the medically necessary service discovered through the screen (assuming the service is not considered free care). Medicaid distinguishes between the screening and the medically necessary service discovered through the screen because the school does not bill any third parties for the provision of the free screening while it does bill for the medical service. The free care provision applies to the particular service in question, and, for this reason, the screening and the service are treated differently for purposes of FFP. Medicaid by law is responsible for paying for the medically necessary services in IEPs, as well as the related administrative activities (i.e., the referral).

We understand that the free care provision serves to limit the ability of schools to bill Medicaid for covered services provided to Medicaid-eligible children because schools that provide needed health services often provide them to all students free of charge. While there are exceptions to the free care principle for Title V and Medicaid services provided to children with disabilities pursuant to an IEP under IDEA, many schools provide a range of services that would not fall under these exceptions, including services provided by school nurses and school psychologists.

The free care principle is relevant to the construction of time study activity codes. To the extent that a medical service is not reimbursable under the Medicaid program due to the free care policy, associated administrative costs also may not be claimed. For example, state laws may require that immunizations be provided to all school children, regardless of the child's income status or whether the child is Medicaid eligible. In such a case the administrative activities related to assisting the child to obtain such immunizations in the school would not be reimbursable as a Medicaid administrative cost. Therefore, such an activity would be reported under Code 9.a., not 9.b., based on the model activity code system in Section IV., C.

C. Activity Codes: Descriptions and Examples

1. Introduction

When staff perform duties related to the proper administration of the state's Medicaid program, federal funds may be drawn as federal financial participation (FFP) for the costs of providing these

administrative services. To identify the cost of providing these services, a time study of staff, or an acceptable substitute system, must be conducted. The time study identifies the time and associated costs related to the Medicaid administrative activities that are allowable and reimbursable under the Medicaid program. The following is a suggested coding scheme and may not reflect all the activities undertaken by a school district. The suggested activity codes may be modified as necessary to reflect local conditions and activities.

The indicators below, which follow each Code, provide the application of the FFP rate, the allowability or non-allowability designation, and the proportional Medicaid share status of the Code. In order to maintain coding objectivity by time study participants, time study sheets used by employees should not include references to rates of FFP, proportional or total Medicaid, or whether such codes are allowable or unallowable under Medicaid.

Application of FFP rate

50 percent — Refers to an activity that is allowable as administration under the Medicaid program and claimable at the 50 percent non-enhanced FFP rate.

Unallowable Activities

U — Refers to an activity that is unallowable as administration under the Medicaid program. This is regardless of whether or not the population served includes Medicaid eligible individuals.

Application of Medicaid Share

TM — (Total Medicaid) Refers to an activity that is 100 percent allowable as administration under the Medicaid program.

PM — (Proportional Medicaid) Refers to an activity which is allowable as administration under the Medicaid program, but for which the allocable share of costs must be determined by the application of the proportional Medicaid share (the Medicaid eligibility rate). The Medicaid share is determined as the ratio of Medicaid eligible students to total students.

Reallocated Activities

R — Refers to those general administrative activities performed by time study participants which must be reallocated across the other activity codes on a pro rata basis. These reallocated activities are reported under Code 10, General Administration. Note that certain functions, such as payroll, maintaining inventories, developing budgets, executive direction, etc., are considered overhead and, therefore, are only allowable through the application of an approved indirect cost rate.

Staff should document time spent on each of the following coded activities:

CODE 1.a.	Non-Medicaid Outreach - U
CODE 1.b.	Medicaid Outreach - TM/50 Percent FFP
CODE 2.a.	Facilitating Application for Non-Medicaid Programs - U
CODE 2.b.	Facilitating Medicaid Eligibility Determination-TM/ 50 Percent FFP
CODE 3.	School Related and Educational Activities - U
CODE 4.	Direct Medical Services - U
CODE 5.a.	Transportation for Non-Medicaid Services - U
CODE 5.b.	Transportation-Related Activities in Support of Medicaid Covered Services - PM/50 Percent FFP
CODE 6.a.	Non-Medicaid Translation - U
CODE 6.b.	Translation Related to Medicaid Services - PM/50 Percent FFP
CODE 7.a.	Program Planning, Policy Development, and Interagency Coordination Related to Non-Medical Services - U
CODE 7.b.	Program Planning, Policy Development, and Interagency Coordination Related to Medical Services -PM/50 Percent FFP
CODE 8.a.	Non-Medical/Non-Medicaid Related Training - U
CODE 8.b.	Medical/Medicaid Related Training - PM/50 Percent FFP
CODE 9.a.	Referral, Coordination, and Monitoring of Non-Medicaid Services - U
CODE 9.b.	Referral, Coordination, and Monitoring of Medicaid Services - PM/50 Percent FFP
CODE 10.	General Administration - R

The following activity codes represent a model set of activity categories including administrative and direct services that may be used and adapted to reflect the state's specific program titles, etc. These codes were developed in accordance with the principles discussed in other sections of this Guide and are recommended for use by states. There is flexibility afforded to states and schools in applying these activity codes. **These activity codes may be modified by states to reflect their unique circumstances and other codes or examples may be added to the categories, as long as such changes are made in accordance with the principles set forth in this Guide**.

For all the activity codes and examples listed below, if an activity is provided as part of, or an extension of, a direct medical service, it may not be claimed as Medicaid administration. Any costs related to medical services should be claimed as Code 4., Direct Medical Services. None of the activity codes listed below allow for the application of the 75 percent enhanced FFP rate because CMS policy is that administrative activities performed in the school setting do not require the skill level of Skilled Professional Medical Personnel (SPMPs). (See Section IV., B., Principle 8. for further information on SPMP claiming.)

CODE 1.a. NON-MEDICAID OUTREACH - U

All school staff should use this code when performing activities that inform individuals about their eligibility for non-Medicaid social, vocational and educational programs (including special education) and how to access them; describing the range of benefits covered under these programs and how to

obtain them. Both written and oral methods may be used. Include related paperwork, clerical activities or staff travel required to perform these activities.

1. Informing families about wellness programs and how to access these programs.

2. Scheduling and promoting activities that educate individuals about the benefits of healthy life-styles and practices.

3. Conducting general health education programs or campaigns that address life-style changes in the general population (e.g., dental prevention, anti-smoking, alcohol reduction, etc.).

4. Conducting outreach campaigns that encourage persons to access social, educational, legal or other services not covered by Medicaid.

5. Assisting in early identification of children with special medical/dental/mental health needs through various child find activities.

6. Outreach activities in support of programs that are 100 percent funded by state general revenue.

7. Developing outreach materials such as brochures or handbooks for these programs.

8. Distributing outreach materials regarding the benefits and availability of these programs.

CODE 1.b. MEDICAID OUTREACH – TM/50 Percent FFP

School staff should use this code when performing activities that inform eligible or potentially eligible individuals about Medicaid and how to access the program. Such activities include bringing potential eligibles into the Medicaid system for the purpose of the eligibility process. Outreach may only be conducted for the populations served by the school districts, i.e., students and their parents or guardians.

The following are examples of activities that are considered Medicaid outreach:

1. Informing Medicaid eligible and potential Medicaid eligible children and families about the benefits and availability of services provided by Medicaid (including preventive treatment, and screening) including services provided through the EPSDT program.

2. Developing and/or compiling materials to inform individuals about the Medicaid program (including EPSDT) and how and where to obtain those benefits. Note: This activity should not be used when Medicaid-related materials are already available to the schools (such as through the Medicaid agency). As appropriate, school developed outreach materials should have prior approval of the Medicaid agency.

3. Distributing literature about the benefits, eligibility requirements, and availability of the Medicaid program, including EPSDT.

4. Assisting the Medicaid agency to fulfill the outreach objectives of the Medicaid program by informing individuals, students and their families about health resources available through the Medicaid program.

5. Providing information about Medicaid EPSDT screening (e.g., dental, vision) in schools that will help identify medical conditions that can be corrected or improved by services offered through the Medicaid program.

6. Contacting pregnant and parenting teenagers about the availability of Medicaid prenatal, and well baby care programs and services.

7. Providing information regarding Medicaid managed care programs and health plans to individuals and families and how to access that system.

8. Encouraging families to access medical/dental/mental health services provided by the Medicaid program.

CODE 2.a. FACILITATING APPLICATION FOR NON-MEDICAID PROGRAMS – U

This code should be used by school staff when informing an individual or family about programs such as Temporary Assistance for Needy Families (TANF), Food Stamps, Women, Infants, and Children (WIC), day care, legal aid, and other social or educational programs and referring them to the appropriate agency to make application.

