

The Centers for Medicare and Medicaid Services (CMS)

**Delivering Services in School-
Based Settings: A
Comprehensive Guide to
Medicaid Services and
Administrative Claiming**

2023

**Delivering Services in School-Based Settings:
A Comprehensive Guide to Medicaid Services and Administrative Claiming**

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I. Introduction

The school setting provides a unique opportunity to deliver health care services to children and adolescents, especially those enrolled in Medicaid¹ and the Children’s Health Insurance Program (CHIP). School-based services (SBS), including but not limited to preventive care, mental health and substance use disorder (SUD) services, physical and occupational therapy, and disease management have been shown to improve both health and academic outcomes.² Schools can play an important role in bridging equity gaps among students in low-income and rural communities where access to health care services may be more limited. To deliver SBS, it is essential that State Medicaid and CHIP agencies (hereafter, “State Medicaid/CHIP agencies”), State Educational Agencies (SEAs), and schools all work together to support students. This guide is designed to facilitate the development and enhancement of these critical partnerships.

Medicaid and CHIP³ are joint State-federal programs that offer health coverage to millions of Americans, including more than half of all children across the country (57 percent = 41.9 million children enrolled in Medicaid and CHIP / 73.1 million children in the US).⁴ Schools and school districts (also known as Local Educational Agencies (LEAs))⁵ work closely with both SEAs and State Medicaid/CHIP agencies to understand complex coverage and Medicaid/CHIP payment issues. When Medicaid or CHIP health care services are delivered in typical health settings (e.g., a hospital or physician’s office) to a Medicaid or CHIP beneficiary,⁶ the provider bills the State Medicaid/CHIP agency (or, for enrollees in a managed care, the managed care plan). Providers bill through a claiming system in order to receive payment, which the State (or managed care plan) pays. The State then claims federal Medicaid or CHIP matching funds for its expenditures. Since LEAs are not typical health care providers (in the sense that their primary mission and activities concern education and not furnishing health care services), SBS billing arrangements can vary by State. How a State Medicaid/CHIP agency decides to structure SBS billing can depend on the structure of a locality’s school system and the capacity for schools to furnish and bill for services.

¹ Unless stated otherwise, all references to Medicaid and Medicaid beneficiaries include Medicaid-expansion CHIPs and beneficiaries enrolled in Medicaid-expansion CHIPs.

² SBS refers to all services provided in schools including direct medical services and administrative activities.

³ Requirements and options described throughout this guide are applicable only to Medicaid and Medicaid-expansion CHIPs, except where CHIP is explicitly referenced.

⁴ See <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html#:~:text=41%2C670%2C091%20individuals%20were%20enrolled%20in,Medicaid%20and%20CHIP%20program%20enrollment> and <https://www.census.gov/library/stories/2021/08/united-states-adult-population-grew-faster-than-nations-total-population-from-2010-to-2020.html#:~:text=By%20comparison%2C%20the%20younger%20population,from%2074.2%20million%20in%202010>.

⁵ LEAs are public boards of education or other public authorities legally constituted within a State for either administrative control or direction of, or to perform a service function for, public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a State. 34 C.F.R. § 300.28. The terms “LEAs” and “school districts” are used interchangeably throughout the document.

⁶ The term “beneficiary” is used here and throughout to refer to an individual who is eligible and currently receiving Medicaid or CHIP, as defined in 42 C.F.R. 435.4; not to be confused with an enrollee, who is a Medicaid beneficiary who is currently enrolled in some form of a Medicaid managed care program.

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While schools are the setting for and can be providers of Medicaid and CHIP-covered services, the State Medicaid/CHIP agency has the leading role in determining which services are covered by Medicaid and CHIP when furnished in or by schools and how school-based providers are paid. These decisions may be made in consultation with LEAs and SEAs, but ultimately it is the State Medicaid/CHIP agency's responsibility to determine how Medicaid and CHIP-covered SBS is implemented in each State. Within the parameters set by the State Medicaid/CHIP agencies, some LEAs allow school providers to submit claims for medical and administrative services directly to State Medicaid/CHIP agencies for services they provide to students, while other LEAs act as the provider and submit claims on behalf of school providers to State Medicaid/CHIP agencies for their direct medical services⁷ to students and administrative activities. Depending on the benefit package, some third-party payers other than Medicaid and CHIP (e.g., employer-sponsored health insurance) do not pay for services provided in schools. Many schools are unaccustomed to the requirements for coverage by health insurers and the complexity of billing, and often it is only the largest of LEAs that have the administrative capacity to engage in Medicaid and/or CHIP billing. Navigating Medicaid and CHIP requirements can place an administrative strain on schools and create disincentives for schools to provide SBS.

States and SBS providers have relied on Medicaid and CHIP for decades to pay for covered services furnished to students with disabilities⁸ under the Individuals with Disabilities Education Act (IDEA). Under IDEA, students with disabilities have an Individualized Education Program (IEP) that can include both education and health care-related services.⁹ Since 2014, SBS can be covered for any student enrolled in Medicaid or CHIP for any health services covered in the State, including routine preventive care, behavioral health, and ongoing primary care and treatment, regardless of whether students generally are charged for such services when furnished as SBS.

This guide seeks to provide direction to State Medicaid/CHIP agencies and LEAs to deliver SBS in a manner that allows LEAs to obtain all the payments for which they can qualify, to then increase access to covered services for enrolled students. This guide also offers possible financially sustainable solutions for State Medicaid/CHIP agencies and LEAs, while acknowledging that behavioral health (mental health and SUD) services, and other medical conditions can be complex and may also require community-based resources outside of schools for effective treatment.

The Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health and Human Services (HHS) in consultation with the US Department of Education (ED),

⁷ Medical services are used in this document to refer generally to any health care related service. It is not to be misconstrued with the meaning of medical services under IDEA, where medical services are services provided by a physician, and, if not for diagnostic or evaluation purposes, are not included in an IEP because they are excluded from IDEA's definition of related services per 34 C.F.R. § 300.34.

⁸ Note "student with a disability" in this document is also meant to include "child with a disability" as defined by the IDEA Part B regulations in 34 C.F.R. § 300.8.

⁹ IDEA in this document primarily refers to students with disabilities 3-21 years old with an IEP. However, we realize that some LEAs support early childhood educational programs for children with disabilities birth to 2 years old under IDEA with Individualized Family Service Plans (IFSPs). Throughout this document when IEPs are mentioned, the intent is to include IFSPs as well, as applicable, unless otherwise stated.

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are issuing this comprehensive guide that encompasses both direct medical and administrative guidance in order to improve the delivery of covered Medicaid and CHIP services in school-based settings. Notably, this guide does not supersede any federal or State statutory or regulatory requirements. Rather, it clarifies and consolidates CMS's guidance on how to meet federal statutory and regulatory requirements and explains the application of such requirements in the context of current practices. Specifically, the purposes of this guide are to:

1. Clarify how payments can be made to school-based entities under Medicaid and CHIP;
2. Discuss strategies and tools to reduce administrative burdens and simplify billing for LEAs, including rural and small LEAs, to help ensure access to Medicaid-covered services for enrolled children;
3. Provide best practices and examples of approved methods that State Medicaid agencies and LEAs have used to pay for Medicaid-covered services;
4. Provide examples of the types of providers that can participate in Medicaid and CHIP within school settings and best practices to enroll qualified providers;
5. Explain previously unaddressed policies and practices that States may employ in implementing SBS; and,
6. Ensure accurate claiming for SBS and fiscal integrity of the Medicaid and CHIP programs.

This guide builds upon guidance CMS issued to States on August 18, 2022,¹⁰ and meets the requirements of Section 11003(a)(1) of the Bipartisan Safer Communities Act (BSCA) (Pub. Law 117-159).¹¹ This guide supersedes the 2003 School-Based Administrative Claiming Guide and the 1997 School-based Services Technical Review Guide. It also includes a series of new flexibilities on billing, documentation, and time studies (e.g., worker logs, random moment time studies (RMTS), etc.) that State Medicaid agencies have the option to adopt to help ease the administrative burden of SBS for LEAs. CMS urges State Medicaid/CHIP agencies to review this guide and work collaboratively with their state education partners to make it easier for schools to deliver and receive payment for critical health care services they furnish. This guide is part of an ongoing effort by CMS to provide additional guidance on and to encourage the appropriate provision of SBS.

A. Executive Summary of New Flexibilities Described in this Guide

CMS and ED recognize the high administrative burden to schools seeking payment for Medicaid and CHIP services. CMS and ED are supportive of school-based health programs and, where possible, encourage States to ease administrative burdens placed on school-based health care providers to promote their participation in Medicaid and CHIP and thereby increase access to covered services while ensuring fiscal and programmatic integrity of the programs. Therefore, CMS and ED are including flexibilities to highlight areas that can ease administrative burdens.

The flexibilities summarized below are options that States can select to ease administrative burdens on LEAs and school-based health care providers when furnishing and seeking payment

¹⁰ See <https://www.medicaid.gov/federal-policy-guidance/downloads/sbscib081820222.pdf>

¹¹ See <https://www.congress.gov/117/plaws/publ159/PLAW-117publ159.pdf>

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for SBS.¹² For all new flexibilities shared in this guide, please see the discussion that follows, as well as Appendix C: *Overview of New Policy Flexibilities Described in this Guide*. For LEAs interested in these new flexibilities, please contact your State Medicaid agency for more information.

Billing and payment methodologies when using a cost-based methodology

- **Roster Billing:** Allow States to compute a rate that is representative of multiple services delivered. LEAs would multiply that rate, on a quarterly or monthly basis, by the number of Medicaid-enrolled students that receive a covered service within the service period. These quarterly/monthly payments would then be reconciled to actual costs at the end of each year.
- **Per Child, Per Month (PCPM) or Per Service, Per Month Rate:** Allow States to create an interim rate that can be 1/12th of the provider's previous year's actual costs, which would be paid out each month on a PCPM basis. Alternatively, an average cost per service could be paid as an interim payment where each service rate (for a set of services furnished to all beneficiaries) is based on an average calculation of expected costs per visit for several different types of services (e.g., physical therapy, occupational therapy, nursing, behavioral health, etc.) provided to all beneficiaries during the covered period. These monthly payments would then be reconciled to actual costs at the end of each year.
- **Option to Not Submit Bills for Each Service:** If a State chooses either roster billing or PCPM methodology, schools in the State would not be required to submit a bill for each service to Medicaid as long as interim rates are paid, and payments are reconciled to actual costs at the end of each year. Regardless of which interim billing methodology a State chooses, schools still are required to document and maintain records of each service delivered. Interim payments help to ensure that Medicaid-covered services have been provided and documented throughout the year and that schools have adequate cash flow.

Billing and payment rates when using Fee-For-Service (FFS) payment methodologies not reconciled to cost

- **Fee Schedule Rates that Exceed the Community Rate:** Allow State Medicaid agencies to pay higher fee schedule rates for services offered in schools, as long as the State Medicaid agency demonstrates that the rate is economic and efficient as required by section 1902(a)(30)(A) of the Social Security Act (the Act).

Billing in general, for any payment methodology

- **Clarification of Restrictions on Bundled Payment Rates:** CMS previously issued a 1999 State Medicaid Director's Letter (SMDL) that prohibited the use of bundled rates in

¹² CMS is available to provide technical assistance to States to best implement their programs. If you have questions regarding implementation of these options, please contact CMS at: SchoolBasedServices@cms.hhs.gov

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school-based settings based on concerns over service documentation and financial oversight. The SMDL was issued prior to States implementing reconciled cost methodologies as the predominant method to pay for SBS. The comprehensive guide clarifies that bundled rates are permissible as interim payments when the bundled rates are reconciled to the actual cost of providing Medicaid services.

- **This guide also addresses the following additional billing and payment topics:**
 - Encourages States to ensure that payment goes directly to schools to pay for providers and that any fees to run the program or offset contractor costs (e.g., to run a time study) charged by the State Medicaid agencies remains small.
 - Highlights how States can use Medicaid grant awards via federal financial participation (FFP) to support positions at State Medicaid agencies and SEAs to support SBS.
 - Advises schools not to pay school-based health services contractors on a contingency fee basis.
 - Identifies parental consent requirements under the Family Educational Rights and Privacy Act (FERPA) and Part B of IDEA.

Documentation

- **De-identified Data:** Allow LEAs and school-based providers to furnish some de-identified or masked data to support Medicaid Enrollment Ratios (MERs) or other allocation statistics. Permitting this type of de-identified data can help support schools in responding to audits. However, this does not supersede the requirement to provide the minimum documentation for Medicaid services (see below). CMS expects State Medicaid agencies and LEAs who want to use this option to seek out CMS and ED for best practices.

Allocations to Medicaid

- **More General Allocation Ratio:** Historically, most school-based providers that were reimbursed actual costs utilized an IEP based ratio to allocate costs to Medicaid at the LEA level: number of Medicaid-enrolled students with an IEP receiving medical services / number of students with an IEP receiving medical services. This guide discusses the allowability of a more general ratio: number of Medicaid-enrolled students / Total number of students in the LEA. This approach eliminates the burden of producing documentation related to non-Medicaid enrolled students with an IEP.
- **Using Time Study Moments as a 1-step Allocation Methodology:** Instead of a 2-step process to allocate costs to Medicaid using a time study to allocate to medical services and then a MER to allocate to Medicaid, allow States to construct time study activity codes to capture time spent on Medicaid-allowable direct care services or administrative activities. The RMTS activity codes would be structured to define moments that are BOTH associated with the delivery of medical services and Medicaid-allowable activities- including both direct care services and administrative activities.

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Time Studies

- **Time Study (e.g., RMTS) Error Rate:** Allow States to increase the error rate of the time study results from +/-2 percent to +/-5 percent. This change will align direct service and administrative activity time study error rates, allowing States to conduct unified time studies.
- **Notification and Response Period:** Allow States to submit time study implementation plans that include up to a 2-day notification window and up to a 2-day response period for queried moments in their time studies for school-based providers, instead of a 0-day notification window and 2-day response window.

Provider Qualifications

- **SBS provider qualifications:** Prior CMS guidance made it difficult for State Medicaid agencies to rely on ED provider qualifications or to establish different provider qualifications for school-based and non-school-based providers of the same Medicaid services. This guidance allows State Medicaid agencies to establish provider qualifications for school-based providers that differ from the qualifications of non-school-based providers of the same Medicaid services, as long as that State's provider qualifications are not unique to Medicaid-covered services.

Third Party Liability

- **Third Party Reimbursement:** Allow States to suspend or terminate efforts to seek reimbursement from a liable third party if they determine that the recovery would not be cost-effective pursuant to 42 C.F.R. §433.139(f), including for IDEA or 504-plan services. This could ease administrative burden at schools.