1. Explaining the eligibility process for non-Medicaid programs, including IDEA.

2. Assisting the individual or family collect/gather information and documents for the non-Medicaid program application.

3. Assisting the individual or family in completing the application, including necessary translation activities.

4. Developing and verifying initial and continuing eligibility for the Free and Reduced Lunch Program.

5. Developing and verifying initial and continuing eligibility for non-Medicaid programs.

6. Providing necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination.

CODE 2.b. FACILITATING MEDICAID ELIGIBILITY DETERMINATION – TM/50 Percent FFP

School staff should use this code when assisting an individual in the Medicaid eligibility process. Include related paperwork, clerical activities, or staff travel required to perform these activities. This activity does not include the actual determination of Medicaid eligibility.

1. Verifying an individual's current Medicaid eligibility status for purposes of the Medicaid eligibility process.

2. Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.

3. Assisting individuals or families to complete a Medicaid eligibility application.

4. Gathering information related to the application and eligibility determination for an individual, including resource information and third party liability (TPL) information, as a prelude to submitting a formal Medicaid application.

5. Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.

6. Referring an individual or family to the local Assistance Office to make application for Medicaid benefits.

7. Assisting the individual or family in collecting/gathering required information and documents for the Medicaid application.

8. Participating as a Medicaid eligibility outreach outstation, but does not include determining eligibility.

CODE 3. SCHOOL-RELATED AND EDUCATIONAL ACTIVITIES – U

This code should be used for school-related activities, including social services, educational services, teaching services, employment and job training, and other activities that are not Medicaid-related. These activities include the development, coordination, and monitoring of a student's education plan. Include related paperwork, clerical activities, or staff travel required to perform these activities.

1. Providing classroom instruction (including lesson planning).

2. Testing, correcting papers.

3. Developing, coordinating, and monitoring the Individualized Education Program (IEP) for a student, which includes ensuring annual reviews of the IEP are conducted, parental sign-offs are obtained, and the actual IEP meetings with the parents. (If appropriate, this would also refer to the same activities performed in support of an Individualized Family Service Plan (IFSP).)

4. Compiling attendance reports.

5. Performing activities that are specific to instructional, curriculum, and student-focused areas.

6. Reviewing the education record for students who are new to the school district.

7. Providing general supervision of students (e.g., playground, lunchroom).

8. Monitoring student academic achievement.

9. Providing individualized instruction (e.g., math concepts) to a special education student.

10. Conducting external relations related to school educational issues/matters.

11. Compiling report cards.

12. Carrying out discipline.

13. Performing clerical activities specific to instructional or curriculum areas.

14. Activities related to the educational aspects of meeting immunization requirements for school attendance.

15. Compiling, preparing, and reviewing reports on textbooks or attendance.

16. Enrolling new students or obtaining registration information.

17. Conferring with students or parents about discipline, academic matters or other school related issues.

18. Evaluating curriculum and instructional services, policies, and procedures.

19. Participating in or presenting training related to curriculum or instruction (e.g., language arts workshop, computer instruction).

20. Translating an academic test for a student.

CODE 4. DIRECT MEDICAL SERVICES – U

School staff should use this code when providing care, treatment, and/or counseling services to an individual. This code also includes administrative activities that are an integral part of or extension of a medical service (e.g., patient follow-up, patient assessment, patient counseling, patient education, parent consultations, billing activities). This code also includes all related paperwork, clerical activities, or staff travel required to perform these activities. Note, some of the following activities may be subject to the free care principle (discussed in Sections IV., 12. and V., J. of the Guide).

1. Providing health/mental health services contained in an IEP.

2. Medical/health assessment and evaluation as part of the development of an IEP.

3. Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports.

4. Providing personal aide services.

5. Providing speech, occupational, physical and other therapies.

6. Administering first aid, or prescribed injection or medication to a student.

7. Providing direct clinical/treatment services.

8. Performing developmental assessments.

9. Providing counseling services to treat health, mental health, or substance abuse conditions.

10. Developing a treatment plan (medical plan of care) for a student if provided as a medical service.

11. Performing routine or mandated child health screens including but not limited to vision, hearing, dental, scoliosis, and EPSDT screens.

12. Providing immunizations.

13. Targeted Case Management (if provided or covered as a medical service under Medicaid).

14. Transportation (if covered as a medical service under Medicaid). See Section V., K. on claiming for transportation as an administrative cost.

15. Activities that are services, or components of services, listed in the state's Medicaid plan.

CODE 5.a. TRANSPORTATION FOR NON-MEDICAID SERVICES – U

School district employees should use this code when assisting an individual to obtain transportation to services not covered by Medicaid, or accompanying the individual to services not covered by Medicaid. Include related paperwork, clerical activities or staff travel required to perform these activities.

1. Scheduling or arranging transportation to social, vocational, and/or educational programs and activities.

CODE 5.b. TRANSPORTATION-RELATED ACTIVITIES IN SUPPORT OF MEDICAID COVERED SERVICES – PM/50 Percent FFP

School district employees should use this code when assisting an individual to obtain transportation to services covered by Medicaid. This does not include the provision of the actual transportation service or the direct costs of the transportation (bus fare, taxi fare, etc.), but rather the administrative activities involved in providing transportation. Include related paperwork, clerical activities or staff travel required to perform these activities. See Section V., K. for a more detailed and thorough discussion of Medicaid transportation policy.

1. Scheduling or arranging transportation to Medicaid covered services.

CODE 6.a. NON-MEDICAID TRANSLATION - U

School employees who provide translation services for non-Medicaid activities should use this code. Include related paperwork, clerical activities or staff travel required to perform these activities.

Non-Medicaid translation can be reported in two ways: As a separate non-Medicaid code (Code 6.a.) or as an example within one or more non-Medicaid activity codes.

1. Arranging for or providing translation services (oral or signing services) that assist the individual to access and understand social, educational, and vocational services.

2. Arranging for or providing translation services (oral or signing services) that assist the individual to access and understand state education or state-mandated health screenings (e.g., vision, hearing, scoliosis) and general health education outreach campaigns intended for the student population.

3. Developing translation materials that assist individuals to access and understand social, educational, and vocational services.

CODE 6.b. TRANSLATION RELATED TO MEDICAID SERVICES – PM/50 percent FFP

Translation may be allowable as an administrative activity, if it is not included and paid for as part of a medical assistance service. However, translation must be provided either by separate units or separate employees performing solely translation functions for the school and it must facilitate access to Medicaid covered services. Please note that a school district does not need to have a separate administrative claiming unit for translation.

School employees who provide Medicaid translation services should use this code. Include related paperwork, clerical activities or staff travel required to perform these activities.

Medicaid translation can be reported in two ways: As a separate Medicaid code (Code 6.b.) or as an example within one or more Medicaid activity codes.

1. Arranging for or providing translation services (oral and signing) that assist the individual to access and understand necessary care or treatment covered by Medicaid.

2. Developing translation materials that assist individuals to access and understand necessary care or treatment covered by Medicaid.

CODE 7.a. PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO NON-MEDICAL SERVICES - U

School staff should use this code when performing activities associated with developing strategies to improve the coordination and delivery of non-medical services to school age children. Non-medical services may include social services, educational services, vocational services, and state or state education mandated child health screenings provided to the general school population. Employees whose position descriptions include program planning, policy development, and interagency coordination may use this code. However, it is a state option whether or not the position descriptions need to be explicit with respect to these specific functions. Include related paperwork, clerical activities or staff travel required to perform these activities.

1. Identifying gaps or duplication of non-medical services (e.g., social, vocational educational and state mandated general health care programs) to school age children and developing strategies to improve the delivery and coordination of these services.

2. Developing strategies to assess or increase the capacity of non-medical school programs.

3. Monitoring the non-medical delivery systems in schools.

4. Developing procedures for tracking families' requests for assistance with non-medical services and the providers of such services.

5. Evaluating the need for non-medical services in relation to specific populations or geographic areas.

6. Analyzing non-medical data related to a specific program, population, or geographic area.

7. Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical problems.

8. Defining the relationship of each agency's non-medical services to one another.

9. Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services and state-mandated health screenings to the school populations.

10. Developing non-medical referral sources.

11. Coordinating with interagency committees to identify, promote and develop non-medical services in the school system.

CODE 7.b. PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO MEDICAL SERVICES – PM/50 percent FFP

This code should be used by school staff when performing activities associated with the development of strategies to improve the coordination and delivery of medical/dental/mental health services to school age children, and when performing collaborative activities with other agencies and/or providers. Employees whose position descriptions include program planning, policy development, and interagency coordination may use this code. However, it is a state option whether or not the position descriptions need to be explicit with respect to these specific functions. This code refers to activities such as planning and developing procedures to track requests for services; the actual tracking of requests for Medicaid services would be coded under Code 9.b., Referral, Coordination and Monitoring of Medical Services. Include related paperwork, clerical activities or staff travel required to perform these activities.