II. Overview of Medicaid, CHIP, and SBS Payment in Schools

A. About Medicaid and CHIP Programs in Schools

Medicaid and CHIP provide health coverage to millions of people living with disabilities and low-income families, children, pregnant individuals, adults, and seniors, including over half of American children (57% = 41.9 million children enrolled in Medicaid and CHIP / 73.1 million children in the US)¹³. Medicaid and CHIP are funded jointly by States and the federal government. Under broad federal guidelines, each State administers its own unique Medicaid and CHIP programs, with different eligibility standards, provider requirements, payment methods, benefit packages, and reporting requirements tailored to the needs of its residents. Children may

¹³ See <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html#:~:text=41%2C670%2C091%20individuals%20were%20enrolled%20in,Medicaid%20and%20CHIP%20program%20enrollment.> & <https://www.census.gov/library/stories/2021/08/united-states-adult-population-grew-faster-than-nations-total-population-from-2010-to-2020.html#:~:text=By%20comparison%2C%20the%20younger%20population,from%2074.2%20million%20in%202010.>

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be eligible to receive health coverage through Medicaid or CHIP based on factors of eligibility such as household income, or may be eligible for Medicaid under eligibility groups where eligibility criteria vary based on factors such as the child's unique health care needs (such as a disability), children in foster care, or former foster children adopted through the adoption assistance program.

Medicaid and CHIP are critical sources of health care coverage for children. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Medicaid benefit provides comprehensive health care services for most individuals under age 21 who are enrolled in Medicaid. The Medicaid statute requires that States provide any medically necessary health care services listed in section 1905(a) of the Act to individuals who are eligible for EPSDT, even if the services are not otherwise available under the State's Medicaid plan. States are required to inform individuals under age 21 who are Medicaid-eligible about the EPSDT benefit, set distinct periodicity schedules for screening, dental, vision and hearing services, and report EPSDT performance information annually to CMS.¹⁴

While there is often overlap between Medicaid and CHIP coverage and benefits, they are separate programs that cover different populations. CHIP provides health coverage to uninsured children in families with incomes too high to qualify for Medicaid coverage, but too low to afford private coverage.¹⁵ While CHIP requirements frequently align with those in Medicaid, there are some differences between the programs, including additional flexibilities that are not applicable in Medicaid.

b. About Medicaid and CHIP School Based Services

SBS play a key role in the health of students. Although schools are primarily providers of education-related activities, the school setting offers a unique opportunity to enroll eligible students in Medicaid or CHIP; facilitate access to coverage; and provide health services directly to Medicaid and CHIP beneficiaries who are students. SBS are an opportunity to meet students where they are and to deliver services where children spend the majority of time each week. SBS can encompass any EPSDT service, including any medically necessary physical, mental health, and SUD services. SBS do not have to be limited to a subset of services in Medicaid or CHIP.

Schools can also help enhance early identification of health needs and can connect students to a broad range of health care services, including mental health and SUD services and health services in the community. Specifically, SBS providers can help promote health and educational

¹⁴ For more information about EPSDT please See https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf.

¹⁵ For more information about CHIP eligibility See <https://www.medicaid.gov/chip/eligibility/index.html>.

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equity and may increase school attendance by conducting these and other activities that may be reimbursable by Medicaid and CHIP:^{16,17}

1. Helping eligible students enroll in the Medicaid and CHIP programs.
2. Connecting students' Medicaid and CHIP-eligible family members with health coverage.
3. Providing Medicaid and CHIP-covered health services in schools (including physical therapy (PT), occupational therapy (OT), nursing, mental health and SUD services, etc.) and seeking payment for services furnished to make those services financially sustainable.
4. Offering Medicaid and CHIP-covered services that support at-risk Medicaid or CHIP eligible students.
5. Providing Medicaid and CHIP-covered services and performing State program administrative activities to improve student wellness.¹⁸
6. Providing Medicaid and CHIP-covered services that reduce emergency room visits.
7. Providing Medicaid and CHIP services and performing State program administrative activities that promotes a healthy environment and promotes learning.

States and SBS providers have long relied on Medicaid and CHIP to pay for covered services furnished to students with disabilities under IDEA. However, State Medicaid/CHIP agencies also may cover services required for students with disabilities under Section 504 of the Rehabilitation Act of 1973 (Section 504) as well as general medical services provided to students including routine preventive care including mental health and SUD services, and ongoing primary care and treatment.

SBS services in Medicaid can fall into either or both of the following categories:

1. Medicaid-eligible children who need general health care services.
2. Medicaid -eligible children with disabilities who receive services in accordance with an IEP or Individualized Family Service Plan (IFSP) established by IDEA, which may be covered by Medicaid. IDEA Part B services in an IEP constitute a free appropriate public education (FAPE) and therefore must be delivered at no cost to the child's parents. IDEA Part C services in an IFSP are generally provided at no cost but are subject to a State's system of payments, which may include the use of Medicaid or public benefits or insurance, private insurance and/or family fees. Between IDEA and Medicaid, Medicaid

¹⁶ This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.

¹⁷ California School Based Health Alliance. Top Ten Benefits of School-Based Health Centers, available at URL: <https://www.schoolhealthcenters.org/school-based-health/awareness-month/why-sbhcs/#:~:text=School-based%20health%20centers%20%28SBHCs%29%20promote%20health%20and%20educational,Improve%20wellness%20policies%20and%20health%20programs.%20More%20items>

¹⁸ See <https://www.thecommunityguide.org/media/pdf/SDOH-School-Based-Health-Centers-508.pdf>

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is the payer of first resort for services included in the IEP or IFSP.¹⁹ While students with disabilities who receive services under Section 504 likewise are entitled to FAPE, their Medicaid coverage is identical to eligible students who need general health care services. Therefore, Medicaid is not the payer of first resort for services to students covered solely by Section 504. However, when a LEA meets its Section 504 obligations to an IDEA-eligible child with a disability through an IEP, then Medicaid will be payer of first resort for any Section 504 services included in the IEP.

In addition, schools offer a unique venue for Medicaid and CHIP to reach eligible but unenrolled students and families. Schools also can be a catalyst for encouraging eligible Medicaid and CHIP children to obtain primary and preventive services, as well as other necessary treatment services. Even if a school does not directly furnish medical services, schools can conduct and receive payment for Medicaid and CHIP outreach and enrollment activities.

The Medicaid Budget and Expenditure System (MBES) expenditures reports for 2021 show more than \$5.98 billion in total computable payments for school-based health care services (both services identified in an IEP and non-IEP services to Medicaid students).²⁰ Schools also received \$14.1 billion in federal IDEA funding in 2023.²¹

III. Scope of Medicaid Services in Schools

A. IDEA and Section 504 of the Rehabilitation Act

Part B of IDEA is a law that makes available a Free Appropriate Public Education (FAPE) to eligible students with disabilities throughout the nation and ensures special education and related services are provided to those students. IDEA governs how States and public agencies²² provide early intervention, special education, and related services to eligible infants, toddlers, children, and youth with disabilities—including those covered under Medicaid. In addition to guaranteeing FAPE to students with disabilities, IDEA has three State grant programs: Part C of IDEA provides grants to States to operate a Statewide system of early intervention services for infants and toddlers with disabilities (ages birth to 3 years) and their families; Part B, Section 619 of

¹⁹ See section 1903(c) of the Act and IDEA sections 612(e) and 640(c) codified at 20 U.S.C. 1412(e) and 1440(c). Medicaid will pay primary, prior to federal IDEA funds for Medicaid-covered services listed in a child's IEP/IFSP even if a third party is likely liable. After the State Medicaid agency makes the primary payment on a claim for an IEP/IFSP service, the State Medicaid agency must then seek to recoup that payment from any liable third party (this is known as “pay and chase”).

²⁰ See Centers for Medicare & Medicaid Services, 2021 MBES Expenditures, <https://www.medicare.gov/medicaid/financial-management/state-expenditure-reporting-for-medicare-chip/expenditure-reports-mbes/index.html>

²¹ See Department of Education Budget Tables 2023, <https://www2.ed.gov/about/overview/budget/tables.html?src=ct>

²² Public agencies are defined in the IDEA Part B regulations at 34 C.F.R. § 300.33 to include “the SEA, LEAs, ESAs, [educational service agencies], nonprofit public charter schools that are not otherwise included as LEAs or ESAs and are not a school of an LEA or ESA, and any other political subdivisions of the State that are responsible for providing education to children with disabilities.”

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IDEA provides grants to SEAs (and, through the SEAs, subgrants to LEAs) to assist eligible children with disabilities ages 3 through 5 years; and Part B, Section 611 of IDEA provides grants to SEAs (and, through the SEAs, subgrants to LEAs) to assist eligible children with disabilities ages 3 through 21 years. IDEA requires that services required to make FAPE available under Part B are provided at no cost to the child's parents. A child's eligibility for IDEA services is determined through a formal evaluation process conducted by qualified personnel. The result of the evaluation for a child determined eligible under IDEA is the development of an individualized plan. Under Part B, an IEP Team develops an IEP, which consists of special education and related services and supplementary aids and services that are provided to the child, and program modifications or supports for school personnel. Under Part C, a team develops an IFSP, which describes the early intervention services to be provided to the child and family.

IDEA provisions require school staff to perform several education-related activities, including the identification, location, and evaluation (initial evaluations and reevaluations) of students with disabilities who are in need of special education and related services (referred to as "child find"), and development and implementation of an IEP.

For most students, the process for determining whether a child is eligible for special education under IDEA includes the following steps:

- **Child Find.** Through the child find process, the States and LEAs must identify, locate, and evaluate all children with disabilities residing in their jurisdiction who need special education and related services.
Initial evaluations and reevaluations. Through the child find process a child's parent or an LEA may refer any child suspected of having a disability for an initial evaluation, which is then conducted by a group of qualified professionals and the parent of the child in order to determine whether the child is a child with a disability under IDEA and to determine their educational needs. LEAs perform reevaluations to determine whether a child continues to be a child with a disability under IDEA, and the continuing educational needs of the child.
- **Individualized Education Plan (IEP).** Based on the assessment and evaluation data, if the group of qualified professionals and the parent of the child determines that a child is a child with a disability under IDEA and needs special education and related services, the LEA IEP Team must develop an IEP for the child. The IEP Team, which consists of a student and their parents, special education and regular education teachers, and other qualified LEA personnel, develops the student's IEP, which addresses, among other things, the nature, frequency, duration, and location of a student's special education, related services, supplementary aids and services, and program modifications and supports for school personnel.

Early Intervention

An Individualized Family Service Plan (IFSP) identifies early intervention services needed for an infant or toddler child from birth until age three (or, if the State has published regulations implementing the extension option, until age five or entry into kindergarten) with a disability.

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The IFSP focuses on the developmental needs of the child and family and the services that the child needs as well as those needed by the family to help them enhance the development of their child. Each child with an IFSP is entitled to service coordination for every family, which service may be billed to Medicaid as case management. A LEA that operates programs for children from birth until age three, for example an early Head Start program, may provide Medicaid SBS that are on a child's IFSP.

Section 504 Plan

Section 504 of the Rehabilitation Act of 1973 (Section 504) protects the rights of individuals with disabilities in programs and activities that receive federal financial assistance, including federal funds.²³ ED's Office for Civil Rights (OCR) enforces Section 504 in programs and activities that receive funds from ED.

Section 504 requires an LEA to provide FAPE to each qualified person with a disability who is in the school district's jurisdiction, regardless of the nature or severity of the person's disability.²⁴ A student with a disability may receive FAPE under Section 504 through the provision of a 504 plan, which often includes specific modifications or services needed to access education. For a student with disabilities covered by both IDEA and Section 504, those services and modifications may be incorporated into the student's IEP. Section 504 services included in a student's IEP are treated the same as IDEA services under Section 1903(c) of the Act, and therefore Medicaid is the payer of first resort for them.

Payment for IEP, IFSP, and 504 Plan Services

The individualized services that IDEA-eligible children with disabilities receive in accordance with their IEP or IFSP may be covered by Medicaid. Medicaid will pay for health-related services included in an IEP or IFSP if they are Medicaid-covered services, including those that are medically necessary under the EPSDT benefit for EPSDT recipients. For Medicaid-enrolled students with an IEP, Medicaid is payer of first resort of Medicaid-covered services included in the IEP (see section 1903(c) of the Act and IDEA sections 612(e) and 640(c), codified at 20 USC 1412(e) and 1440(c); 34 C.F.R. § 300.154(h); and 42 C.F.R. § 433.139). Coverable services also include child find evaluations and reevaluations, as described above. If a parent provides consent for the LEA to bill Medicaid for services furnished to a child and to share information with the relevant State Medicaid agency, the LEA may bill and receive Medicaid payment for the IEP services provided.

IDEA Part B services included in an IEP constitute FAPE and therefore such services must be delivered at no cost to the child and child's family and, as between IDEA and Medicaid,

²³ Section 504 of the Rehabilitation Act of 1973, 29 USC § 794; 34 C.F.R. Part 104.

²⁴ See 34 C.F.R. § 104.3(l)(2): "Qualified handicapped person means: With respect to public preschool elementary, secondary, or adult educational services, a handicapped person (i) of an age during which nonhandicapped persons are provided such services, (ii) of any age during which it is mandatory under state law to provide such services to handicapped persons, or (iii) to whom a state is required to provide FAPE under section 612 of the Education of the Handicapped Act"

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Medicaid is the payer of first resort.²⁵ Even if a State determines that schools or providers of IDEA services generally are legally liable third parties, the Medicaid statute contains an exception at section 1903(c) of the Act, which requires that Medicaid serve as the primary payer to schools and providers of services included in an IEP or IFSP under IDEA. Further, IDEA sections 612(e) and 640(c), codified in 20 U.S.C. 1412(e) and 1440(c), provide that nothing in IDEA permits a State to reduce medical or other assistance available, or to alter eligibility, under Titles V (relating to maternal and child health) and XIX of the Social Security Act (relating to Medicaid for infants and toddlers with disabilities and to the provision of a FAPE to students with disabilities) in the State.

Section 504 plan-eligible students not eligible for IDEA

Medicaid is not the payer of first resort for services to students with disabilities who are covered only by Section 504 and not IDEA. The IEP is an education document that focuses on the special education and related service needs of students ages three through twenty-one. All children eligible for IDEA are also students with disabilities protected by Section 504. In addition, many children who are not eligible for IDEA are students with disabilities protected by Section 504. However, unlike IDEA, a student with a disability is entitled to FAPE under Section 504 regardless of whether the student needs special education. So, *there is a set of “504-only” students who are not IDEA eligible but are nonetheless entitled to related aids and services and supplementary aids and services under Section 504 only.* The Medicaid coverage for those “504-only” students is identical to eligible students who need general health care services, as those services not included in a student’s IEP are not considered the same as IDEA services under Section 1903(c) of the Act. Therefore, CMS does not consider LEAs to be legally liable third parties to the extent they are acting to ensure that students receive needed medical services to access FAPE consistent with Section 504. Therefore, LEAs may bill Medicaid for related services students receive under Section 504 only once they bill any outside legally liable third parties.

B. Early Education and Medicaid School-Based Services

This Medicaid SBS claiming guide is focused primarily on services provided to children in kindergarten through high school, who are typically five years old and older. However, there are several early childhood programs (e.g., Early Head Start, Head Start, school-based pre-schools, etc.) that may be operated by LEAs, and therefore much of the guidance here may be relevant to these early education programs.

CMS recognizes the importance of early education, which refers to formal and informal educational programs that guide the growth and development of children throughout their preschool years (birth to age five). The first years of life build the foundation for life-long health and wellness, educational achievement, and economic security. A child’s health directly affects their ability to learn, grow, and thrive. Similarly, high-quality early learning opportunities for

²⁵ See section 1903(c) of the Act and IDEA sections 612(e) and 640(c) codified at 20 U.S.C. 1412(e) and 1440(c). Medicaid will pay primary, prior to federal IDEA funds for Medicaid-covered services included in a child’s IEP/IFSP even if a third party is likely liable. After the State Medicaid agency makes the primary payment on a claim for an IEP/IFSP service, it will then seek to recoup that payment from any liable third party (this is known as “pay and chase”).

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children have long-term positive impacts on their health, even into adulthood. Access to quality health care, nutrition, safe environments, and stable, nurturing, and stimulating relationships with parents and caregivers are each critical to building a strong early childhood foundation.²⁶

Young children enrolled in Medicaid who are not yet attending school are entitled to the EPSDT benefit, which requires states to provide access to any Medicaid-coverable service under section 1905(a) of the Social Security Act, in any amount that is required, regardless of whether the service is covered in the Medicaid State plan. EPSDT is a key part of Medicaid for eligible children and adolescents, both those receiving services in schools as well as those who access community-based providers. More information about EPSDT and other benefits can be found in section III subsection E of this guide.

In addition to EPSDT, the following programs are federal efforts to improve and support early education and health initiatives for young children enrolled in Medicaid:

Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics and supported, in part, by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). The Bright Futures Program aims to improve the health of our nation's infants, children, and adolescents. It does this by maintaining and sharing clinical guidelines that are age-specific, based on the best available scientific evidence, and helps to increase the quality of primary and preventive care. Many state Medicaid agencies have integrated the Bright Futures/AAP Periodicity Schedule recommendations into the state's Medicaid EPSDT benefit, thus ensuring that children and adolescents obtaining care through government agencies receive the same covered preventive services as those who are covered by private health insurance plans subject to preventive services coverage requirements under the Affordable Care Act that include services identified in the *Bright Futures* guidelines.²⁷

Birth to 5: Watch Me Thrive! is a coordinated federal effort to encourage healthy child development, universal developmental and behavioral screening for children, and support for the families and providers who care for them. The goals of the program are to help families celebrate developmental milestones such as seeing a child's first smile, first step, and first words; promote universal screening including developmental and behavioral screenings to assure that children are making progress in areas such as language, social, or motor development; enhance developmental supports by sharing tools, guidance, and tips recommended by experts to help families support their children's development; and identify possible delays and challenges early to assure that young children get the services and supports they need as early as possible to help them thrive.²⁸

Head Start services are available at no cost to children ages birth to five in eligible families who are enrolled in a Head Start program. Head Start preschool services work with families with children ages three to five. Early Head Start services work with families with children ages birth to three, and many also serve expectant families. Many programs operate both Head Start

²⁶ See <https://www2.ed.gov/about/inits/ed/earlylearning/files/health-early-learning-statement.pdf>

²⁷ See <https://www.aap.org/en/practice-management/bright-futures/about-bright-futures/>

²⁸ See <https://www2.ed.gov/about/inits/list/watch-me-thrive/index.html>

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preschool and Early Head Start services. Programs deliver child development services in center-based, home-based, or family childcare settings. All Head Start programs continually work to ensure that eligible children and families receive high-quality services in safe and healthy settings that prepare children for school and life.²⁹ Although Medicaid eligibility policy varies greatly by state, all states must cover children through age five in households with income less than 133 percent of the federal poverty level. Head Start and Medicaid both serve additional special populations of children, such as those receiving Supplemental Security Income (SSI) and those in foster care. Under federal Head Start Program Performance Standards, health care is a core Head Start component. The federal Head Start Program Performance Standards require that Head Start programs assist families in accessing health insurance coverage and are receiving regular and ongoing preventive care and needed treatment.³⁰

The federal Head Start Program Performance Standards also outline several requirements in the areas of health, mental health, and substance use disorder treatment and preventive services. With many of these requirements, programs must facilitate a child's access to services, but in some cases, programs can provide health and mental health services through direct provision or consultation. Additionally, programs are required to promote children's health and well-being by providing medical, oral, nutritional, and mental health education support services. Depending on how programs implement these requirements, these services may be covered by Medicaid.

These and other programs (e.g., Early Head Start, Head Start, school-based pre-schools, etc.) can be operated by LEAs, and therefore much of the guidance here is relevant to these early education programs.

C. Expanding Services beyond IEP Services (i.e., “Free Care” Policy)

THINGS TO CONSIDER:

- *Medicaid-covered services may be delivered to all Medicaid-enrolled students in school settings, and not just those with an IEP or Section 504 plan.*
- *Services which are not included in a student's IEP or 504 Plan may be covered, including mental health and SUD services and nursing services, such as medication monitoring and counseling.*
- *Medicaid-covered services in a student's IEP must be delivered at no cost to the child's family, and Medicaid is the payer of first resort.*
- *Medicaid is the payer of first resort for all services included in a student's IEP, whether they are required under both the IDEA and Section 504 or required only under Section 504. Medicaid is not the payer of first resort for services included only in a student's Section 504 plan*

²⁹ See <https://www.acf.hhs.gov/ohs/about/head-start>

³⁰ See 45 C.F.R. § 1302.42; <https://eclkc.ohs.acf.hhs.gov/erse/article/poverty-guidelines-determining-eligibility-participation-head-start-programs>

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Schools routinely provide preventive services like health care screenings, vision exams, hearing tests, scoliosis exams, and dental sealants free of charge to all students. Services provided by the school nurse (e.g., attending to a student’s sore throat and/or dispensing medicine) may also be provided free of charge to all students in a school system. Schools may seek payment for all Medicaid-covered services provided to children enrolled in Medicaid, regardless of whether the services are provided at no cost to other students. CMS encourages States to adopt free care in order to promote the use of schools as a setting in which to provide all Medicaid-enrolled children with Medicaid-covered services. In addition to expanding access and improving health equity among low-income children, it is also an opportunity for States to draw down federal Medicaid matching funds to support Medicaid SBS.

Prior to 2014, CMS policy on “free care” precluded payment for services provided to a Medicaid-enrolled individual that were available without charge to the community at large. On December 15, 2014, through State Medicaid Director Letter (SMDL) # 14-006, *Medicaid Payment for Services Provide Without Charge (Free Care)*,³¹ CMS withdrew the historical “free care” policy that Medicaid payment was generally not allowable for services that were available without charge to the beneficiary. The SMDL specified that all Medicaid-covered services provided to Medicaid-enrolled children by qualified providers may be billed to the Medicaid program regardless of whether those services are provided to other students free of charge. Accordingly, Medicaid payment is available for Medicaid-covered services that are provided to Medicaid beneficiaries, regardless of whether there is any charge for the service to the beneficiary or the community at large. For example, nursing services furnished in schools may be covered by Medicaid even if the services are not outlined in a Medicaid-enrolled child’s plan of care and/or if there is no charge for the nursing services when furnished to other students.

Historically, Medicaid-covered SBS were limited to services identified in a Medicaid-enrolled student’s IEP. Consequently, many States have language in their Medicaid State plans tying coverage of services to an IEP. Such States would need to amend their Medicaid State plan to expand Medicaid coverage for services furnished in schools beyond what is included in an IEP in order to pay for the services provided to Medicaid-enrolled students who do not have IEP, for services provided to Medicaid-enrolled students with an IEP that are not specifically identified in the IEP. Several States have approved SPAs that allow Medicaid payment for any Medicaid-covered health service provided to any Medicaid-enrolled student regardless of whether the student has a disability, or the service is included in a student’s IEP, or there is any charge for the service when furnished to other students.

The free care policy, as discussed in SMDL #14-006, offers a robust opportunity for LEAs to obtain financial support for services that they may already provide. CMS strongly encourages States to promote the use of schools as a setting in which to provide Medicaid-enrolled students and adolescents with Medicaid-covered services. Example SPAs that cover services delivered in

³¹ CMS State Medicaid Director Letter, December 15, 2014. Medicaid Payment for Services Provided Without Charge (Free Care) See <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf>.

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the school-based setting are available in the *General Requirements for Billing, Claiming, and Accounting for SBS Medical and Administrative Costs* section of this guidance and CMS is available for technical assistance (TA) to any interested State.

D. Medicaid Coverage Requirements

THINGS TO CONSIDER:

- *Medicaid is a federal-state partnership. The federal government provides broad guidelines within which each State must operate and the States are responsible for implementing the programs on the ground*
 - *CMS encourages SEAs, LEAs, and schools to partner with their State Medicaid agencies and to engage with community providers to better understand which Medicaid services may be furnished in school-based settings and work together to explore opportunities to obtain payment for Medicaid-covered services for Medicaid-enrolled students.*
-

The Medicaid State plan is a comprehensive written statement that describes the nature and scope of a State’s Medicaid program and contains assurances that the program will be operated per the requirements of Title XIX of the Act, its implementing regulations, and other applicable official issuances. When States make permissible program changes, they may need to submit a SPA for CMS approval to ensure that the Medicaid State plan is complete, accurate, and up to date.

There is no distinct Medicaid State plan benefit called “school health services” or “school-based services,” but various Medicaid benefits can be provided by or in schools. If coverage and payment for services provided by schools is currently precluded under limiting language in the approved Medicaid State plan, States may submit a SPA to allow for coverage of such services and to make payment for them, with such expenditures eligible for FFP.

A coverage SPA must meet all applicable federal legal requirements, including comparability, freedom of choice of provider, and statewideness, except in limited circumstances where a particular benefit included in that SPA allows for any of these requirements not to apply, found at 42 C.F.R. § 431.54.

- *Comparability:* 42 C.F.R. § 440.240 provides that a Medicaid-covered benefit generally must be provided in the same amount, duration, and scope to all enrollees within a group (i.e., categorically needy or medically needy), and that the amount, duration, and scope of services provided to the categorically needy must not be less than provided to the medically needy.
- *Freedom of choice:* 42 C.F.R. § 431.51 provides that a beneficiary may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to furnish the services and willing to furnish them to that particular beneficiary. Further discussion of freedom of choice requirements can be found in Section G of this guidance.

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- *Staterwideness:* 42 C.F.R. § 431.50 provides that the plan will be in operation statewide under equitable standards for assistance and administration that are mandatory throughout the State.

In addition, a coverage SPA must be consistent with any requirements for the particular benefit that may be specified in law, and must specify any permissible limitations on amount, duration, and scope of services, such as those permissible under 42 C.F.R. § 440.230, that the State wishes to impose.

E. Section 1905(a) Benefits Commonly Provided in Schools (i.e., Medicaid Benefits)

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit

The EPSDT benefit provides a comprehensive array of preventive, diagnostic, and treatment services for most Medicaid-enrolled children under age 21. The EPSDT benefit is more robust than the Medicaid benefits available for adults 21 and over and is designed to help ensure that EPSDT-eligible children and adolescents receive early detection and care so that health problems are averted or diagnosed and treated as early as possible. As specified in section 1905(r)(5) of the Act, the EPSDT benefit entitles most eligible Medicaid-enrolled children and adolescents to services and treatments that fit within any of the benefit categories of Medicaid-coverable services listed in section 1905(a) of the Act if medically necessary, as determined by the State, to “correct or ameliorate” identified conditions. A service does not need to “cure” a condition to be covered under EPSDT; services that improve or prevent deterioration of the child’s current health condition are also required to be covered because of the “ameliorate” provision in the statute.

Vision Services

Medicaid covers vision screening, diagnosis, and treatment services for all EPSDT-eligible children enrolled in Medicaid as part of the EPSDT benefit, as specified in section 1905(r)(3) of the Act. Students with vision disorders may fall behind in school, exhibit behavioral disorders in the classroom, and lag in reaching developmental milestones.³² When a screening shows possible vision problems, the child should be referred for further evaluation. EPSDT requires Medicaid coverage of necessary diagnostic and treatment services, including further testing, eyeglasses, and other vision services, even if the services are not covered for adults. States must arrange for treatment, and the treatment must be provided with reasonable promptness.

Physicians’ Services Benefit

The physicians’ services benefit is defined in section 1905(a)(5) of the Act and in regulations at 42 C.F.R. § 440.50. Physicians’ services are furnished within the scope of practice of medicine or osteopathy as defined by State law, whether furnished by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy. Physicians’ services can be furnished in the school, office, the recipient’s home, a hospital, a skilled nursing facility,

³² National Center for Children’s Vision and Eye Health at Prevent Blindness; <https://nationalcenter.preventblindness.org/>; CDC

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or elsewhere. Since psychiatrists are physicians, their services could be covered under this benefit.

Dental Care Benefit

Medicaid covers dental services for all EPSDT-eligible children enrolled in Medicaid as part of the EPSDT benefit, as specified in section 1905(r)(3) of the Act. Dental services are listed at section 1905(a)(10) of the Act and further described in regulations at 42 C.F.R. § 440.100. Although oral screening performed by a physician may be part of a physical exam, it does not substitute for a dental examination performed by a dentist. A referral to a dentist is required for every EPSDT-eligible child in accordance with the periodicity schedule set by a State for EPSDT-eligible beneficiaries. Preventive oral health services offered in schools are an effective way to reach millions of students and help them prevent cavities. For example, dental sealants, fluoride varnish, and oral assessments may be provided in schools, if covered by the State.

Transportation

Federal regulations at 42 C.F.R. § 431.53 require State Medicaid agencies to specify in the Medicaid State plan that they will ensure necessary transportation for beneficiaries to and from providers and describe the methods that the agency will use to meet this requirement. The transportation assurance requirement is further strengthened for EPSDT services at 42 C.F.R. § 441.62. States are required to cover necessary transportation, if requested, to help ensure EPSDT-eligible beneficiaries can access medically necessary services. Generally, transportation to schools is not necessary transportation for purposes of the Medicaid program, since the primary purpose of attending school is for education. Section 1903(c) of the Act provides that States may not be “prohibited or restricted from receiving payment ... for medical assistance for covered services ... because such services are included in the child’s IEP or IFSP.” Accordingly, the need for specialized transportation must be specified in the IEP/IFSP for Medicaid payment as specialized transportation.

School-based specialized transportation is defined as transportation to a medically necessary service (as outlined in the IEP of a Medicaid-enrolled child) provided in a specially adapted vehicle that has been physically adjusted or designed to meet the needs of the individual student under IDEA (e.g., special harnesses, wheelchair lifts, ramps, specialized environmental controls, etc.) to accommodate students with disabilities in the school-based setting. Special physical adaptations could also include air conditioning and specialized suspension systems. In all cases, the medical need for physical or environmental adaptations during transport from home to school and back home must be identified in the IEP/IFSP.

Personal Care Services Benefit

Personal care services (PCS) are a Medicaid State plan benefit specified in section 1905(a)(24) of the Act that, when covered, must be authorized for an individual by a physician in a plan of treatment or in accordance with a service plan approved by the State. PCS may include a range of human assistance provided to persons with disabilities and chronic conditions in order to enable them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by themselves. Such assistance often relates to performance of activities of daily living (ADLs) and instrumental

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activities of daily living (IADLs). ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. For example, PCS in the classroom may include services such as repositioning of the student, removing materials from a backpack, assisting the student with communication, and attending to the students' personal needs.