1. Identifying gaps or duplication of medical/dental/mental services to school age children and developing strategies to improve the delivery and coordination of these services.

2. Developing strategies to assess or increase the capacity of school medical/dental/mental health programs.

3. Monitoring the medical/dental/mental health delivery systems in schools.

4. Developing procedures for tracking families' requests for assistance with medical/dental/mental services and providers, including Medicaid. (This does not include the actual tracking of requests for Medicaid services.)

5. Evaluating the need for medical/dental/mental services in relation to specific populations or geographic areas.

6. Analyzing Medicaid data related to a specific program, population, or geographic area.

7. Working with other agencies and/or providers that provide medical/dental/mental services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligibles, and to increase provider participation and improve provider relations.

8. Working with other agencies and/or providers to improve collaboration around the early identification of medical/dental/mental problems.

9. Developing strategies to assess or increase the cost effectiveness of school medical/dental/mental health programs.

10. Defining the relationship of each agency's Medicaid services to one another.

11. Working with Medicaid resources, such as the Medicaid agency and Medicaid managed care plans, to make good faith efforts to locate and develop EPSDT health services referral relationships.

12. Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services to the school populations.

13. Working with the Medicaid agency to identify, recruit and promote the enrollment of potential Medicaid providers.

14. Developing medical referral sources such as directories of Medicaid providers and managed care plans, who will provide services to targeted population groups, e.g., EPSDT children.

15. Coordinating with interagency committees to identify, promote and develop EPSDT services in the school system.

CODE 8.a. NON-MEDICAL/NON-MEDICAID RELATED TRAINING - U

School staff should use this code when coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefit of the programs other than the Medicaid program. For example, training may include how to assist families to access the services of education programs, and how to more effectively refer students for those services. Include related paperwork, clerical activities, or staff travel required to perform these activities.

Non-medical/non-Medicaid training can be reported in two ways: As a separate code (Code 8.a.) or as an example within one or more non-medical/non-Medicaid activity codes.

1. Participating in or coordinating training that improves the delivery of services for programs other than Medicaid.

2. Participating in or coordinating training that enhances IDEA child find programs.

CODE 8.b. MEDICAL/MEDICAID RELATED TRAINING – PM/50 Percent FFP

School staff should use this code when coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefits of medical/Medicaid related services, how to assist families to access such services, and how to more effectively refer students for services. Include related paperwork, clerical activities, or staff travel required to perform these activities.

Medical/Medicaid training can be reported in two ways: As a separate code (Code 8.b.) or as an example within one or more Medical/Medicaid activity codes.

1. Participating in or coordinating training that improves the delivery of medical/Medicaid related services.

2. Participating in or coordinating training that enhances early identification, intervention, screening and referral of students with special health needs to such services (e.g., Medicaid EPSDT services). (This is distinguished from IDEA child find programs.)

3. Participating in training on administrative requirements related to medical/Medicaid services.

CODE 9.a. REFERRAL, COORDINATION, AND MONITORING OF NON-MEDICAID SERVICES - U

School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of non-medical, such as educational services. Include related paperwork, clerical activities or staff travel required to perform these activities.

1. Making referrals for and coordinating access to social and educational services such as child care, employment, job training, and housing.

2. Making referrals for, coordinating, and/or monitoring the delivery of state education agency mandated child health screens (e.g., vision, hearing, scoliosis).

3. Making referrals for, coordinating, and monitoring the delivery of scholastic, vocational, and other non-health related examinations.

4. Gathering any information that may be required in advance of these non-Medicaid related referrals.

5. Participating in a meeting/discussion to coordinate or review a student's need for scholastic, vocational, and non-health related services not covered by Medicaid.

6. Monitoring and evaluating the non-medical components of the individualized plan as appropriate.

Case Management. Note that case management as an administrative activity involves the facilitation of access and coordination of program services. Such activities may be provided under the term Case Management or may also be referred to as Referral, Coordination, and Monitoring of non-Medicaid Services.

Case management may also be provided as an integral part of the service and would be included in the service cost.

School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of NON-Medicaid covered services.

CODE 9.b. REFERRAL, COORDINATION, AND MONITORING OF MEDICAID SERVICES – PM/50 Percent FFP

School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of medical (Medicaid covered) services. Referral, coordination and monitoring activities related to services in an IEP are reported in this code. Activities that are part of a direct service are not claimable as an administrative activity. Furthermore, **activities that are an integral part of or an extension of a medical service (e.g., patient follow-up, patient assessment, patient counseling, patient education, patient consultation, billing activities) should be reported under Code 4, Direct Medical Services.** Note that targeted case management, if provided or covered as a medical service under Medicaid, should be reported under Code 4, Direct Medical Services. Activities related to the development of an IEP should be reported under Code 3, School Related and Educational Activities. Include related paperwork, clerical activities, or staff travel necessary to perform these activities.

1. Identifying and referring adolescents who may be in need of Medicaid family planning services.

2. Making referrals for and/or coordinating medical or physical examinations and necessary medical/dental/mental health evaluations.

3. Making referrals for and/or scheduling EPSDT screens, interperiodic screens, and appropriate immunization, but NOT to include the state-mandated health services.

4. Referring students for necessary medical health, mental health, or substance abuse services covered by Medicaid.

5. Arranging for any Medicaid covered medical/dental/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/mental health condition.

6. Gathering any information that may be required in advance of medical/dental/mental health referrals.

7. Participating in a meeting/discussion to coordinate or review a student's needs for health-related services covered by Medicaid.

8. Providing follow-up contact to ensure that a child has received the prescribed medical/dental/mental health services covered by Medicaid.

9. Coordinating the delivery of community based medical/dental/mental health services for a child with special/severe health care needs.

10. Coordinating the completion of the prescribed services, termination of services, and the referral of the child to other Medicaid service providers as may be required to provide continuity of care.

11. Providing information to other staff on the child's related medical/dental/mental health services and plans.

12. Monitoring and evaluating the Medicaid service components of the IEP as appropriate.

13. Coordinating medical/dental/mental health service provision with managed care plans as appropriate.

Case Management. Note that case management as an administrative activity involves the facilitation of access and coordination of services covered under the state's Medicaid program. Such activities may be provided under the term Administrative Case Management or may also be referred to as Referral, Coordination, and Monitoring of Medicaid Services.

Case management may also be provided as an integral part of a medical service and would be included in the service cost. The state may also cover targeted case management as an optional service under Medicaid.

School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of Medicaid covered services. Include related paperwork, clerical activities or staff travel required to perform these activities.

CODE 10. GENERAL ADMINISTRATION - R

This code should be used by time study participants when performing activities that are not directly assignable to program activities. Include related paperwork, clerical activities, or staff travel required to perform these activities. Note that certain functions, such as payroll, maintaining inventories, developing budgets, executive direction, etc., are considered overhead and, therefore, are only allowable through the application of an approved indirect cost rate.

Below are typical examples of general administrative activities, but they are not all inclusive.

1. Taking lunch, breaks, leave, or other paid time not at work.

2. Establishing goals and objectives of health-related programs as part of the school's annual or multi-year plan.

3. Reviewing school or district procedures and rules.

4. Attending or facilitating school or unit staff meetings, training, or board meetings.

5. Performing administrative or clerical activities related to general building or district functions or operations.

6. Providing general supervision of staff, including supervision of student teachers or classroom volunteers, and evaluation of employee performance.

7. Reviewing technical literature and research articles.

8. Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.

V. CLAIMING ISSUES

A. Documentation

The time study methodology and instructions, as well as the cost allocation requirements issued by the state Medicaid agency to the schools, must stipulate the documentation the schools must maintain to support the claims submitted to the state. The documentation for administrative activities must clearly demonstrate that the activities/services directly support the administration of the Medicaid program. In accordance with the statute, the regulations, and the Medicaid state plan, the state is required to maintain/retain adequate source documentation to support the Medicaid payments for administrative claiming. The basis for this requirement can be found in statute and regulations. See section 1902(a)(4) of the Act and 42 CFR 431.17; see also 45 CFR 74.53 and 42 CFR 433.32(a) (requiring source documentation to support accounting records) and 45 CFR 74.20 and 42 CFR 433.32(b and c) (retention period for records). The administrative claiming records must be made available for review by state and federal staff upon request during normal working hours (section 1902(a)(4) of the Act, implemented at 42 CFR 431.17). It is the state's responsibility to ensure that the applicable policies are applied uniformly throughout the state, and that claims submitted to CMS are in conformance with such requirements.

Documentation maintained in support of administrative claims must be sufficiently detailed to permit CMS to determine whether the activities are necessary for the proper and efficient administration of the state plan. Simply checking a box on a time study form does not facilitate independent validation of the sample results.