Preventive Services Benefit

Preventive services are a benefit specified in section 1905(a)(13) of the Act. Medicaid regulations at 42 C.F.R. § 440.130(c) generally define preventive services as services recommended by a physician or other licensed practitioner of the healing arts, within the scope of authorized practice under State law, to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and efficiency. Preventive services include, but are not limited to, immunizations, well-child care, clinical and behavioral interventions to manage chronic disease and reduce associated risks, and counseling to support healthy living and self-management of chronic disease. For example, a State may cover hearing and vision screenings or developmental testing as preventive services, including in a school setting.

Rehabilitative Services Benefit

Rehabilitative services are a benefit specified in section 1905(a)(13) of the Act. Medicaid regulations at 42 C.F.R. § 440.130(d) generally define rehabilitative services as “any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.” This benefit category is often used to authorize mental health and SUD services. The State will need to describe the rehabilitative services it seeks to cover and list the practitioners who will furnish the services, along with their qualifications. For example, a State may seek to cover individual and group counseling, or peer support services for children in schools with mental health conditions or SUDs. More details about how states may choose to cover Mental Health and SUD services can be found in Section G, below. On August 15, 2007, CMS issued SMDL, #07-011, to provide guidance to States seeking to cover peer support services under the Medicaid program.³³

Physical Therapy, Occupational Therapy, and/or Speech Pathology/Audiology Benefit

PT, OT, and services for individuals with speech, hearing, and language disorders may be covered under multiple benefit categories but must meet regulatory requirements at 42 C.F.R. § 440.110. PT and OT must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under State law and provided to a beneficiary by or under the direction of a qualified therapist. Services like speech pathology services or PT, which support a student's ability to learn, are an important component of Medicaid SBS. For example, PT in schools may assist the student to travel throughout the school environment;

³³ See <https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd081507a.pdf>

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participate in classroom activities; and maintain and change positions in the classroom; as well as manage stairs, restrooms, and the cafeteria.

Other Licensed Practitioner Services Benefit

Section 1905(a)(6) of the Act provides States flexibility in covering services provide by licensed practitioners as defined by State law. As set forth in 42 C.F.R. § 440.60(a), other licensed practitioner services are, “any medical or remedial care or services, other than physicians’ services, provided by licensed practitioners within the scope of practice as defined under State law.” Under the Medicaid State plan, States may elect to cover services furnished by State-licensed practitioners, including in school settings. For example, this benefit could be used to cover the services of a licensed clinical social worker to furnish counseling, a licensed psychologist to administer psychological tests, a licensed nurse to administer medications, or a nurse practitioner to perform physical exams.

Case Management and Targeted Case Management Benefit

States can choose to furnish case management services under sections 1905(a)(19) and 1915(g) of the Act and 42 C.F.R. § 440.169, to assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services. A State may elect to cover case management under the Medicaid State plan. A State may also opt to provide this benefit without regard to the statewideness and comparability requirements at section 1902(a)(1) and (a)(10)(B) of the Act, in which case the benefit is referred to as targeted case management (TCM). This means that States can target the benefit to a specific population, as described in section 1915(g)(1) of the Act, such as Medicaid-eligible individuals with mental health conditions or SUDs, or to individuals who reside in specified areas of the State (or both). Case management services could help coordinate services a beneficiary receives across both school and community settings.

F. Mental Health and Substance Use Disorder Services in Schools

THINGS TO CONSIDER:

- *Early access to appropriate mental health and SUD services conducted by comprehensive school-based mental health and substance use treatment systems has been associated with enhanced academic performance, decreased need for special education, fewer disciplinary encounters, increased engagement with school, and elevated rates of graduation.*

- *Medicaid payment can be made for Medicaid-covered mental health and SUD services, including those identified in students’ IEPs and Section 504 plans.*

Providing mental health care and SUD services in school settings can help address a range of issues among students that affect academic achievement. School-based mental health and substance use programs that incorporate prevention, early intervention, and graduated levels of

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treatment services and supports have been associated with enhanced academic performance, decreased need for special education, and fewer disciplinary encounters.

School-based mental health and SUD programs can provide critical access to care for mental health and substance use issues at a time of life when most people with these conditions develop them (50 percent of adult disorders begin before age 14).³⁴ When mental health and SUD services are available in school settings, youth with mental health and/or substance use issues are far more likely to be identified early and to initiate and complete care. SBS can support earlier detection of mental health and SUD symptoms and implementation of strategies that teach students emotional and behavioral regulation that can help lessen the impact of student mental health disorders on well-being and academic achievement.

CMS has issued several guidance documents recently highlighting Medicaid coverage for school-based mental health and SUD services. In 2019, CMS partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) to issue joint guidance that provides detailed information regarding best practices and well-developed models for implementing mental health and SUD services in schools, as well as information on Medicaid authorities that States may use to cover mental health and SUD services.³⁵ This guidance describes multi-tiered approaches that support evidence-based practices to address varied levels of need among students, from prevention and early intervention services to intensive supports for students with significant mental health conditions and/or SUD. These multi-tiered models include screening as well as targeted support for students exhibiting signs of potentially struggling with mental health conditions or SUDs, and services for those identified as experiencing mental health or substance use problems. In addition, this 2019 guidance also states that “[w]ithin federal requirements affecting coverage, payment, and financing of Medicaid services, schools may establish collaborations with community providers.” More recent guidance, “Coverage and Payment of Interprofessional Consultation in Medicaid and the Children’s Health Insurance Program (CHIP),”³⁶ may be helpful for supporting school-based mental health and SUD services.

A CMS informational bulletin (CIB) issued August 18, 2022 provides several relevant clarifications regarding the EPSDT benefit for children and adolescents. This CIB highlights, for example, that States may cover services, including prevention and early intervention services, for children and adolescents who may have mental health conditions or SUD but who do not yet have a diagnosis; and this guidance notes that hard, fixed, or arbitrary limits on coverage (including based on lists of specific diagnoses) are not permitted.³⁷ This guidance also describes several examples of States providing Medicaid coverage of school-based screenings for mental health conditions and SUDs among students and promoting collaboration between community mental health providers and schools to provide SBS and supports.

³⁴ Lipari, R.N., Hedden, S., Blau, G. and Rubenstein, L. *Adolescent mental health service use and reasons for using services in specialty, educational, and general medical settings*. The CBHSQ Report: May 5, 2016. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.

³⁵ See https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/cib20190701_83.pdf

³⁶ See <https://www.medicaid.gov/federal-policy-guidance/downloads/sho23001.pdf>

³⁷ See <https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf>

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As of October 24, 2019, mental health and SUD services are also mandatory services in CHIP. State Health Official letter # 20-001³⁸ outlines the requirements for separate CHIPs to cover services to prevent, diagnose, and treat a broad range of mental health and substance use disorder conditions. Specifically, States' CHIP behavioral health benefit package must cover age-appropriate, validated behavioral health screening and assessment tools; preventive services; and treatment services, including but not limited to medication-assisted treatment for opioid use disorders and tobacco cessation. As with other CHIP-covered services, CHIP mental health and SUD services may be provided in school-based settings.³⁹

State Medicaid/CHIP agencies are encouraged to work with CMS and use the guidance and the informational bulletin referenced above to increase coverage of mental health and SUD services in schools to improve access to care.

G. Provider Participation in the Medicaid and CHIP Programs

For services that may be covered by Medicaid and CHIP to be payable (including when furnished in the school setting), the provider furnishing such services must be enrolled in the State Medicaid or CHIP program, as applicable. If the individual practitioner directly providing the service is a provider type not eligible to separately enroll as a Medicaid or CHIP provider, they must be an employee or contractor of an enrolled Medicaid or CHIP provider, and that enrolled provider would be considered the furnishing provider. If the individual practitioner directly providing the service is a provider type that *is* eligible to separately enroll as a Medicaid or CHIP provider, they would be considered the furnishing provider and must be enrolled, regardless of whether the entity employing or contracting with them is also an enrolled provider. If the furnishing provider is not enrolled with Medicaid or CHIP or chooses not to bill Medicaid or CHIP for the service, then Medicaid or CHIP payment cannot be made for the service and any expenditures related to the service are not allowable. For medical services to be payable under the Medicaid or CHIP State plan, all of the following requirements must be met:

- The medical services must be furnished to a Medicaid- or CHIP-eligible individual.
- The medical services must be a Medicaid- or CHIP-covered service and must meet any specific coverage requirements applicable to the service. States are reminded that, even if a particular service is not generally covered under the Medicaid State plan for adults, coverage is required under the EPSDT benefit for an EPSDT-eligible beneficiary if the service could be covered under section 1905(a) of the Act.
- The furnishing provider must be enrolled as a participating provider in the Medicaid or CHIP program, with a provider agreement and a Medicaid or CHIP provider identification number.

Examples of this principle are:

³⁸ See <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20001.pdf>

³⁹ Section 2103(c)(9) of the Social Security Act permits States to provide separate CHIP covered services through school-based health centers. Section 2110(a) of the Act and 42 C.F.R. § 457.402 include services provided in schools in the definition of child health assistance under CHIP.

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Example 1. The LEA is an enrolled Medicaid provider. The LEA furnishes and bills for medical services provided in the school by its employees and contractors who are of a provider type(s) not eligible to separately enroll as Medicaid providers. Expenditures for direct medical services furnished to the LEA's Medicaid-enrolled students are allowable where service-specific coverage requirements are met. Such services would be claimed by the LEA, who is considered the furnishing provider and has been screened and enrolled as a Medicaid provider. The LEA could also employ or contract with Medicaid-enrolled providers to provide Medicaid-covered services to Medicaid-enrolled students; these services could be claimed directly by the providers, or, consistent with the requirements of 42 C.F.R. § 447.10(g), the LEA could pay the providers a contractual rate, and the LEA then would claim for the services.

Example 2. The LEA is not an enrolled Medicaid provider. Even though it facilitates the provision medical services, the LEA does not bill for any direct medical services, including those listed in an IEP. The school arranges medical services identified in an IEP for a Medicaid-enrolled student with special education needs. In this example, the costs of the related direct services would be allowable under the Medicaid program, but the services could not be billed to Medicaid by the LEA since the LEA is not enrolled as a Medicaid provider. Instead, the services could be claimed by the providers that furnished them if they are enrolled as Medicaid-participating providers.

Example 3. The LEA is not an enrolled Medicaid provider. The LEA refers Medicaid-enrolled students without IEPs to Medicaid-participating providers in the community.⁴⁰ The community-based providers bill Medicaid for the Medicaid-covered services they provide. If the LEA performs administrative activities related to the services that are billed to Medicaid by community providers, the costs of such activities can be allowable under the Medicaid program, as discussed in this guide.

Example 4. Regardless of whether an LEA participates in the Medicaid program, referrals made to community-based providers that are not enrolled with the State Medicaid program are not billed to Medicaid. In this case, the costs of administrative activities related to such medical services (such as administrative costs of making referrals) would not be allowable under Medicaid, because the activities would not be in support of the provision of a Medicaid-covered service. (for more information on administrative claiming can be found in section VI. E. Administrative Claiming for SBS)

H. Provider Qualifications for Practitioners in Schools

THINGS TO CONSIDER:

- *States are encouraged to identify schools as providers of Medicaid services.*

⁴⁰ If the LEA is not enrolled as a Medicaid provider, it cannot receive direct service payment for referring for services that require a referral as a condition of coverage. Pursuant to section 1902(a)(78) and (kk)(7) of the Act, providers who order, refer, prescribe, or certify eligibility for Medicaid services (in addition to providers who furnish such services) must be enrolled.

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- *To receive payment for providing Medicaid-covered services, SBS providers must be qualified providers of those services.*
- *States must meet the freedom of choice of provider requirement in section 1902(a)(23) of the Act.*
- *Provider qualifications for school-based providers may differ from the qualifications of non-school-based providers of the same Medicaid services, as long as states' provider qualifications are not unique to Medicaid-covered service.*
- *Provider qualifications for school-based providers may differ from the qualifications of non-school-based providers of the same Medicaid services, as long as states' provider qualifications are not unique to Medicaid-covered services.*

Provider Qualifications for Practitioners in Schools

CMS strongly encourages States to make available the broadest array of qualified providers for Medicaid-covered physical health, mental health, and SUD services to children both inside and outside of school settings. CMS supports reducing administrative burden for States to expand access to qualified practitioners in school settings who provide Medicaid services while ensuring quality of care across settings where children may receive such services. This guidance is relevant both to practitioners employed by schools where the school is enrolled as a Medicaid provider, and to practitioners who are individually enrolled with the State Medicaid program and who provide services in the school. The school setting should be viewed as part of a continuum of care and services across the community that are covered for eligible children and youth.

Accordingly, CMS is updating the guidance it provided in 1997 on freedom of choice of providers and provider qualifications for SBS. In that guidance, CMS instructed States that they could not rely on ED provider qualifications for Medicaid reimbursement, or establish different provider qualifications for school-based and non-school-based providers within Medicaid.⁴¹ We now are updating that guidance in order to give States greater flexibility to cover services provided by school-based health care providers whose provider qualifications under State and local law might vary from the qualifications for non-school-based providers of the same services, or whose scope of practice might be limited under State or local law to the school setting. Under this updated approach, states should not impose provider qualifications that are unique to Medicaid-covered services. For example, if a school-based provider is qualified under State or local law to provide counseling to any child (or any child in the school system), the State cannot impose additional provider qualification requirements under State law as a condition for receiving Medicaid payment for counseling provided to a Medicaid beneficiary.

Additionally, to comply with the comparability and EPSDT requirements in federal Medicaid law, and to ensure access to covered services for children with disabilities who might not be able to attend school. As such, States should not limit Medicaid coverage of services only to

⁴¹ See pages 15-16: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Medicaid_and_School_Health_Technical_Assistance_Guide_9.pdf

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providers qualified to provide services only in a school setting, and should ensure that eligible children and their families can access qualified providers for all Medicaid services regardless of whether a child is attending school. Thus, it is still the case that, as CMS stated in its 1997 guidance, States cannot limit Medicaid-eligible children to school health providers for Medicaid-covered services.⁴²

Section 1902(a)(23)(A) of the Act provides that beneficiaries may obtain Medicaid services from any qualified provider who undertakes to provide beneficiaries with those services. Specifically, unless an exception applies under federal statute or regulations,⁴³ States are required to ensure that a beneficiary may obtain Medicaid services from any institution, agency, pharmacy, person, or organization, that is (i) qualified to furnish the services and (ii) willing to furnish them to that particular beneficiary. These two prongs, being qualified and being willing, establish the foundation of the free choice of provider requirements. However, regulations at 42 C.F.R. § 431.51(c)(2) permit States to set reasonable standards relating to the qualifications of providers. This includes setting reasonable qualifications for providers furnishing services in schools.