In the past, federal agencies have generally accepted minimal documentation of time study random moment sampling. However, circumstances under which school-based administrative activities are sampled for purposes of FFP under the Medicaid program differ. In other instances, the costs to be distributed are generally federally reimbursable and the results of the sample only determine the percentage of the costs that are directed to each federal program. In contrast, when sampling is conducted to determine federal financial participation under the Medicaid program for the costs of school-based administrative activities, the vast majority of the costs are not federally reimbursable. Therefore, it is critically important for additional documentation to be maintained, in order to verify the appropriateness of the claims in terms of allowability and allocability and to limit the risk of the federal government.

The burden of proof and validation of time study sample results remains the responsibility of the states. To meet this requirement, some states currently include space on time study forms for a brief narrative description of the Medicaid activity, function, or task being performed. Client name or case number is also noted where applicable. States should consider this approach to documentation, or some comparable procedure that adequately documents Medicaid sampled activities.

Additional guidance regarding documentation for compensation of salary and wages is found in OMB Circular A-87, Attachment B, Section 11.h.(5):

> Personnel activity reports or equivalent documentation must meet the following standards:

(a) They must reflect an after-the-fact distribution [i.e., distribution following completion of the activity] of the actual activity of each employee,

(b) They must account for the total activity for which each employee is compensated,

(c) They must be prepared at least monthly and must coincide with one or more pay periods, and

(d) They must be signed by the employee as being a true statement of activities and the employee/office will retain documentation to support the report.

Note, the requirement to document costs monthly does not necessarily mean that time studies must be conducted monthly. OMB Circular A-87 makes a distinction between documentation of costs and the methods/mechanisms for allocating such costs. While costs must be documented at least on a monthly basis, time studies, which are conducted for purposes of allocating costs, can occur on a quarterly basis or some other statistically valid time frame. ASMB C-10, the U.S. Department of Health and Human Services' implementation guide for OMB Circular A-87, provides further guidance on the requirements and circumstances dictating the frequency of time and effort reporting.

Other principles related to documentation and documentation requirements that apply in addition to the above requirements are:

- The documentation related to salaries and wages, including personnel activity reports, is required;
- Accounting records should be supported by source documentation such as canceled checks, paid bills, payrolls, contract and subgrant award documents;
- The documentation related to foster care payments and administrative costs is required;
- Case management services based on time studies are an acceptable form of documentation for a given period;
- Costs must be verified as being incurred in a particular federal program;
- Undocumented personnel costs are not allowed; and
- Adequate documentation for labor costs is required.

Position descriptions can be useful as supporting documentation for staff participating in time studies. However, position or job descriptions are often generic and may indicate that "other administrative duties" are included, without providing a definition for those administrative functions. In many cases, these "other administrative duties" may be understood to include the performance of Medicaid related activities and the completion of time studies. In that regard, it may be helpful, though it is not required, to include in the time study participants' position descriptions further explanation or documentation of the Medicaid related activities performed, particularly if the position descriptions do not reflect any aspect of the performance of such activities. However, schools are not required to modify job descriptions in order to incorporate time study activities. Furthermore, CMS does not require position descriptions to be maintained for staff that are not participating in the school-based administrative claiming program.

B. Sampling/Time Studies

Recognizing the necessity of using a sample to develop administrative claims, OMB Circular A-87 permits the use of "substitute systems" for allocating salaries and wages to federal awards to be used in place of activity reports when employees work on multiple activities or cost objectives. Any such system must be approved by the funding agency. These sampling systems (or time studies) may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort or outcomes. For time studies, all activities need to be sampled even if they are not strictly related to Medicaid. Relevant sections of OMB Circular A-87 include the following:

- Attachment A, Section A.1. Each awarding grant bears its fair share of costs; C, Basic Guidelines, 1.h: Not included as match for another federal program. 1. J: Be adequately documented. 3.c: Costs cannot be shifted from one grant to another to avoid restrictions.

- Attachment B, Selected Items of Cost, 11. Compensation for personnel services, h (1-4): Standards for payroll documentation. (6) Substitute Systems are: subject to approval; include random moment sampling or other quantifiable measures; (a) must meet acceptable statistical sampling standards including: (I) include all salaries of employees to be allocated; (ii) the entire time period involved must be covered; (c) less than full compliance with statistical sampling standards may be accepted by the agency if it concludes that the proposal will result in lower costs to federal awards than the compliant system.

Major time study issues include the following: development and approval of the activity codes to be used (discussed in Section IV. of this Guide), the participants to be sampled, the sampling plan, statistical validity (95 percent or higher confidence level for a 5 percent error limit), documentation, training for staff in the sample universe, and monitoring. The following subsections discuss those issues in greater detail:

1. Sample Universe

A basic step in the development of an approvable time study is the determination of the sample universe, i.e., the school district staff person(s) who will participate in (be sampled under) the time study. The composition of school district staff should be reviewed to determine whether a statewide pool or multiple pools is necessary. This is because a statewide pool may not reflect the diversity of duties at large, medium, and small school districts or at rural versus urban school districts.

Medicaid administrative activities may be performed by school employees who also provide direct medical services (for example, nurses, physical therapists, educational staff, such as the Director of Exceptional Student Education, and teachers aides). However, if the costs of such staff are completely offset (see Section V. C., Offset of Revenues), there would be no purpose to include them in the sample universe. That is, only staff for whom some costs remain after any applicable offsets should be included in the time study. For example, if federal funding sources or third party payors other than Medicaid meet 100 percent of the costs of social workers, then there would be no reason to include such workers in the time study and they must be excluded from participation. Furthermore, due to the offset, the costs of such staff would also not be included in the costs to be allocated.

It may also be appropriate to exclude certain other workers from the study. For example, medical staff hired by the schools as contractors and reimbursed on a fixed fee basis (for example, audiologists paid a set amount for each hearing test performed) and who do not perform any other administrative activities, should not be included in the time study. Such workers should not be included in the sample universe and therefore their costs would be excluded from the base to be allocated.

Allocation of certain costs, required to be funded by sources other than the Medicaid program, may need to be offset from Medicaid costs, or may be precluded from allocation to the Medicaid program. However, school staff whose salary costs are **not** entirely met by one or more federal grants may be eligible to be included in the sample. Thus, if funds from an educational grant pay only a percentage of the individual's costs, that person can be sampled as long as the costs are offset by the funds from the educational grant. Also, any matching funds required by the educational grant should be excluded. In addition, staff members such as physical therapy aides may need to be included in the sample universe and not simply allocated based on the activities of associated professionals (e.g., physical therapists).

If a time study participant's salary is funded by local public school dollars, the staff person can be included in the sample universe. If third party funds only partially cover the salary, the staff person can be included in the time study, but such amounts need to be applied in offsetting the claims made under the Medicaid program. The determination of which employees should be included in the sample universe and which costs of such employees should be included in the cost pool, and the conditions associated with the funding source, must all be considered in determining the universe of participants for the time study.

A list of the job titles of school staff that participate in Medicaid administrative activities, and therefore would be included in the sample universe, should be maintained.

2. Sampling Plan Methodology

OMB Circular A-87 states that, with regard to sampling:

> "Substitute systems for allocating salaries and wages to federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort."

As indicated, one of the most commonly used sampling methodologies for time studies is random moment sampling (RMS). The RMS method represents an acceptable method for accurately assessing the time spent on administrative activities.

RMS covers the entire sampled period, such as a quarter, but does not include periods when schools are not in session, such as holidays.

For time study reporting purposes, there are two options for the treatment of staff in-service days, during which school staff report to school but do not perform their usual duties and functions:

- The in-service day can be included among the potential days to be randomly sampled, with the related costs included in the cost pool; or

- Both the in-service day **and** the related costs may be excluded from the time study.

If an employee chosen for the time study is absent during the reporting period, their absence should be reported on the time study, and the related costs included in the cost pool. The sampling universe must include all employees whose costs are to be allocated. According to OMB Circular A-87, "The entire time period involved must be covered by the sample; and the results must be statistically valid and applied to the period being sampled."

OMB Circular A-87 also indicates that time reports be completed at least monthly. RMS meets these requirements. OMB Circular A-87 does provide that a less than fully compliant sample can be used if the cognizant agency can demonstrate that the proposed system "will result in lower costs to federal awards than a system that complies with the standards." The "cognizant agency" is defined in OMB Circular A-87 as the federal agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals developed under OMB Circular A-87 on behalf of all federal agencies. Flexibility is afforded, within the bounds of statistical validity. However, the validity and reliability of the sampling methodology must be acceptable to CMS. That is, the state must include details of how its time study methodology will be validated.

To ensure an adequate number of responses, many schools oversample and/or factor in a non-response rate in their time study methodology. Under this methodology, oversampled responses are sometimes substituted for responses not received. However, oversampled responses should not be substituted for completed responses in which there are no or few reported Medicaid activities in order to increase the Medicaid reimbursable portion of the claim. No completed responses should be deleted or ignored. Another potential problem is employees who are instructed to not complete the time study if they typically do not perform many Medicaid activities. To avoid this, all non-responses should be coded to non-Medicaid time study codes. In addition, codes should be established to fully account for vacations, sick time, lunch hours, and other paid time not at work.

3. Treatment of Summer Period

The summer period is distinguished from the regular school year, and refers to the period between the end of one regular school year and the beginning of the next regular school year. In general, a time study is developed and conducted with respect to a particular period, and must represent and incorporate the actual activities performed during that period. The time study mechanism and the associated application are then used to allocate the costs associated with the activities performed during the period.

Costs incurred during a summer period may relate to costs and activities associated with the regular school year, and therefore, sometimes special treatment is necessary. The summer (break) period refers to the period between the end of one regular school year and the beginning of the next regular school year. Often, in the school setting, costs related to the regular school year are connected to the summer period. That is, salaries/benefits may continue to be paid to time study participants during the months of the summer period, even though the costs of these continuing salary payments during the summer represent and reflect activities actually performed during the regular school year.

The time study methodology for addressing the summer period must reflect the practices of the applicable claiming unit related to the summer period. The treatment of continued salary and related costs that are actually paid during the summer, but which reflect and represent activities actually performed during the regular school year, must be distinguished from the treatment of salary and related costs that are paid during the summer and reflect activities actually performed during the summer. For example, a time study performed during the summer period would not be appropriate to use for purposes of allocating those salary costs paid during the summer period, if such costs actually represent activities actually performed during the regular school year. In that regard, the time studies performed during the regular school year would represent and be appropriate for allocating the costs of the continued salary payment from the regular school year that are paid during the summer.

As indicated, the results of the time studies performed during the regular school year would be applied to allocate the associated salary costs paid during the summer. In general, this is acceptable if administrative activities are not actually performed during the summer break, but salaries (reflecting activities performed during the regular school year) are prorated over the year and paid during the summer break. However, if activities are actually performed during the summer period, the application of the results of time studies from the regular school year would not accurately reflect the costs associated with the summer period activities. In that case, a time study would also need to be conducted with respect to the summer period.

The following examples demonstrate different circumstances that may characterize the summer period:

Example 1. During the summer break outside of the regular school year, if employees are only being paid and are not performing any school-related activities, the claim for the payments made during the summer period could be determined by using the average results of the time studies for the three prior quarters in that school year.

Example 2. During the summer break outside of the regular school year, if school employees actually perform activities during that time, a time study similar to those performed during the school year would need to be conducted.

Example 3. If the regular school year begins in the middle of a calendar quarter (that is, the end of August or sometime in September), the first time study for that school year should include all days from the beginning of the school year. For example, if the school year begins August 31st, then August 31st must be included among the potential days to be chosen for the time study.

Example 4. If the school year ends in the middle of a calendar quarter (for example, sometime in June), the last time study for the school year should include all days through the end of the school year. Therefore, if the school year ends June 25th, then all days through and including June 25th must be included among the potential days to be chosen for the time study.

4. Time Study Documentation

As with all administrative costs that are related to time study activities, there must be documentation of the costs for which FFP will be claimed under Medicaid. Documentation to be retained must support

and include the following: the sample universe determination, sample selection, sample results, sampling forms, cost data for each school district, and summary sheets showing how each school district's claim was compiled. All claims by the LEAs and schools are summarized and submitted to the state Medicaid agency for payment. The individual sample sheets may or may not be kept locally. Sometimes individual sheets are maintained locally while summary records are maintained at a central location.

Note that if a portion of a sampled employee's time is also billed as medical services, then the administrative time study results should be validated in part by comparing the time coded to direct medical services (Code 4) to the actual amount of hours billed directly. The results should be within a reasonable tolerance or else the time study may result in an effective double payment.

The proportional Medicaid share, which is based on the applicable claiming unit, should be updated periodically, preferably quarterly. The frequency with which the proportional Medicaid share is updated should relate to the claiming period. In that regard, documentation of the proportional Medicaid share, including the frequency with which the Medicaid percentage is calculated and the rationale for it, should be maintained and available. The determination of the proportional Medicaid share is typically the responsibility of the state Medicaid agency.

States have operational flexibility for validating the results of time studies related to administrative activities; for example, states could compare the administrative claims to the parallel claims for direct services under Medicaid. However, regardless of the validation mechanism that states employ, appropriate documentation supporting their claims must be maintained and available for audit purposes. The state and CMS should work together to develop an acceptable validation mechanism.

5. Training for Staffing Time Study

All staff in the sample universe should be adequately trained before the sampling begins. Training should cover all aspects of the sampling process. Staff should be clear on how to complete the form, how to report activities under the appropriate time study code, the difference between health related and other activities, and where to obtain technical assistance if there are questions. Professional staff must understand the distinctions between the performance of administrative activities and direct medical services.

There should be a mechanism in place to assess how often training is necessary and to revise the training schedule, if appropriate. To ensure consistent application, all training documentation, including the schedule of training on sampling and the approved activity codes, should be maintained and available for audit purposes. The training schedule should show the training required of the sample takers, staff being sampled, and frequency of training. The frequency of training should take into account turnover at the local level. Staff may be trained before or after they are selected for inclusion in the time study. However, staff should not be chosen for the time study solely on the basis of having obtained prior training, as that might indicate bias in the sampling methodology.

6. Monitoring Process

In order to ensure that the time study is statistically valid (for example, at the 95 percent or higher confidence level for a 5 percent error level), the state Medicaid agency must monitor the compliance of the school districts with the requirements of the sampling methodology. A description of the monitoring of the sample results should be included. This description should include information on the frequency of reviews at the local level, staff performing the reviews, and the review protocol.

C. Offset of Revenues

Certain revenues must offset allocation costs in order to reduce the total amount of costs in which the federal government will participate. To the extent the funding sources have paid or would pay for the costs at issue, federal Medicaid funding is not available and the costs must be removed from total costs (See OMB Circular A-87, Attachment A, Part C., Item 4.a.). The following include some of the revenue offset categories which must be applied in developing the net costs:

- All federal funds.
- All state expenditures which have been previously matched by the federal government (includes Medicaid funds for medical assistance (such as the payment rate for services under fee-for-service)).
- Insurance and other fees collected from non-governmental sources must be offset against claims for Medicaid funds.
- All applicable credits must be offset against claims for Medicaid funds. Applicable credits refer to those receipts or reduction of expenditure type transactions that offset or reduce expense items allocable to federal awards as direct or indirect costs.
- A program may not claim any federal match for administrative activities if its total cost has already been paid by the revenue sources above. A government program may not be reimbursed in excess of its actual costs, i.e., make a profit.

D. Cost Allocation Plans

Requirements for the development, documentation, submission, negotiation, and approval of public assistance cost allocation plans are set forth in Subpart E of 45 CFR Part 95 and ASMB C-10. All administrative costs (direct and indirect) are normally charged to federal awards by implementing the public assistance cost allocation plan (CAP). OMB Circular A-87, Cost Principles for State, Local and Indian Tribal Governments - Attachment D - extends these requirements to all federal agencies whose programs, including Medicaid, are administered by a state public assistance agency. OMB Circular A-87 policy is that state public assistance agencies will develop, document and implement, and the federal government will review, negotiate, and approve, public assistance CAPs.

In accordance with the federal regulations indicated above and OMB Circular A-87, a public assistance CAP must be amended and approved by the Division of Cost Allocation (DCA) within DHHS before FFP would be available for administrative claims in the Medicaid program. In this regard, the public assistance CAP must provide, in accordance with the approved interagency agreements, for reimbursement of the administrative activities performed in the school setting and for which claims will

be made by the LEAs, school districts, and schools to the state Medicaid agency. The public assistance CAP must make explicit reference to the methodologies, claiming mechanisms, interagency agreements, and other relevant issues that will be used by the LEAs, school districts, and schools for making such claims and appropriately allocating costs. CMS does not have direct authority for approval of the public assistance CAPs; that is the purview of the DCA. However, CMS works directly with the DCA in the public assistance CAP review and approval process; under this process, the DCA will not approve such public assistance CAPs without CMS review and approval of the methodologies referenced in the public assistance CAP. Therefore, the referenced elements must be reviewed and approved by CMS before implementation of the school-based administrative claiming program and before the claiming of FFP.

See also Section IV., B., Principle 11. titled, "Review and Approval of Program and Codes by CMS."