States generally have broad flexibility to identify the providers of a covered Medicaid service, including their qualifications. When identifying provider qualifications for Medicaid-covered services, States may refer to State, local, or other generally applicable licensure or certification requirements, including certification by the federal, state, or local ED or national accrediting bodies. For example, when covering two optional Medicaid benefits that are commonly furnished in the school setting, preventive services (section 1905(a)(13) and 42 C.F.R. § 440.130(c)) and rehabilitative services (section 1905(a)(13) and 42 C.F.R. § 440.130(d)) States can, in the Medicaid State plan, define the amount, duration, and scope of the services covered under the benefit, and list providers who are qualified to provide the services by referencing generally applicable licensure, certification or other experience, education, or training criteria.

While States generally have a great deal of flexibility to set provider qualifications for Medicaid services, provider qualifications for some Medicaid services are defined in federal law. For example, providers of PT, OT, speech therapy, and audiology services must meet federal provider requirements specified at 42 C.F.R. § 440.110, regardless of the section 1905(a) benefit category under which these services are covered. This regulation includes provider qualification requirements for licensure, certification, and education. While States generally have their own licensure and/or certification standards for these providers under State law, States can cover these services in Medicaid only if the providers meet the criteria in the federal regulations.

If the State has included school-based providers as qualified providers of specific services in the Medicaid State plan, then individual school-based providers may seek to become Medicaid providers. For example, states may determine that counseling provided under the rehabilitative services benefit may be provided by licensed psychologists, social workers, family therapists, professional counselors, as well as certified school psychologists or school social workers who

⁴² See page 18: [https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Medicaid and School Health Technical Assistance Guide 9.pdf](https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Medicaid%20and%20School%20Health%20Technical%20Assistance%20Guide%209.pdf).

⁴³ Exceptions include those listed at 42 C.F.R. 431.51(c). States and territories might also have waivers of freedom of choice, such as those under section 1902(j) or section 1115(a)(1) of the Act, and freedom-of-choice of providers generally does not apply under Medicaid managed care, as described in the regulations at 42 C.F.R. part 438.

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may not have the same qualifications. In some circumstances, a practitioner may be enrolled individually as a Medicaid provider and may either bill directly for the services they furnish or, consistent with 42 C.F.R. § 447.10(g), reassign their right to payment to the school or an agency contracted by the school to provide Medicaid-covered services. In other circumstances, the LEA or agency contracted by the school to provide Medicaid-covered services may be enrolled as a Medicaid provider and may be considered the “furnishing provider” for services provided by its employees. See section II.C., above: “Provider Participation in the Medicaid Program” for more information about compliance with federal enrollment requirements.

Covering Medicaid services furnished by school-based providers can expand access to these services for eligible children and youth. School-based providers furnish services that support a child’s education and social and emotional development. Under this updated guidance, States should have greater flexibility to incorporate school-based providers into the Medicaid program to expand access to services provided at the right time in the right place for children and youth. We urge states to utilize this flexibility to recognize an array of school-based and non-school-based providers to help maximize beneficiary access to Medicaid services. Additionally, States are encouraged to review existing state licensure, certification, and other applicable state requirements, including credentialing criteria, for SBS providers to identify ways to streamline their participation in Medicaid. We do recognize that children and youth may also have providers of the same types of services in the community and we encourage States to create communication pathways between school and community-based providers to facilitate coordinated care.

IV. Delivery of Services

A. Managed Care

THINGS TO CONSIDER:

- *While there are many different types of managed care arrangements, there are common characteristics regarding the delivery of and payment for services through a managed care plan (MCP). For delivery of services, patients generally must be enrolled with a primary care physician who is responsible for coordinating their care. MCPs generally provide patients with access to a selected provider network in which services are coordinated with a focus on prevention and early detection of illnesses and conditions.*

 - *MCPs are generally paid a monthly capitation payment by State Medicaid agencies for the provision of a specified package of services for enrolled beneficiaries.*

 - *In exchange for the monthly capitation payment, the MCPs assume financial risk for the provision of an agreed upon package of services. The MCPs also pay providers, establish a provider network, and educate providers and enrollees about the covered services available under the plan.*
-

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CMS strongly encourages State Medicaid agencies that have not carved SBS out of managed care to work with MCPs⁴⁴ and schools to aid in the provision of and payment for SBS. Given that more than 80 percent of children in Medicaid are enrolled in managed care,⁴⁵ this partnership between federal and State governments and MCPs plays a major role in the delivery of health care for students enrolled in Medicaid. Even when some or all of SBS are carved out of managed care, 42 C.F.R. § 438.208 requires the MCP to coordinate services the enrollee receives in a FFS delivery system and from any other MCP.

While there are many different types of managed care arrangements, State Medicaid agencies have flexibility in determining how services are provided. State Medicaid agencies may elect to deliver some services through the MCPs and retain some services under FFS delivery; in fact, the majority of States carve SBS out of managed care and cover them under a FFS delivery system. The MCP contract must clearly describe which services and administrative activities are included under the contract, to avoid duplication of payment and performance of assigned responsibilities.⁴⁶ This requires enough specificity to avoid confusion about what is included in a covered benefit and whether the MCP is responsible for covering the benefit.

State Medicaid agencies must ensure that EPSDT-eligible individuals under age 21 have access to the full EPSDT benefit (see subsection *Section 1905(a) Benefits Commonly Provided in Schools* and subsection *General Rules Applicable to Medicaid and CHIP Payments* for SBS). Any Medicaid benefits not covered under the MCP contract remain the responsibility of the State Medicaid agency.

CMS strongly encourages State Medicaid/CHIP agencies to proactively establish and/or strengthen relationships between MCPs, schools/LEAs, and school-based providers.⁴⁷ This is especially important when designing and implementing a managed care program. State Medicaid agencies can encourage MCPs to establish and strengthen collaborative relationships with schools/LEAs and school-based providers in a variety of ways, including through MCP incentive arrangements such as performance improvement projects and quality improvement activities, as appropriate.

⁴⁴ Includes managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, as defined at 42 C.F.R. § 438.2. See <https://www.eC.F.R..gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.2>

⁴⁵ MACPAC Data, Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2019 See <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-30.-Percentage-of-Medicaid-Enrollees-in-Managed-Care-by-State-and-Eligibility-Group-FY-2019.pdf>

⁴⁶ In accordance with 42 C.F.R. 438.5(e), the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO, PIHP, or PAHP administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, cost of capital, and other operational costs associated with the provision of services identified in § 438.3(c)(1)(ii) to the populations covered under the contract. We remind States that State plan administrative activities not related to the plan's furnishing of services may not be incorporated into the Medicaid managed capitation rates.

⁴⁷ CMS Informational Bulletin, Information on School-Based Services in Medicaid: Funding, Documentation and Expanding Services, August 18, 2022 See <https://www.medicaid.gov/federal-policy-guidance/downloads/sbscib08182022.pdf>

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State Medicaid agencies should proactively include schools during the MCP re-procurement and contracting processes to provide opportunities to shape new or revisit existing MCP requirements. While there are no specific statutory requirements for State Medicaid agencies to require that MCPs establish relationships with school-based providers, State Medicaid agencies can require MCPs to establish relationships, strengthen partnerships, and coordinate care with school-based providers, including school-based health centers, in their managed care contracts, including through contractual managed care performance standards. These latter contractual performance standards can be effectuated through managed care contract arrangements such as managed care plan incentive payments⁴⁸ or withhold arrangements⁴⁹ for their plans or State-directed payments for providers.⁵⁰

B. Delivering Medicaid SBS through Telehealth

State Medicaid/CHIP agencies have the flexibility to cover Medicaid- and CHIP-covered services delivered through telehealth, including in school-based settings. In order for a medical service performed to be payable, the provider furnishing such services must be enrolled in the Medicaid or CHIP program and bill Medicaid or CHIP for the service.

School-based telehealth involves the use of telecommunications, including interactive video conferencing and store-and-forward transmissions, to deliver a variety of health care and other services to students children while they are present in school settings.⁵¹ Generally, State Medicaid/CHIP agencies that elect to cover services furnished through telehealth in their Medicaid and CHIP programs may choose the types of services that are covered when delivered through telehealth, areas within the State where this coverage is available, and the types of providers who may receive Medicaid or CHIP payment for services delivered via telehealth. State Medicaid/CHIP agencies should review the range of providers and practitioners authorized to bill Medicaid or CHIP for services delivered via telehealth in their State, including those delivering services in school settings. Although State Medicaid/CHIP agencies are not generally required to submit a SPA to authorize telehealth as a service delivery mechanism for otherwise-covered services, they would need to do so if they wish to pay for telehealth-delivered services differently from services delivered face-to-face, or if they want to remove any express limitations

⁴⁸ States may also use incentive payments to reward managed care plans in line with performance targets specified in the managed care plan contract. These incentive payments represent additional funds over and above the capitation rates. Incentive payments must comply with all requirements in 42 C.F.R. § 438.6(b)(2), including that managed care plan contracts incorporating incentive payments must not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement.

⁴⁹ States can also implement a withhold arrangement with their managed care plans as well. For a withhold arrangement, a portion of a capitation payment is withheld from the plans, which can be earned back by the plan for meeting targets specified in the contract such as meeting quality performance targets specified in the managed care plan contract. Contracts that provide for a withhold arrangement must ensure that the capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound as determined by an actuary in accordance with 42 C.F.R. § 438.6(b)(3).

⁵⁰ Under 42 C.F.R. § 438.6(c), there are several requirements and conditions on State direction of payments by an MCP to service providers.

⁵¹ See <https://telehealth.hhs.gov/providers/school-based-telehealth/>

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in the approved Medicaid State plan that would preclude desired coverage of services delivered via telehealth.

Access to health care through telehealth at school may reduce student absenteeism.⁵² Many State Medicaid agencies have experience with establishing payment for Medicaid-covered services delivered via telehealth, including pediatric mental health and SUD services. The flexibility of Medicaid and CHIP telehealth policy allows State Medicaid/CHIP agencies to cover services that may be more convenient to schedule and receive through telehealth, such as therapy services, and thereby increase uptake of such services where clinically appropriate. State Medicaid/CHIP agencies should be mindful of applicable privacy laws when covering telehealth services and should review their provider licensure and credentialing requirements to evaluate whether they need to be modified to allow for telehealth service delivery, particularly in the event the State Medicaid/CHIP agency wishes to make payment for services furnished by providers located out-of-State who furnish services to individuals within the State. For more information on this and other details of providing Medicaid services across State lines, please refer to the Medicaid telehealth toolkit⁵³ and CMS Informational Bulletin (CIB) published on October 20, 2021, *Guidance on Coordinating Care Provided by Out-of-State Providers for Children with Medically Complex Conditions*.⁵⁴

State Medicaid agencies also may pay providers for additional costs associated with delivering services via telehealth within Medicaid payment methodologies. For example, additional overhead costs associated with the telehealth technology and set-up for sites where an individual receives care may be incorporated into FFS rates. State Medicaid agency payment methodologies should be clear about whether and how payments are modified and how providers may bill for services furnished via telehealth.

C. Confidentiality & Parental Consent

THINGS TO CONSIDER:

- *State Medicaid/CHIP agencies may share beneficiary information with schools enrolled as Medicaid and CHIP providers, or other Medicaid or CHIP providers, when the purpose of the disclosure is directly connected to the administration of the Medicaid or CHIP State plan, including establishing eligibility, providing services, or billing for services.*
- *Medicaid/CHIP agencies may only share beneficiary information with a Medicaid or CHIP provider (such as a school) if the provider has standards of confidentiality comparable to those of the State Medicaid/CHIP agency.*
- *FERPA and IDEA require the school district to obtain the consent of the parent before disclosing a student's personally identifiable information (PII) to the State Medicaid/CHIP agencies for billing and for cost reimbursement purposes.*

⁵² See <https://journals.sagepub.com/doi/full/10.1177/2333794X19884194>

⁵³ See <https://telehealth.hhs.gov/licensure/licensing-across-state-lines>

⁵⁴ See <https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf>

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- *For children with disabilities, IDEA’s regulations currently require that before a school district can bill Medicaid or CHIP for the first time to pay for special education and related services identified in an IEP under IDEA, it must obtain a parent’s signed and dated written consent.*

- *On May 18, 2023, ED published in the Federal Register a proposed rule to modify IDEA Part B requirement in 34 C.F.R. § 300.154(d)(2)(iv) that an LEA must obtain parental consent prior to accessing an IDEA-enrolled child’s or the parent’s public benefits or insurance for the first time. This regulation has unintentionally created a barrier to LEAs’ ability to access Medicaid payment to support critical services for children with disabilities by treating them their non-disabled peers and is not required by IDEA. This proposed rule would help ensure that there is no reduction in benefits to children. It would also protect the rights of children and parents by continuing the no-cost, privacy, and notification protections when LEAs bill Medicaid.*

- *In some circumstances an educational agency or institution subject to FERPA may meet the definition of a covered entity under the Health Insurance Portability and Accountability Act (HIPAA), because it electronically bills health insurance, such as Medicaid or CHIP. However, in most elementary and secondary school settings, even where the school is a covered entity under FERPA, privacy protections apply because the HIPAA Privacy Rule specifically excludes from its coverage those records that are protected by FERPA.⁵⁵*

Safeguarding Information Concerning Medicaid and CHIP Applicants and Beneficiaries

Section 1902(a)(7) of the Act and implementing regulations at 42 C.F.R. part 431, subpart F, require State Medicaid agencies to provide safeguards that restrict the use or disclosure of information concerning Medicaid applicants and beneficiaries to uses or disclosures that are directly connected with the administration of the Medicaid State plan.⁵⁶ The same requirements also apply to separate CHIPs through a cross reference at 42 C.F.R. § 457.1110(b). Purposes that are directly connected to the Medicaid State plan administration include: establishing eligibility, determining the amount of medical assistance, providing services for recipients, and conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan under 42 C.F.R. § 431.302. State Medicaid/CHIP agencies may share beneficiary information with schools enrolled as Medicaid and CHIP providers or other Medicaid or CHIP providers, when that disclosure meets one of the purposes above, such as establishing eligibility or providing services. Any data elements disclosed must be consistent with a purpose that is directly connected to the administration of the Medicaid State plan, per section 1902(a)(7) of the Act and 42 C.F.R. §§ 431.301-302.⁵⁷

⁵⁵ See: <https://studentprivacy.ed.gov/resources/joint-guidance-application-ferpa-and-hipaa-student-health-records>

⁵⁶ Section 1902(a)(7)(B) of the Act also allows State Medicaid agencies the option to exchange Medicaid applicant and beneficiary information necessary to verify the certification of eligibility of children for free or reduced-price school meals.

⁵⁷ U.S. Department of Health and Human Services Administration for Children and Families (ACF) and CMS, “Toolkit on Data Sharing for Child Welfare Agencies and Medicaid,” January 20, 2022, <https://www.acf.hhs.gov/sites/default/files/documents/cb/data-sharing-and-medicaid-toolkit.pdf>. (See Page 12, Footnote 29)

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States must provide safeguards that meet standards of confidentiality when they disclose applicant or beneficiary data in accordance with 42 C.F.R. §§ 431.306 and 457.1110(b) (described in more detail below). The types of information that States must safeguard include names, addresses, social security numbers, medical services provided, social and economic conditions or circumstances, and any information received in connection with a legally liable third party under 42 C.F.R. § 433.138. For a list of the minimum set of information that must be protected, see 42 C.F.R. § 431.305.