The school-based administrative claiming program must be supported by a system that has the capability to isolate the costs directly related to the support of the Medicaid program from all other costs incurred by the school and that will ultimately be claimed by the state Medicaid agency as administration. Such costs must comply with the cost allocation principles described in OMB Circular A-87, which requires that costs be "necessary and reasonable" and "allocable" to the Medicaid program. Claims for the school district's indirect costs are only allowable when the entity has an approved indirect cost rate issued by the cognizant agency and costs are claimed in accordance with the rate.

E. Administrative Claiming Implementation Plan

CMS requires that the state Medicaid agency submit an administrative claiming implementation plan that provides a comprehensive description of the mechanisms and processes for claiming Medicaid administrative costs. To the extent the implementation plan provides support and documentation referenced in the public assistance cost allocation plan amendments, it must be approved by CMS before FFP is available. Note, states are not required to submit a state plan amendment in order to participate in school-based administrative claiming; however, they do need to have their updated CAPs approved (See Section D., Cost Allocation Plans).

The implementation plan should include the following elements:

- **Interagency agreements:** An interagency agreement must be in place between the state Medicaid agency, the state Department of Education and/or the school district or local entity conducting the activities. Requirements and elements of interagency agreements are discussed in Section III. of this guide.

- **Treatment of Indirect Costs:** The state Medicaid agency must indicate whether indirect costs will be claimed. Indirect costs may only be claimed if there is an indirect cost rate approved by the cognizant agency responsible for approving such rates. With respect to school-based administrative costs, the cognizant agency is the U.S. Department of Education or its delegate. Where indirect costs are allowed, the school district must certify that costs claimed as direct costs do not duplicate those costs reimbursed through application of the indirect cost rate.

- **Certified Public Expenditures:** If administrative payments for school-based services will be made utilizing certified public expenditures (CPE) to satisfy the state match requirements under Medicaid,

the claiming plan should describe how the availability of sufficient state funds to match title XIX expenditures will be documented and demonstrated. The description should demonstrate that the funds are not already being used to match federal funds of other federal programs, or being reimbursed by other federal grants.

- **Description of Current Administrative Activities Paid by Medicaid:** Other state and local agencies (e.g., state and local health departments and mental health authorities) may be performing and receiving FFP for the same services that are being considered for FFP in the school setting. Similarly, Medicaid managed care plans may be providing the same services to school aged children. The state should provide a description of the current administrative activities of these other entities and their relationship to the Medicaid activities provided in the schools. For example, a chart or matrix could be used to identify activities for which each agency currently receives FFP, and how these will change when schools are reimbursed for performing Medicaid administrative activities.

- **Time Study Plan:** The implementation plan should include details regarding the sampling methodology for selecting time study participants, including the types of job classifications eligible to be sampled, selection of time study days, and provisions for applying a 95 percent or higher confidence level (for a 5 percent error level) (or some other statistically valid measure) to the time study.

  The plan should include training schedules for both time study participants and coordinators. The training must include sampling techniques and the use of the time study codes and how they apply to activities in the school environment. Accordingly, a set of the approved time study codes should be included or attached to the implementation plan.

- **Monitoring Process:** The review protocol, which will be applied at the appropriate school and state agency levels, must be described. This description should include the frequency of reviews, who is responsible for conducting the reviews, and resolution process for issues identified through the reviews.

F. Timely Filing Requirements

Section 1132(a) of the Act requires that a claim for FFP must be filed within a two-year period that begins on the first day of the calendar quarter immediately following the quarter in which the expenditure was made. The implementing regulations for timely filing are at 45 CFR Subpart A and provide specific guidelines for determining when an expenditure is said to have been made, so as to initiate the two-year filing period. Federal regulations at 45 CFR 95.13(d) indicate that a state agency's expenditure for administration is considered to have been made in the quarter the payment was actually made by the state agency.

45 CFR 95.4 further identifies a state agency as any agency of the state, including the state Medicaid agency, its fiscal agents, a state health agency, or any other state or local organization which incurs matchable expenses.

> Example. A state Medicaid agency incurs an expenditure in January 2002. The end of the calendar quarter in which the expenditure occurs would be March 31, 2002. In order to meet the

> two-year timely filing limit, the state Medicaid agency must file a claim with CMS within two years after the calendar quarter in which the expenditure occurred, or by March 31, 2004.

In determining the two-year filing limit, the state agency must give consideration to the expenditure reporting cycle. The expenditure is not considered "filed" until it is received by CMS on the CMS-64 Expenditure Report, which is required to be filed 30 days after the end of a reporting quarter. This reduces the apparent amount of time in which the claim can be considered timely filed.

G. State Law Requirements

The OMB Circular A-87 states in item 1.c. of Attachment A, "General Principles for Determining Allowable Costs," Section C, Basic Guidelines: "To be allowable under federal grants, costs must meet the following criteria . . . .be authorized or not prohibited under state or local laws and regulations." Thus, FFP for school-based services and administrative outreach claims is not available if the state is not in compliance with its own statutes. A question of state law may surface during a review of state practices or be brought to light by other means; however, it is not expected that an exhaustive review of all state laws be conducted. If there is a question of whether the state agency is in violation of state law, a legal opinion should be sought, preferably from the state Attorney General.

H. Contingency Fees

Many school districts or local education authorities have chosen to use the services of consultants. The OMB Circular A-87 states in item 33.a, of Attachment B, "Selected Items of Costs," that:

> Cost of professional and consultant services rendered by persons or organizations that are members of a particular profession or possess a special skill, whether or not officers or employees of the governmental unit, are allowable, subject to section 14 when reasonable in relation to the services rendered **and when not contingent upon recovery of the costs from the Federal Government** (added emphasis).

Medicaid claims for the costs of administrative activities and direct medical services may not include fees for consultant services that are based on, or include, contingency fee arrangements. Thus, if payments to consultants by schools are contingent upon payment by Medicaid, the consultant fees may not be used in determining the payment rate of school-based services and/or administration. Further, as discussed in Office of Inspector General (OIG) Chief Counsel Advisory Opinion Number 98-4, contractual arrangements with consultants based on percentage billing arrangements may increase the risk of upcoding and similar abusive billing practices. Although this is not a per se application, the opinion suggests the need for caution in using such arrangements to avoid prohibited payments under the anti-kick back statute, section 1128(b) of the Act.

Note also that OMB Circular A-87 states in item C.1., of Attachment A, "General Principles for Determining Allowable Costs," that to be allowable, costs must be authorized or not prohibited under state or local laws or regulations.

States or schools may directly contract with consultants to perform administrative activities such as outreach. Such contracts must comply with all applicable federal procurement requirements (such as competition and sole source provisions) and which are specified in federal regulations.

I. Provider Agreements

In order for a school to participate as a provider of services and receive FFP through the Medicaid program for those services, it must have a provider agreement with the state. The basis and authority for this requirement can be found at sections 1902(a)(4), 1902(a)(27), 1902(a)(57) and 1902(58) of the Act and implementing regulations at 42 CFR 431.107. Schools do not need to be Medicaid providers in order to participate in Medicaid administrative claiming, but there are some administrative activities that schools will not be eligible to receive FFP for unless they have a provider agreement. For example, a school or claiming unit that has an agreement with the state Medicaid agency to claim administrative costs can provide, and receive FFP for, Medicaid outreach activities regardless of whether the school participates as a provider in the Medicaid program. However, if the school does not participate as a provider in the Medicaid program, it cannot bill Medicaid for the cost of direct medical services provided by school staff (e.g., physical therapists). Furthermore, since the Medicaid program would not reimburse for any of the services provided by the school due to its lack of a provider agreement, the costs of administrative activities in support of those services, such as referrals by the school, would not be reimbursable under Medicaid as administration.

J. Third Party Liability (TPL)/Medicaid as payor of last resort/Free Care

Third party liability requirements preclude Medicaid from paying for Medicaid coverable services provided to Medicaid beneficiaries if another third party (e.g., other third party health insurer or other federal or state program) is legally liable and responsible for providing and paying for the services. For example, Medicaid cannot pay for school-based services provided pursuant to section 504 of the Rehabilitation Act of 1973 because education agencies or programs have a legal liability under that law to provide and pay for section 504 services for eligible children. Likewise, Medicaid cannot pay for school-based primary and preventive services if the school is required by state or local law to provide and pay for such services.

The Medicaid program is generally the "payor of last resort." This principle is based in Medicaid statute under two provisions; third party liability (TPL) provisions and those relating to the consideration of individual's income and resources in determining Medicaid eligibility.

The TPL provisions require the state Medicaid agency to take all reasonable measures to ascertain the legal liability of all potential third parties for paying for care and services covered under the state's Medicaid plan. Furthermore, the state is required to seek such payment by the third parties before making payment under Medicaid and also to seek such payment as a recovery after making payment under the Medicaid program. Additionally, the Medicaid statute is explicit in requiring the state Medicaid agency to consider income and resources in determining an individual's eligibility.

An exception or qualification to this principle, contained at section 1903(c) of the Act, relates to medical services contained in a child's IEP. If such services are contained in a child's IEP, the child is eligible for Medicaid, and the services are covered by the Medicaid program, then Medicaid may pay for such

services. It must be clarified that this statutory exception to the payor of last resort principle does not make CMS the payor of first resort for these services (and related administrative costs). Instead, under this statutory exception, Medicaid would pay before the education agency in the case of IEP-related services and activities. Another qualification is contained at section 1902(a)(11) of the Act, under which Medicaid can pay before title V for the allowable care and services that may be reimbursed under title V of the Act (Maternal and Child Health Services block grant).

Therefore, except for special circumstances, the state Medicaid agency is the payor of last resort for the costs of services and activities that are also payable under other programs or by third parties. Furthermore, Medicaid does not pay for the health services or administration costs related to those services that are provided free of charge to all students (See also Section IV., B., Principle 12. on free care).

K. Transportation as Administration

CMS's policy concerning Medicaid payment for transportation in the school setting is addressed in other guidance issued by CMS, such as the 1997 guide, "Medicaid and School Health: Technical Assistance Guide," a May 21, 1999 State Medicaid Director letter, and subsequent issuances. This Guide is not intended to address claiming for the costs of the actual transportation. Rather, on the subject of transportation, this Guide is intended to address the administrative activities related to transportation, such as scheduling or arranging for transportation to a covered medical service for a Medicaid eligible child.

As a Medicaid administrative activity, Codes 5.a. and 5.b. in Section IV., C. cover the time spent in assisting a child with transportation to a service, but do not cover the actual cost of the transportation (bus fare, taxi fare, etc.). Payment for actual transportation costs is claimed under a separate mechanism. Actual allowable transportation costs, whether the transportation is claimed as administration or as a direct service, would be directly claimed and reimbursed under the Medicaid program in accordance with the state's approved Medicaid state plan and cost allocation plan. Direct claiming and FFP for transportation costs is separate from the time study claiming mechanism.

When FFP for the costs of transportation services is claimed as administration, the requirements of OMB Circular A-87 for determining allowable costs, as well as any other applicable requirements for claiming administration under Medicaid, must be met. This includes the development of a cost allocation methodology to ensure that Medicaid only pays for that portion of the specialized mode of transportation allocable to Medicaid beneficiaries.

APPENDIX

A number of federal, state, and local programs operate in the school setting, only some of which may focus on traditional education goals. Interaction and overlap among these programs often provide numerous benefits to children, although sometimes with an additional burden in administrative complexity on the part of program administrators. The following section contains a brief overview of the Medicaid program, as it operates in the school environment, and the Individuals with Disabilities Education Act (IDEA). These two federal programs, Medicaid and IDEA, with distinct and separate statutory authorities, are closely linked in the school setting, even though their underlying purposes and perspectives differ. In order to understand the procedures for claiming school-based administrative expenditures under Medicaid, it is important to consider both the Medicaid and Education perspectives.

A. Medicaid

1. Medicaid's Role In School-Based Health Services Programs

Schools have been at the forefront in developing and implementing programs to increase access to medical services for children. CMS has long recognized that school-based health services play an important role in ensuring that children and adolescents receive needed health care in a setting that is appropriate, while ensuring that there is minimum disruption in the educational process.

In 1988, Medicaid's role in supporting school-based health care was greatly expanded by the enactment of the Medicare Catastrophic Coverage Act (Public Law 100-360). It clarified in Medicaid statute that the Medicaid program is primary to the IDEA program in paying for the costs of direct medical services provided to Medicaid-eligible children with special health care needs identified pursuant to the IDEA program. Each child eligible under the IDEA program must have an Individualized Education Program (IEP), which includes a statement of the special education and related services to be provided to or on behalf of the child. These services include needed school-based services that are considered medical services by Medicaid that may be covered under the Medicaid program.

Many school-based health programs deliver a broad range of services that are covered by Medicaid, affording access to care for children who might otherwise go without needed services. For Medicaid to cover school-based services, they must be primarily medical and not educational in nature. The services must be provided by a qualified Medicaid provider to children in families that meet Medicaid income eligibility requirements. And they must be considered medically necessary for the child. The services can include:

- routine and preventive screenings and examinations;
- diagnosis and treatment of acute, uncomplicated problems;
- monitoring and treatment of chronic medical conditions; and
- provision of medical services to children with disabilities under the IDEA.

Administrative activities in support of services that are not included in an IEP and that are provided to Medicaid children in schools are usually **not** Medicaid coverable because most of these services are generally provided free of charge to non-Medicaid children. Such services include primary and preventive services provided by nurses or other qualified professionals in the school setting, such as

dispensing medication, attending to acute non-emergent problems (sore throat, earache, etc.), well child examinations, and vision and hearing screenings. (Free care and third party liability are addressed in Section IV., B., Principle 12. and Section V., J. of the Guide.)

2. Early and Periodic, Screening, Diagnostic and Treatment (EPSDT)

The Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) program is Medicaid's comprehensive and preventive children's health program that emphasizes the early assessment of children's health care needs through periodic examinations. The EPSDT program is a unique benefit in Medicaid because the scope of required services can be broader than what is otherwise included under a state's Medicaid state plan in general. EPSDT is a required state plan service that, by statute, includes any necessary coverable services under section 1905(a) of the Social Security Act (the Act) (42 U.S.C. 1396d), whether or not those services are covered under the state plan. While the EPSDT program may be known by other, more descriptive names in different states (i.e., Well Child Care, Health Check, KIDMED), the basic design is similar in order to meet federal requirements. Still, states have considerable discretion in administering their EPSDT programs as long as they comply with the federal requirements. In many states, schools play a large role in many EPSDT activities, particularly with respect to outreach, screening, diagnosis and treatment.

a. EPSDT Screening

Schools often deliver screening services that comport with EPSDT requirements. Screenings include: a comprehensive health and developmental history, a comprehensive unclothed physical exam, appropriate immunizations, and laboratory tests. Health education and anticipatory guidance are also an integral part of an initial or periodic screen.

b. EPSDT Treatment

The EPSDT program requires a state Medicaid agency to cover necessary health care, diagnostic services, and treatment that is within the federal Medicaid framework to "correct and ameliorate" defects and physical and mental illnesses and conditions discovered by screening, whether or not those services are otherwise available under the state plan to individuals age 21 and older. While EPSDT has tremendous potential for increasing health care services provided to the eligible population, certain restrictions apply. In order for Medicaid to pay for a medical service provided to a child or adolescent, the service must meet a number of federal coverage requirements. The services must be described under one of the service categories referenced in section 1905(a) of the Act (42 U.S.C. 1396d), the service must be medically necessary, and it must be provided by a qualified Medicaid provider. In the school, just as in any other setting, federal policies on FFP in the Medicaid program must be followed with respect to the 1988 legislation which revised section 1903(c) of the Act (42 U.S.C. 1396b(c)) regarding IDEA, the free care exclusion rule and third party liability. (Free care and third party liability are addressed in Section IV., B., Principle 12. and Section V., J. of the Guide.)

c. EPSDT Administrative Claiming

The EPSDT administrative requirements, found in section 1902(a)(43) of the Act (42 U.S.C. 1396a(a)(43)), are part of the legal basis and authority for obtaining FFP for administrative costs

associated with health care provided in or by schools. The following administrative activities are a required part of a state's EPSDT program:

- informing Medicaid eligible individuals about the availability of EPSDT services;
- providing or arranging for the provision of EPSDT screening services;
- arranging for (directly or through referral to appropriate providers or agencies) needed corrective (and ameliorative) treatment;
- assisting families identifying and choosing Medicaid providers; and
- conducting follow-up to ensure children receive needed diagnosis and treatment.

The EPSDT requirement to inform children and families of the availability of EPSDT services is done at the time of enrollment and periodically thereafter as necessary.

3. State Children's Health Insurance Program (SCHIP)

The State Children's Health Insurance Program (SCHIP), specified under title XXI of the Act, enables states to provide health insurance to children in families with incomes too high to qualify for the Medicaid program but too low to afford private health insurance. SCHIP coverage is provided by the states through separate title XXI state child health programs, title XXI Medicaid expansions, or a combination of both. All states have approved SCHIP plans and receive enhanced federal matching payments for SCHIP expenditures up to a fixed state SCHIP allotment that varies on a federal fiscal year basis. States may spend up to 10 percent of their total annual SCHIP expenditures (federal and state) on non-benefit activities, including: outreach conducted to identify and enroll children in SCHIP; administration costs; health services initiatives; and other child health assistance. Many states have had success using schools to disseminate information about SCHIP as well as the Medicaid program.