Medicaid and CHIP Standards of Confidentiality

State Medicaid/CHIP agencies may only share beneficiary information with a Medicaid or CHIP provider (such as a school) if the provider has standards of confidentiality comparable to those of the State Medicaid agency in accordance with 42 C.F.R. § 431.306(b), or the State CHIP agency in accordance with 42 C.F.R. § 457.1110(b), which cross-references to subpart F of 42 C.F.R. part 431, including § 431.306. The Medicaid and CHIP standards of confidentiality include, but are not limited to, the following:

- The agency must have criteria that specify the conditions for release and use of information about Medicaid or CHIP applicants and beneficiaries;
- Information access is restricted to persons or agency representatives subject to standards of confidentiality that are comparable to those of the agency;
- Publishing of names of Medicaid or CHIP applicants and beneficiaries is prohibited; and
- The agency must obtain written permission from a family or individual before responding to a request for information from an outside source (see additional information below).

Beneficiary Consent for the Release of Information:

Generally, State Medicaid/CHIP agencies or any entity subject to comparable standards of confidentiality must obtain permission from a family member or individual, whenever possible, before responding to a request for a release of Medicaid or CHIP applicant or beneficiary information from an outside source.⁵⁸ Examples of entities that might be considered an outside source include a non-Medicaid or CHIP provider or another health plan outside of the Medicaid or CHIP network (e.g., employer-sponsored health insurer).

Medicaid or CHIP providers, or other contractors with whom the State has a written agreement to perform key functions of the administration of the Medicaid State plan (e.g., enrollment broker, transportation broker, MCP), are not considered an outside source, so there would be no beneficiary consent required prior to release of the beneficiary's information. When a provider is sharing information with the Medicaid/CHIP agency, the Medicaid/CHIP agencies would also not be considered an outside source. Therefore, Medicaid regulations do not require the Medicaid/CHIP agency or providers (such as a school) to obtain consent from the beneficiary or family member prior to exchanging the individual's information for a purpose directly connected to the administration of the Medicaid State plan, which includes billing Medicaid or CHIP for providing services to beneficiaries.

⁵⁸ See 42 C.F.R. § 431.306(d).

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While Medicaid regulations do not require Medicaid or CHIP providers to obtain the beneficiary's permission prior to exchanging their information with the State Medicaid/CHIP agencies for purposes directly connected with the Medicaid State plan, as described above, other laws such as FERPA may require such permission (see section below on FERPA parental consent requirements).

Parental Right under Education Laws: FERPA and IDEA

This section details the basic requirements for protecting a student's education records and the associated parent consent requirements under FERPA (20 U.S.C. § 1232g; 34 C.F.R. Part 99) as well as parent consent requirements under Part B of IDEA (20 U.S.C. 1417 and 34 C.F.R. §§ 300.610-300.626 and §300.154(d)(2)(iv)). IDEA incorporate some of the requirements under FERPA, but also include several provisions that are specifically related to children with disabilities receiving services under IDEA and provide protections beyond the FERPA requirements. When analyzing the privacy and confidentiality requirements for children with disabilities, it is critical to begin by examining IDEA requirements first.⁵⁹

FERPA and IDEA protect the privacy of a student's "education records," which are generally defined as records that are directly related to a student and maintained by an educational agency or institution or by a party acting for the educational agency or institution. An "educational agency or institution," generally means a school district, a public elementary or secondary school, or an institution of postsecondary education such as a college or university. The law applies to all schools that receive funds under an applicable program of ED.

Under FERPA and IDEA Part B, a school generally may not disclose PII from a student's education records to a third party unless the student's parent has provided prior written consent with some limited exceptions (See 34 C.F.R. § 99.31 and See 34 C.F.R § 300.622).⁶⁰ Accordingly, a school district would be required to obtain the consent of the parent before disclosing PII for billing purposes to a State Medicaid/CHIP agency. For children with disabilities, IDEA's regulations additionally require school districts to obtain a parent's agreement in writing (i.e. consent) before billing Medicaid or CHIP for the first time to pay for special education and related services under IDEA (See 34 C.F.R §300.154(d)(2)(iv)(B)).⁶¹ States are encouraged to create forms and other tools so that these separate consent requirements under FERPA and IDEA Part B can be requested together.⁶²

For all students, consent must specify:

⁵⁹ The Department of Education has created an IDEA and FERPA Crosswalk. See https://studentprivacy.ed.gov/sites/default/files/resource_document/file/IDEA-FERPA%20Crosswalk_08242022.pdf

⁶⁰ A parent guide to understanding FERPA can be found in the appendix.

⁶¹ As noted above, on May 18, 2023, the Department of Education published in the Federal Register a proposed rule to modify IDEA Part B requirement in 34 C.F.R. § 300.154(d)(2)(iv) that an LEA must obtain parental consent prior to accessing an IDEA-enrolled child's or the parent's public benefits or insurance for the first time.

⁶² The Department of Education has created a model consent form that addresses the applicable requirements. See <https://sites.ed.gov/idea/idea-files/osep-dear-colleague-letter-on-model-notice-public-insurance/>

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- The PII that the school district may disclose (for example, records or information about the services that may be provided to the student),
- The purpose of the disclosure (for example, billing for special education and related services), and
- The agency to which the school district may disclose the information (for example, the State Medicaid/CHIP agency). (See 34 C.F.R. § 99.30(b) and §300.622)
- Additionally, for children with disabilities, IDEA’s regulations currently require that before a school district can bill Medicaid for the first time to pay for special education and related services under IDEA, it must obtain a parent’s signed and dated written consent

Schools may wish to take advantage of opportunities occurring at the beginning of each school, such as “Back to School” nights, and “Back to School” packets of information that are sent home to inform families on how to enroll their child in health coverage through the Medicaid and CHIP programs, if eligible, and to secure parent consent under FERPA and IDEA for Medicaid and CHIP billing.

A parent guide to understanding FERPA can be found in the appendix.

HIPAA May Apply in Some School Settings to Protect the Privacy of Health Information

In some circumstances, an educational agency or institution subject to FERPA may meet the definition of a covered entity under HIPAA because it electronically bills health insurance, such as Medicaid or CHIP. However, in most elementary and secondary school settings, even where the school is a covered entity, FERPA privacy protections apply instead of the HIPAA Privacy Rule. For information about how FERPA and HIPAA apply to protect the privacy of student health records, see <https://studentprivacy.ed.gov/resources/joint-guidance-application-ferpa-and-hipaa-student-health-records>. This guidance, jointly issued by the ED and HHS, addresses the situations in which each law applies, when they require consent or HIPAA authorization for disclosures, parents’ rights with respect to minor students’ health records, and many more questions on this topic that are frequently asked by school administrators, health care professionals, and others.

V. Children’s Health Insurance Program and School-based Health Services

CHIP is an optional State coverage program for uninsured children and pregnant individuals in families with incomes above Medicaid eligibility limits that are not able to afford private coverage. States can design their CHIP program in one of three ways:

- **Separate CHIP:** a program under which a State receives federal funding to provide child health assistance to uninsured, low-income children that meets the requirements of section 2103 of the Act.

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- **Medicaid expansion CHIP:** a program under which a State receives federal funding to expand Medicaid eligibility to additional children.
- **Combination Separate CHIP and Medicaid expansion CHIP:** a mix of the two above.

CHIP is implemented through a partnership between CMS and States, and State health care expenditures are matched at an enhanced federal matching rate that is above the regular Title XIX Medicaid federal matching rate for services.⁶³ The enhanced matching rate for each State is determined annually. Title XXI funds are available for States to provide direct coverage to children under a separate CHIP and/or Medicaid expansion CHIP.

Separate CHIPs generally have more flexibility than Medicaid programs, including Medicaid expansion CHIPs, as States are able to determine the covered services, service delivery systems, cost sharing, and other coverage requirements for these programs so long as they conform to federal requirements pertaining to eligibility standards,⁶⁴ mandatory covered services,⁶⁵ and exclusions on cost sharing.⁶⁶ Medicaid expansion CHIPs receive Title XXI federal funding to expand Medicaid eligibility to higher-income children who receive the same benefits, such as EPSDT, as other children under the Medicaid State plan.

A. CHIP Coverage for SBS

CHIP statutes and regulations allow States to use Title XXI funding for items and services provided to eligible students in school-based settings. Specifically, section 2103(c)(9) of the Act permits States to provide separate CHIP-covered services through school-based health centers. Additionally, the definition of child health assistance at section 2110(a) of the Act and 42 C.F.R. § 457.402 includes services provided in schools, such as nursing care services and other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. Several States offer coverage of SBS to separate CHIP beneficiaries.⁶⁷ Examples of SBS that States currently cover in separate CHIP include, but are not limited to:

- Nursing care services;
- Tobacco cessation;
- Crisis intervention and stabilization;
- Outpatient mental health and SUD services; and
- PT, OT, and services for individuals with speech, hearing, and language disorders.

Title XXI funds may also be used for coverage of SBS for Medicaid-enrolled students through a Medicaid expansion CHIP. Medicaid expansion CHIPs follow Medicaid coverage requirements outlined in Title XIX of the Act and implementing regulations. Therefore, States should follow Medicaid requirements and standards for providing SBS to optional targeted low-income students enrolled in a Medicaid expansion CHIP.

⁶³ Section 2105(a)(1) of the Act permits payments to States for child health assistance provided in CHIP using the enhanced federal match rate. Section 2105(b) of the Act defines the enhanced federal match rate and describes how the rate is determined.

⁶⁴ See <https://www.medicaid.gov/chip/eligibility/index.html>

⁶⁵ See <https://www.medicaid.gov/chip/benefits/index.html>

⁶⁶ See <https://www.medicaid.gov/chip/chip-cost-sharing/index.html>

⁶⁷ Approved CHIP SPAs are available to view on [Medicaid.gov](https://www.medicaid.gov).

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States also have the flexibility to determine the delivery system they will use to provide SBS to CHIP beneficiaries. States that operate their separate CHIP programs through managed care often carve out SBS from their CHIP managed care network, and provide these services through FFS. Other States contractually require CHIP managed care plans to include school-based health centers in their managed care networks. States also elect to include SBS in their CHIP Primary Care Case Management (PCCM) models.

B. Health Services Initiatives (HSIs) for SBS

HSIs are an additional option States may implement to cover items and services, including SBS, for low-income students. HSIs are permitted under section 2105(a)(1)(D)(ii) of the Act and are defined in regulations at 42 C.F.R. § 457.10, and may include direct services or public health initiatives. An HSI must directly improve the health of low-income children⁶⁸ less than 19 years of age who are eligible for CHIP and/or Medicaid, but may serve children regardless of income.

The federal portion of HSI expenditures is funded through a State's available CHIP allotment for a fiscal year, as determined under section 2104 of the Act. Meanwhile, States finance the non-federal portion of HSI expenditures. HSI expenditures are subject to a cap that also applies to administrative expenses. Under section 2105(c)(2)(A) of the Act, claims for HSIs and administrative expenses together cannot exceed 10 percent of the total amount of Title XXI funds claimed by the State each quarter. Within the 10 percent limit, States must fund costs associated with administration of the CHIP State plan first; any funds left over may be used for an HSI, subject to the 10 percent cap.

Currently, 14 States have approved HSIs that cover SBS for low-income students. Four of these States use HSI funding to support the Vision to Learn program, which offers vision screening and glasses to students in schools. In addition, ten States have HSIs that provide other types of SBS to students. Examples include:

- Services provided in school-based health centers such as health screenings; health education; care coordination; and referrals to providers.
- Funding to school districts to assist with salary expenses for registered nurses that work in schools.
- Grants to schools to develop or expand the capacity of school-based health centers to provide public health services.
- Training and naloxone kits to school personnel to treat overdoses and prevent overdose-related deaths for students in school settings.

CMS is available to provide technical assistance to States on each of these options to cover SBS and outreach in CHIP. CMS will also use the Technical Assistance Center (TAC)⁶⁹ established

⁶⁸ As defined in 42 C.F.R. Section 457.10, a low-income child means a child whose household income is at or below 200 percent of the federal poverty line for the size of the family involved.

⁶⁹ The Technical Assistance Center: Section 11003(a)(2) of the BSCA requires CMS, in consultation with the ED, to establish a TAC for Medicaid SBS. This TAC will seek to: assist and expand the capacity of State Medicaid

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through BSCA to identify other potential areas of State Medicaid/CHIP agency need and interest for additional technical assistance around CHIP and HSIs.

VI. General Requirements for Billing, Claiming, and Accounting for SBS Medical and Administrative Costs

This section is for both State Medicaid/CHIP agencies and LEAs and outlines general rules applicable to Medicaid and CHIP payments and provides definitions of billing and claiming principles for both direct medical services and administrative activities. This section is designed to outline the Medicaid State plan requirements concerning payment for State Medicaid agencies, inform LEAs and providers about the requirements for Medicaid or CHIP payment, and inform all about the applicable federal cost principles. Specifically, this section provides examples of how to claim for payment and provides guidance on documentation and SPA requirements related to billing, claiming, and accounting for direct and indirect medical service and administrative costs in school-based settings. The section concludes with federal requirements for third party liability (TPL) and the implications of TPL when billing for SBS.

A. General Rules Applicable to Medicaid and CHIP Payments for SBS

THINGS TO CONSIDER: Non-Federal Share Financing for SBS

- *There are multiple options for State Medicaid/CHIP agencies to fund the non-federal share of Medicaid and CHIP expenditures, including State legislative appropriations, Intergovernmental Transfers (IGTs) and Certified Public Expenditures (CPEs).*
- *There are also multiple payment methodology options for State Medicaid/CHIP agencies to use to pay providers.*
- *State Medicaid/CHIP agencies are required to use certain payment methodologies when certain sources of non-federal share are used.*
- *Many SBS are supported by public schools or LEAs using CPEs; in those cases, States must pay providers according to a reconciled cost payment methodology in the approved Medicaid State plan.*
- *CMS strongly encourages State Medicaid/CHIP agencies to pass on the federal share of any costs claimed as SBS expenditures for which the non-federal share is supported by a CPE*

agencies, LEAs, and school-based entities to provide assistance under Medicaid. This could include convening small group stakeholder calls with target audience members and schools located in small, rural communities, and developing specific resource materials tailored to the specific needs of those communities. The primary “target audience” for the TAC is made up of State Medicaid Agencies and their directors/designees, State Education Agencies, LEAs; and School Based Entities.

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directly to the LEAs/school-based providers, as additional funding and investment will help to support additional efforts to improve the delivery and administration of SBS.

• Section 1903 of the Act, and implementing regulations in 42 C.F.R. § 433.51, describe allowable sources of the non-federal share and specific mechanisms that may be used by units of State and local governments to participate in financing the non-federal share. These provisions extend to sources of the non-federal share of financing for CHIP through 42 C.F.R. § 457.628.