Outreach activities related to a state's separate title XXI SCHIP program are funded only under the state's available title XXI SCHIP allotments. However, outreach activities provided with respect to an SCHIP-related Medicaid expansion are funded either from the state's SCHIP allotment or from regular Medicaid funding, at the state's option. Joint outreach efforts for Medicaid and SCHIP may similarly be matched by either Medicaid or SCHIP. Under the provisions of OMB Circular A-87 and associated regulations, costs that are common to more than one program are generally allocated to the related programs in accordance with the relative benefits received by each program. However, the SCHIP statute provides for an exception to this general cost allocation principle, allowing states some flexibility in claiming FFP for outreach activities. Detailed guidance on these state options was provided in a December 8, 1997 letter to State Health Officials on SCHIP financial issues, which is available on the CMS SCHIP website, http://www.cms.hhs.gov/schip/.

States have been granted considerable flexibility in developing and implementing their SCHIP programs, subject to CMS oversight. In order to determine specific state SCHIP requirements, schools and other interested parties should contact their state Medicaid agency, or the agency designated to operate the SCHIP program in the state.

B. Individuals with Disabilities Education Act (IDEA)

1. Purpose of IDEA

The Individuals with Disabilities Education Act (IDEA) Amendments of 1997, Public Law 105-17, is the most recent version of this important federal special education law. The IDEA was passed to "assure that all children with disabilities have available to them… a free appropriate public education which emphasizes special education and related services designed to meet their individual needs." Specific principles in the IDEA include:

- Free appropriate public education;
- Appropriate evaluation;
- Individualized education program;
- Least restrictive environment;
- Parent and student participation in decision making; and
- Procedural safeguards.

In the context of the IDEA, "free appropriate public education" means that special education and related services are provided to children with disabilities at public expense, under public supervision and direction, and without charge, that meet the standards of the state education agency. The public school system must serve disabled children by responding to their individual needs, regardless of the nature or severity of their disabilities.

- "Special education" is defined at 34 Code of Federal Regulations (CFR) 300.26 to mean specially designed instruction which meets the unique needs of the child and includes instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings and instruction in physical education.

"Related services" are defined at 34 CFR 300.24 as "transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education." This includes:

- Counseling services;
- Early identification and assessment of disabilities;
- Medical services for diagnostic and evaluation purposes;
- Occupational therapy;
- Orientation and mobility services;
- Parent counseling and training;
- Physical therapy;
- Psychological services;
- Recreation;
- Rehabilitation counseling services;
- School health services;
- Social work services in schools; and

- Speech-language pathology and audiology services.

Not all of the special education and related services required by the IDEA are within the scope of the federal Medicaid program. Only those medically necessary IDEA services that are described in the definition of "medical assistance" can be covered as Medicaid services when furnished by qualified participating Medicaid providers.

The IDEA authorizes federal funding to states for related services provided to children through a child's Individualized Education Program (IEP), including those that are referred to and covered as medical services under Medicaid. Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, amended section 1903(c) of the Act to permit Medicaid payment for medical services provided to children under the IDEA through a child's IEP. This amendment was enacted to require Medicaid to be primary to the Department of Education for payment of the health-related services provided under IDEA. Medicaid covers services included in an IEP under the following conditions:

- The services are medically necessary and included in a Medicaid covered category (speech therapy, physical therapy, etc.,);
- All other federal and state Medicaid regulations are followed, including those for provider qualifications, comparability of services and the amount, duration and scope provisions; and
- The services are included in the state's plan or available under EPSDT.

Further discussion of school based medical services can be found in the guidance document, "Medicaid and School Health: A Technical Assistance Guide," issued by CMS in August 1997.

2. Child Find

Part B, section 612(a)(3) of the IDEA provides for the identification, location, and evaluation of children with disabilities within the state, and mandates that a "practical" method be developed and implemented to determine which children with disabilities should be provided services. A state is only eligible for funding under IDEA if the state demonstrates that it meets certain conditions, including conducting "child find" activities, as defined in the IDEA. These "child find" activities are undertaken to identify children in need of special education and related services. Medicaid is **not** responsible for covering or paying for "child find" or other activities that fulfill education mandates. Note, while child find activities are not claimable as Medicaid administration, there are related activities, such as Medicaid outreach, which are allowable under Medicaid.

Activities performed for purposes of the Medicaid program, such as informing potential eligible children and their families about Medicaid, how to access the program, and facilitating the Medicaid application process, are included as Medicaid outreach. In contrast, child find is specifically mandated in the IDEA and includes activities carried out for educational purposes. Therefore, a distinction is made between the educational activities, such as child find, and Medicaid outreach for purposes of claiming in Medicaid. (See Section IV., B., Principle 10. for further information on child find.)

3. Evaluation and Assessment Activities

Part B, section 614 of the IDEA outlines the evaluation process for determining if a child has a disability as defined in section 602, and determining the educational needs of the child. This section focuses on appropriate evaluation principles, and provides protection from unnecessary, costly, or inappropriate assessment activities. The evaluation and assessment are conducted to determine if the child has a disability and if the child's particular disability affects the student's educational performance; the evaluation and assessment must provide relevant information that directly assists the school in determining the educational needs of the child. Re-evaluation must be accomplished at least every 3 years. These evaluations are conducted, in part, to determine a child's health related needs for purposes of the IEP. (See Section IV., B., Principle 10. for further information on IEP-related medical evaluations and assessments.)

4. Individualized Education Program (IEP)

For those children identified and determined to be disabled in accordance with section 602 of the IDEA, an IEP must be developed by a team of individuals as defined in section 614. (In the case of a child with a disability age 3 through 5, under certain conditions an Individualized Family Service Plan (IFSP) may be developed to serve as an IEP.) The IEP is statutorily defined as a written statement for each child with a disability that, among other elements, includes:

- A statement of the child's present levels of educational performance;
- A statement of measurable annual goals, including benchmarks or short term objectives;
- A statement of the special education and related services and supplementary aids and services to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided for the child;
- An explanation of the extent, if any, to which the child will not participate with non-disabled children in the regular class and in the activities described above;
- A statement of any individual modifications in the administration of state or district-wide assessments of student achievement needed for the child to participate in the assessment;
- The projected date for the beginning of services and modifications and the anticipated frequency, location, and duration of services and modifications;
- For children age 14 or younger, if appropriate, a statement of transition service needs;
- For children beginning at age 16 or younger, if appropriate, a statement of needed transition services for the student;
- A statement of the child's progress toward annual goals and how the child's parents will be informed of the progress toward the annual goals;
- Transfer of rights statement.

The phases of the IEP process are generally described as follows:

a. Pre-IEP

Pre-IEP activities include "child find" activities designed to identify children in need of evaluation and assessment activities performed to determine if the child has a disability as defined by section 602 of the IDEA and to determine the educational needs of the child. There are no claimable administrative expenditures under Medicaid associated with these pre-IEP activities. Medicaid does not pay for the IEP team meetings or for costs related to attendance at those meetings by medical professionals. However, if a state has opted to include targeted case management in its Medicaid plan as a service, Medicaid can pay for the activities of the child's case manager.

b. Development of IEP

The development of an IEP is a requirement of the IDEA, the primary purpose of which is to facilitate the child's education. Because it is an education requirement, Medicaid does not pay for the administrative activities associated with the development of the IEP. Once the IEP is established and implemented, however, Medicaid can pay for administrative activities that are directly related to the provision of those Medicaid covered services that are identified in the IEP, and which are furnished to Medicaid eligible children.

The IEP is developed by a team of individuals, including:

- The child's parents;
- At least one of the child's regular education teachers and/or one special education teacher or provider;
- A representative of the school district who is knowledgeable about specific curriculum;
- An individual who can interpret the instructional implications of evaluation results;
- Other individuals, at the discretion of the parents or the school district, who have knowledge or special expertise regarding the child; and
- The child with the disability, whenever appropriate.

The IDEA further specifies that in the development of the IEP, the team is to consider the strengths of the child and the concerns of the parents for enhancing the education of their child, and also consider the results of the initial or most recent evaluation of the child. Special factors, such as behavior issues, language limitations, accommodations for visual or hearing impairments, and the need for assistive technology devices/services must also be considered in the development of the IEP.

c. Review/Revision of IEP

The school district is mandated to review the IEP periodically, but not less than annually, and, if needed, to revise the program to address any lack of expected progress toward individually defined goals, or to address the results of a re-evaluation of the child. The IEP can be revised at any time if the child is not making expected progress or if new factors arise.

These activities are for the purpose of fulfilling education-related mandates under the IDEA. As such, the associated costs of these activities are not allowable as administrative costs under the Medicaid program.

A more detailed discussion of IEPs and the IDEA can be found in Section IV., B., 10.