State Medicaid agencies have considerable flexibility in how they establish Medicaid provider payments. Section 1902(a)(30)(A) of the Act provides that State Medicaid Agencies must “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”

However, federal funds for Medicaid services, including SBS, are only available when all of the following requirements are met:

- The individual receiving the service is an enrolled Medicaid individual;⁷⁰
- The service is a covered Medicaid service, provided in accordance with the approved Medicaid State plan, including all medically necessary services as required under the EPSDT benefit provided to EPSDT-eligible students;⁷¹
- The billing provider for the service is a participating Medicaid provider and meets all applicable federal and State provider qualification requirements;⁷²
- The Medicaid State plan contains a payment methodology that is consistent with efficiency, economy, and quality of care;⁷³
- TPL requirements for the service are met (note: for Medicaid-covered services identified in a beneficiary’s IEP, Medicaid can be the primary payer);⁷⁴
- Medicaid payment does not duplicate payments from other third-party sources for the same service;⁷⁵
- The State Medicaid agency and provider maintain auditable documentation of services and Medicaid cost reporting to support claims for FFP;⁷⁶
- The State Medicaid agency must provide the non-federal share of the payment for Medicaid services from a permissible source;⁷⁷ and
- All other applicable program requirements for the service, payment, and associated claiming are met.

⁷⁰ Sections 1902(a)(10) , 1903(a), and 1905(a) of the Act

⁷¹ *id.*

⁷² Sections 1902(a)(27) and 1905(p)(1) of the Act

⁷³ Section 1902(a)(30)(A) of the Act; 42 C.F.R. § 430.10

⁷⁴ 42 C.F.R. part 433 subpart D; section 1903(c) of the Act

⁷⁵ 42 C.F.R. part 433 subpart D

⁷⁶ 42 C.F.R § 431.107; 42 C.F.R. § 430.40(c)

⁷⁷ Section 1902(a)(2) of the Act; 42 C.F.R. § 433.51

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In addition to having options for setting Medicaid provider payment methodologies and rates, State Medicaid/CHIP agencies also have options for how they fund the non-federal share of Medicaid and CHIP payments. The options associated with Medicaid and CHIP financing and provider payments that are available to State Medicaid/CHIP agencies are discussed in further detail below.

Medicaid and CHIP are jointly financed by States Medicaid/CHIP agencies and the federal government, with most service expenditures matched at the State-specific, statutorily defined FMAP for Medicaid, and the enhanced FMAP for CHIP, for direct medical services. Administrative expenditures generally receive a 50 percent federal match in Medicaid, but higher matching rates are available for certain administrative expenditures. CHIP administrative expenses receive the full enhanced FMAP, but administrative expenses are limited to 10 percent of total program expenditures. As noted above, funding for the non-federal share (the portion of a State's Medicaid or CHIP expenditure that is not made up of federal matching funds) may come from a variety of sources, including State general revenue funds and contributions from local governments through processes known as IGTs and CPEs, as noted above. When State Medicaid agencies propose to establish and update their Medicaid State plan payment methodologies or rates, CMS asks for information on the non-federal share that will be used to fund the service payments in order to ensure that the non-federal share financing is from a permissible source.

The following sections describe multiple approaches that States may use to contribute to the non-federal share for SBS, including CPEs, the most widely used approach.

1. State Legislative Appropriations

State appropriations are general revenue funds appropriated by the State legislature directly to the State Medicaid/CHIP agency to pay for Medicaid/CHIP expenditures. When establishing rates for providers, State Medicaid agencies usually develop a published fee schedule that may be the same Medicaid State plan rates paid to service providers in other health care settings or develop cost-based rates specific to SBS, and State Medicaid agencies periodically update their rates by submitting SPAs to CMS for approval. Providers (e.g., LEAs, school-based providers) must be paid and retain the entire Medicaid service payment described in the approved Medicaid State plan, which means that the State cannot require the provider to redirect any portions of the Medicaid payments received, except for certain ordinary business expenses or otherwise in a manner consistent with 42 C.F.R. § 447.10, and in particular paragraph § 447.10(i).⁷⁸

2. Intergovernmental Transfers (IGTs)

IGTs are a financing mechanism that allow State or local units of government within a State to provide the non-federal share by transferring funds to the State Medicaid agency. Once the

⁷⁸ Retention of less than 100 percent could trigger a net applicable credit in certain circumstances, with return of associated FFP to CMS; a net applicable credit may result where the State's claimed expenditure is greater than the payment ultimately received by the provider. See section 1903(d)(3) of the Act for information regarding overpayments.

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Medicaid agency receives the transfer and has the funds within its administrative control, the funds may be used as the non-federal share of Medicaid payments made to providers. IGTs are often made up of funds appropriated by legislatures to a unit of State or local government for the specific purpose of supporting the provision of Medicaid services in the State. Because units of government may participate in an IGT funding mechanism, entities such as LEAs may use IGTs to finance Medicaid SBS. States frequently develop IGT agreements with localities that specify the amount of funds that the locality will transfer to pay for Medicaid services and activities, and the timing of when the transfers will occur. As with appropriations, when IGTs are used as the source of non-federal share, most State Medicaid agencies pay providers using the same Medicaid State plan rates paid to service providers in other health care settings or develop cost-based rates specific to SBS. Once the Medicaid agency receives the IGT funds, the full amount (federal and non-federal share) of the payment described in the Medicaid State plan is paid by the State Medicaid agency to a service provider, which must retain the entire payment as payment in full. As above, the State cannot require the provider to redirect any portions of the Medicaid payments received, except for certain ordinary business expenses or otherwise in a manner consistent with 42 C.F.R. § 447.10, and in particular paragraph § 447.10(i).

3. Certified Public Expenditures (CPEs)

CPEs are also a Medicaid financing mechanism that allows units of government, including a governmental provider (e.g., LEA, county hospital), to participate in financing the non-federal share. Unlike IGTs, a unit of government does not transfer funds to the State Medicaid agency when using a CPE, but certifies that it has expended amounts during a defined period that constitute a Medicaid expenditure for Medicaid-covered services and allowable activities. The certified amount is the total computable Medicaid expenditure (i.e., it includes both the non-federal and federal share). The State claims this amount for federal matching and receives the federal share of allowable expenditures from CMS. When CPEs are used as a financing mechanism, the Medicaid payment must be limited to the actual cost that the certifying entity incurs in providing the Medicaid-covered services and conducting the allowable activities, as 42 C.F.R. § 433.51(b) requires a CPE be limited to the amount “representing expenditures eligible for FFP,” which cannot exceed the amount the certifying entity actually has expended. As such, for medical service payments, State Medicaid agencies are required to use a payment methodology through which the certifying entity documents Medicaid expenditures through an approved cost identification process.

Cost identification for SBS is typically implemented through annual cost reporting. The cost report follows cost principles set forth in federal Office of Management and Budget (OMB) regulations in 2 C.F.R. Part 200, as implemented by HHS in 45 C.F.R. Part 75, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards. More information on cost identification processes can be found within the *Cost Principles for SBS Direct Medical Service Claiming and Administrative Claiming Used in CPEs* section of this guide.

Although State Medicaid agencies are not required to pay the federal share associated with CPEs to providers, CMS strongly encourages State Medicaid agencies to do so in order to ensure providers are reimbursed for their incurred costs of furnishing Medicaid-covered services and

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conducting allowable activities that benefit the Medicaid program. This is particularly important in school-based settings to help to support efforts to improve the delivery and administration of SBS.

4. Participation in the Non-federal Share - Public Charter & Private Schools

Public charter schools are funded predominantly by State and local funds, including local tax revenue or appropriations, as governmental entities.⁷⁹ Accordingly, they are eligible to provide for the non-federal share of Medicaid or CHIP expenditures through CPEs, consistent with the preceding discussion. However, other school entities that are not units of State or local government, including private schools, cannot participate in a CPE funding mechanism. Such entities would not be considered public agencies under 42 C.F.R. §§ 433.51(b) and 457.220. Direct payments to private or non-governmental educational institutions for Medicaid and CHIP SBS are available, but are typically funded by State appropriations to the Medicaid/CHIP agency and paid through fee schedules. Private and other non-governmental school entities may only participate in a CPE to the extent that an LEA, as the entity providing the CPE, contracts with the private or other non-governmental school entity to provide Medicaid/CHIP services, as long as the arrangement adheres to the requirements discussed within this guide. Governmental LEAs may also transfer non-federal share funds via IGTs to the State Medicaid agency for services provided in private schools as long as the service provider receives and retains the entire Medicaid payment described in the Medicaid State plan, except for certain ordinary business expenses or otherwise in a manner consistent with 42 C.F.R. § 447.10, and in particular paragraph § 447.10(i).

B. Paying for SBS Under an Approved Medicaid State Plan

As noted above, within the parameters of section 1902(a)(30)(A) of the Act, State Medicaid agencies have considerable flexibility in how they set provider FFS payment rates.⁸⁰ The approved Medicaid State plan must comprehensively describe State payment methodologies. Generally, State Medicaid agencies use one of the following three methods to pay SBS providers: the FFS rates established for services provided by providers in non-school-based settings; cost-based FFS payment rates specific to schools; or the incurred cost of Medicaid services reported through cost reports. Each of these payment methods is discussed in further detail below.

SPAs using FFS rates can be streamlined and reference the relevant State fee schedules that would be used for SBS. Cost-based rates need a more detailed SPA to explain and justify the cost-based rates that will be used in SBS. The rates are often justified using previous year cost reports. SPAs using incurred costs are generally the most complex with the most detailed information, in order to comply with federal cost rules. Generally, these SPAs include sections that describe the cost-identification process including interim payments, a comprehensive section

⁷⁹ Public agencies are defined in IDEA Part B regulations at 34 C.F.R. § 300.33 to include “the SEA, LEAs, ESAs, [educational service agencies], nonprofit public charter schools that are not otherwise included as LEAs or ESAs and are not a school of an LEA or ESA, and any other political subdivisions of the State that are responsible for providing education to children with disabilities.”

⁸⁰ For SBS services delivered in Medicaid managed care, please refer to Section IV.A. above.

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describing the types of providers and school staff involved in providing SBS, and a reconciliation process to reconcile actual costs to interim payments that occurs once cost reports are audited and finalized. There are more details below, including examples, about these three methodologies.

CMS works closely with States to ensure that they are aware of the requirements associated with SPAs for Medicaid service coverage and payment methodologies, and has made resources to assist States publicly available on Medicaid.gov.⁸¹

1. FFS Payment Rates and Community Payment Rates

Under a FFS rate methodology, the State establishes a fee schedule for each Medicaid-covered service. Providers submit claims for the services that they provide to the State Medicaid agency through billing systems and receive payments at the applicable fee schedule rate for a service. Most State Medicaid agencies that rely on FFS rates pay school-based providers using the same Medicaid State plan payment rates paid to providers in non-school settings. Frequently, the rate schedules for Medicaid services are available on State Medicaid agency websites and are accompanied by manuals that discuss billing procedures and coverage limitations.

At the time of this guide's publication, some examples of States with SPAs to pay the regular Medicaid fee-schedule rate for certain SBS are: Wyoming SPA 22-0001,⁸² Nevada SPA 19-0005,⁸³ and Montana SPA 21-0023.⁸⁴ In the approved Wyoming SPA, the State references that EPSDT services provided in schools are paid at the lower of either the provider's usual and customary charge or the Wyoming Medicaid fee schedule in effect at the time the service is provided.

State Medicaid agencies may also opt to develop unique payment rates for school-based providers, for example, to more closely reflect the differential in operational expenses incurred by such providers. The State Medicaid agency will be asked to document the rate calculations for these services in the school setting and assure that those rates are consistent with efficiency, economy, and quality of care. One current example of an alternative fee schedule for school-based providers is South Carolina SPA 22-0010.⁸⁵ South Carolina established an alternative fee-schedule for behavioral health providers that provide services in schools, choosing to pay school-based behavioral health providers at a rate higher than the State's Medicaid fee-schedule rate.

Historically, CMS limited fee schedule rates for services provided in school settings to the regular Medicaid FFS fee schedule rate, which is the rate paid for the same service when

⁸¹ Medicaid SPA Processing Toolkit. See <https://www.medicaid.gov/resources-for-states/spa-and-1915-waiver-processing/medicaid-spa-processing-tools-for-states/index.html>

⁸² Wyoming SPA 22-0001. See <https://www.medicaid.gov/medicaid/spa/downloads/WY-22-0001.pdf>. Approved July 18, 2022.

⁸³ Nevada SPA 19-0005. See <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NV/NV-19-005.pdf>. Approved October 24, 2019.

⁸⁴ Montana SPA 21-0023. See <https://www.medicaid.gov/medicaid/spa/downloads/MT-21-0023.pdf>. Approved December 22, 2021.

⁸⁵ South Carolina SPA 22-010. See <https://www.medicaid.gov/medicaid/spa/downloads/SC-22-0010.pdf>. Approved September 9, 2022.

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rendered outside of the school-based setting. For instance, if the fee schedule rate for an OT service that is rendered outside of the school is \$99 per 15-minute unit, the fee schedule rate for the same OT service in the school setting could not exceed the \$99 rate paid outside of the school setting. This policy was based on the presumption that approved Medicaid State plan payment rates have already been determined to be economic and efficient payment rates for the same services. Based on discussions with and feedback from stakeholders, we understand there may be circumstances in a school-based setting that warrant a fee schedule rate that may be higher than the rate that is paid for the same service when rendered outside of the school-based setting. Costs may be higher in a school setting due to a higher number of paid staff participating in the care of the Medicaid-eligible students and the scope of potential Medicaid-covered services that could be included in a child's IEP. As such, States may elect to pay higher fee schedule rates for services offered in schools as long as the State demonstrates that the rate is economic and efficient as required by section 1902(a)(30)(A) of the Act.

2. Payments to Non-School Providers for Services Provided in Schools

Schools may arrange for Medicaid-enrolled community providers to come into schools to provide Medicaid-covered services. These providers may bill under their own provider identification number and receive payment at the Medicaid State plan payment rate for the services provided. In this instance, the school is simply arranging for the provider to come and provide care (and facilitating the obtaining of any necessary parent or guardian consent for the provision of and billing for services), but is not responsible for billing, claiming, or documenting the services that are provided to the students. For example, if the school arranges for a dental provider or a mobile dental clinic to come to the school, the school would make arrangements to facilitate obtaining any necessary parent or guardian consent, but the dental provider or the mobile dental clinic would be responsible for billing the State Medicaid agency for Medicaid-covered services furnished to Medicaid-enrolled students; as discussed above, the State Medicaid agency may provide in its approved payment methodology for higher payment rates for SBS than for services furnished in other settings.

3. Prospective Cost-Based Rates Specific to Schools

In addition to FFS fee schedule rates generally available to all participating Medicaid providers, State Medicaid agencies may set rates that are specific to Medicaid SBS providers, for example, to account for different costs that such providers may incur when furnishing services in a school-based setting. Cost-based rates are calculated using cost reports and utilization data from a base period that is submitted by LEAs to State Medicaid agencies to establish the rates. These rates are usually set for a defined encounter on a statewide basis (e.g. a State Medicaid agency would set a statewide rate for a 15-minute encounter with a physical therapist), but can be LEA specific. The rates may consider the salaries and benefits of qualified providers, the medical supplies and equipment used to furnish services and the overhead associated with covered services, resulting in a rate per service. Funding for prospective cost-based payments cannot use CPEs, as the actual incurred costs are not accounted for and there is no reconciliation process. In developing these rates, State Medicaid agencies should periodically monitor changes in service provision and cost to ensure rates are updated so that Medicaid-enrolled students receive the types, quantity, and

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intensity of services required to meet their medical needs and the rates remain economic and efficient.

4. Reconciliation to the Cost of Medicaid Services Provided in Schools

State Medicaid agencies may elect to use a payment methodology to reimburse SBS providers for the costs they incur when providing Medicaid-covered services. Under this methodology, which is the most commonly used payment method for Medicaid SBS, State Medicaid agencies make interim payments to providers throughout the year and reconcile the interim payments to the portion of incurred costs properly attributable to Medicaid that providers identify through a cost report. For a detailed discussion of interim payment methodologies, please see the *Interim Payments & Final Cost Reconciliation* section; as well as the Appendix. States that use CPEs, as discussed under Non-Federal Share Financing for SBS, must use an actual reconciled cost payment methodology for SBS based on the definition of a CPE in 42 C.F.R. § 433.51(b) as “certified by the contributing public agency as representing expenditures eligible for FFP,” and we would recognize actual expenditures through the use of a reconciled cost methodology.

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Under a reconciled cost methodology, each LEA completes a cost-reporting process to identify and allocate the costs of providing Medicaid-covered services. The costs are allocated between services that were provided to Medicaid-enrolled students and those that were provided to non-Medicaid students. CMS encourages schools to work with their State's Medicaid program staff to develop an appropriate cost identification and allocation methodology that meets federal and State requirements. To determine the portion of the incurred cost of furnishing SBS that can be certified as allowable Medicaid expenditures, State Medicaid agencies generally require school-based providers to use a uniform cost report. To ensure proper identification of costs, most school-based providers use audited financial statements as the first step to develop their cost reports. The audited financial statements include an adjusted trial balance, which lists all of the expenses incurred and the applicable revenues received by the school-based provider. These balances are then transferred to the cost report and allocated using statistics to identify Medicaid's portion of allowable SBS cost. The basic components of a Medicaid State plan reconciled cost methodology include, but may not be limited to, the following:

- An interim payment methodology describing the amounts paid to SBS providers prior to cost reporting and reconciliation.⁸⁶
- A cost identification and allocation methodology, including the allowable direct costs⁸⁷ and the applicable cognizant agency indirect cost rate.⁸⁸
- An allocation of SBS costs to the Medicaid program, using allocation statistics (e.g., an RMTS, and a MER).⁸⁹
- A certification statement, to be signed by a school or LEA official, certifying that the portion of allowable incurred costs allocated to Medicaid accurately accounts for Medicaid expenditures as generally applicable to federal grant awards in 45 C.F.R. § 75.415(a).
- A detailed cost reconciliation process and, as applicable, settlement procedures.
- Detailed cost report instructions for providers to assist in billing, reporting, and allocating cost, and submitting necessary information to the Medicaid agency.

⁸⁶ 45 C.F.R. § 95.4 defines an "adjustment to prior year cost" as "an adjustment in the amount of a particular cost item that was previously claimed under an interim rate concept and for which it is later determined that the cost is greater or less than that originally claimed." Since actual costs of services cannot be determined until the end of the accounting period, under an interim rate concept, the providers are paid an interim rate during the year. Whatever estimated cost basis is used for determining interim payments during the year, the intent is that the interim payments should approximate actual costs as nearly as is practicable so that the retroactive adjustment based on actual costs will be as small as possible."

⁸⁷ 45 C.F.R. §§ 75.405, 75.413

⁸⁸ 45 C.F.R. §§ 75.2, 75.414

⁸⁹ 45 C.F.R. § 75.405

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Examples of approved reconciled cost SPAs are included in the *State Plan Methodology Cost Reporting Examples* section.

C. Cost Principles for SBS Direct Medical Service Claiming and Administrative Claiming Used in CPEs

THINGS TO CONSIDER:

- *The use of CPEs requires State Medicaid agencies/LEAs to follow federal cost principles in 2 C.F.R. part 200 as implemented by HHS in 45 C.F.R. part 75 using a cost report*
 - *Allowable costs need to be categorized as direct costs (direct medical or administrative), per 45 C.F.R. part 75.413, or indirect costs, per 45 C.F.R. § 75.414 - usually using the cognizant agency unrestricted indirect cost rate (UICR) per 45 C.F.R. Appendix IV to part 75 (C)(2)*
 - *SBS costs for direct medical and administrative costs need to be identified in cost pools and allocated to Medicaid.*
-

This section provides an overview of general cost principles that need to be followed if State Medicaid agencies choose to reimburse for SBS using a reconciled cost methodology, which are typically used for CPE-funded SBS. In practice, the same cost principles discussed within this section are generally also applied to SBS payment methodologies that use prospective cost-based rates, but that do not actually include a reconciliation to cost report data. Within this section, we include high-level explanations and examples of the concepts outlined in federal regulations for claiming incurred costs for SBS. Additionally, several of the terms associated with the cost principles are defined and illustrated with examples.

The principles for accounting for costs claimed for federal grant awards are described in government-wide regulations promulgated by OMB in 2 C.F.R. Part 200. Generally, HHS programs use the same basic principles, and HHS-specific regulations are set forth in 45 C.F.R. Part 75. These principles are intended to ensure that the non-federal entity efficiently and effectively administers the federal award in a manner that complies with sound program management, program objectives, and terms and conditions of the federal award, while not engaging in any behavior that violates other applicable legal requirements. CMS relies on these principles when reviewing State Medicaid agency reconciled cost methodologies to ensure that claims for FFP represent amounts properly identified and allocated to Medicaid.

Although direct medical SBS costs are associated with the health care related items and services provided to students under Medicaid benefits and administrative activities are associated with operating the Medicaid program, similar allocation principles apply to both in order to determine the portion of total SBS cost that may be claimed for FFP as Medicaid expenditures.

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To claim FFP for direct medical services based on the actual cost of providing SBS, State Medicaid agencies must describe a comprehensive reimbursement methodology within the Medicaid State plan. Similarly, to claim FFP for administrative expenditures, the States must describe cost identification procedures in a Public Assistance Cost Allocation Plan (PACAP), which may be further supplemented by a Medicaid administrative claiming plan.⁹⁰

While the same cost allocations principles apply to both direct medical claims and administrative claims, the methods and procedures State Medicaid agencies use to document Medicaid medical and administrative expenditures are different. For direct medical claims, State Medicaid agencies use cost-report templates completed by providers that detail the medical service-related costs associated with Medicaid-covered health care services. The State-developed cost reports include instructions providers use to identify, allocate, and certify the cost of providing the Medicaid SBS. For administrative expenditures, State Medicaid agencies document their costs through the submission of a PACAP. The PACAP outlines all functions performed by the State related to the public assistance program and how it assigns the costs of performing these functions to all relevant entities within the State, including vendors and contractors. The PACAP submission includes both a narrative section as well as financial documents that are used to allocate costs from the aggregate costs incurred from running the entire program to each entity that performs specific activities and incurs costs.

Both direct services and administrative claiming must be consistent with federal cost allocation principles in 2 C.F.R. Part 200 as implemented by HHS in 45 C.F.R. Part 75. In general, direct costs are those costs that benefit a single cost objective (e.g., in SBS, the salaries and benefits of the providers) and are allocated to Medicaid generally using a two-step process. The first step is a time study to allocate providers' time to all medical services (e.g., through the use of the RMTS or worker log). The second step is the use of a MER, which allocates costs to Medicaid using a ratio of the relevant Medicaid-enrolled population (e.g., ratio of students with an IEP who are Medicaid beneficiaries to all students with an IEP (which should all be verifiable in an audit), or ratio of students who are Medicaid beneficiaries to the entire student population). Indirect costs are generally determined through a cognizant agency process, which assigns an indirect cost rate to an LEA or other school entity. That rate is then multiplied by the direct costs that relate to the provision of medical services. The product of the direct cost multiplied by the cognizant agency indirect cost rate is the total allowable indirect cost. The result of the allocations are the direct and indirect costs that can be attributed to Medicaid.

In subsection *CMS Review of Medicaid SBS SPAs & Cost Reports*, there are examples of claiming using direct costs for medical services, while subsection *Cost Principles for SBS Direct Medical Service Claiming and Administrative Claiming Used in CPEs* provides examples of claiming using direct costs for administrative services.

1. Allowable Costs

⁹⁰ 45 C.F.R. part 95, subpart E; 45 C.F.R. § 95.517

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Expenditures for Medicaid administrative activities must be “found necessary by the Secretary for the proper and efficient administration of the plan.”⁹¹ Regulations at 45 C.F.R. § 75.403 describe the factors that States must apply to determine whether administrative activities may be claimed for federal Medicaid matching funds. Specifically, claimed administrative activities must be necessary and reasonable for the operation of the Medicaid program and properly allocable to it.⁹²

Certain activities, even if they provide value to Medicaid-enrolled students, may not be considered necessary for the proper and efficient administration of the Medicaid program, and cannot be claimed for Medicaid payment. For example, costs related to outreach activities that focus on Medicaid services or eligibility requirements are generally considered Medicaid administrative activities. However, activities related to outreach that intend to explain or discuss requirements applicable to other federal or State benefit programs that are not directly in support of the Medicaid program are not allowable as Medicaid administrative activities.⁹³

For Medicaid direct services, allowable costs are those costs that are directly related to the provision of Medicaid-covered services, as specified in the approved Medicaid State plan. Generally, for Medicaid SBS, this includes direct costs, which are salaries and fringe benefits of enrolled Medicaid providers providing services in schools and medical supplies and equipment associated with the provision of covered services,⁹⁴ as well as indirect costs, which include allowable overhead expenditures.⁹⁵ Direct and indirect costs are further defined in more detail below.

2. Cost Pools (Cost Objectives)

Cost objectives, as defined in 45 C.F.R. § 75.2, are a program, function, activity, award, organizational subdivision, contract, or work unit for which cost data are desired and for which provision is made to accumulate and measure the cost of processes, products, jobs, capital projects, etc. A cost objective may be a major function of the non-federal entity (e.g., LEA or school district), a particular service or project, a federal award, or an indirect cost activity. Cost objectives are sometimes known, and are referred to in this document, as “cost pools.” As part of the cost identification process for Medicaid SBS direct service and administrative costs, each entity billing Medicaid (e.g., an LEA or school district) must clearly define the cost pools from which amounts attributable to Medicaid will be identified and claimed for reimbursement.

Cost pools must be mutually exclusive (i.e., no cost can appear in more than one cost pool) and homogenous within the pool (i.e., costs associated with personnel who perform similar job duties, such as direct service providers, must be treated the same for purposes of aggregating their costs within a cost pool). For purposes of SBS claiming, examples of cost pools are the salaries and fringe benefit costs of types of qualified Medicaid providers, such as occupational,

⁹¹ Section 1903(a)(7)

⁹² 45 C.F.R. § 75.403(a)

⁹³ For more information about allowable administrative activities, see *Cost Principles for SBS Direct Medical Service Claiming and Administrative Claiming Used in CPEs*.

⁹⁴ 45 C.F.R. § 75.413(b)

⁹⁵ 45 C.F.R. § 75.414

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physical, and speech therapists. Cost pools may be further defined by the scope of job functions that personnel perform. For instance, cost pools may be structured to identify: personnel who only perform direct medical services, personnel who only perform administrative activities, and personnel who perform both direct medical and administrative activities.

States need to describe each cost pool used to claim for Medicaid reimbursement for medical services in the Medicaid State plan, as well as the methodology to be used to identify the portion of the cost pool attributable to Medicaid (either in the Time Study Implementation Plan or in the Medicaid State plan with a MER or other allocation). Within the Medicaid State plan, cost pools are described as a list of qualified provider types and the costs directly associated with providing Medicaid-covered services that, once properly allocated to Medicaid, may be claimed for Medicaid reimbursement. The Medicaid State plan must detail a comprehensive methodology describing how the cost pools are allocated to determine personnel time spent performing Medicaid-covered activities, and then further stepped down to identify the Medicaid portion of cost that may be claimed using an allocation ratio (as detailed in the *Allocations* subsection). Similarly, under a Time Study Implementation Plan, for each qualified provider type included in a given cost pool, the State Medicaid agency describes the provider costs of performing specific administrative activities and direct services as applicable, as well as a comprehensive methodology describing how the activity costs are allocated to Medicaid.

Different cost pools may be allocated using different methodologies, as appropriate. For example, while a time study is frequently used to allocate personnel time based on a sample of random moments during a work day to identify time spent on allowable Medicaid activities, one-way trips are frequently used to allocate specialized transportation services. These allocation variations are largely dependent on the type of SBS providers assigned to a cost pools and should be discussed with CMS to ensure that they are approvable.

Other direct cost pool expenditures could include, for example, computers and computer systems, and supplies used to support either direct medical or administrative activities. As time studies are designed to capture the time an individual spent performing allowable activities, it may not always be appropriate to use time study allocation methodologies to allocate costs, for example, for systems or supplies.

CMS approval authority for the cost allocation methodology when submitted as part of the Medicaid State plan is found in 42 C.F.R. § 430.10, which says that “[t]he State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for [FFP] in the State program.” Once a State Medicaid agency proposes its cost allocation methodology for SBS to be included in the Medicaid State plan, CMS has the authority to approve or disapprove based on 42 C.F.R. § 430.15.

Common examples of SBS cost pools used by State Medicaid Agencies include the following:

- Direct Medical Cost Pool, which could include:

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- Nurses and nursing services – Direct services allocated by a time study (e.g., RMTS) and MER
- Therapists (mental health, SUD, PT, OT, Speech, rehabilitation, etc.) – Direct services allocated by a time study (e.g., RMTS) and MER
- Personal Care Services (PCS) – Direct services allocated by a time study (e.g., RMTS) and MER
- Specialized Transportation – Specially adapted buses/vehicles and relevant transport expenses claimed as direct services allocated by one-way trips for students and MER, for students with specialized transportation as a related service in their IEP under IDEA
- Administrative Claiming Cost Pool, which could include:
 - Medicaid enrollment specialists – Allocated by a time study (e.g., RMTS) and MER
 - Specialized Transportation – Specially adapted buses/vehicles and relevant transport expenses claimed as administrative claiming allocated by one-way trips for students and MER, for students with specialized transportation as a related service in their IEP under IDEA (when not claimed as a direct medical service)

Note: Specialized transportation costs should not be double-counted (i.e., the same costs should not be included in multiple cost pools). States are able to claim specialized transportation costs under administrative claiming or direct medical cost pools, but not both.

3. Direct Costs

Direct costs are costs that can be identified specifically with a particular final cost objective, such as a federal award, or other internally or externally funded activity, or that can be directly assigned to such activities relatively easily with a high degree of accuracy.⁹⁶ Costs incurred for the same purpose in like circumstances must be treated consistently as either direct or indirect costs. Any costs that are directly related to the provision of a Medicaid-covered service are “direct costs” for cost identification purposes. For direct medical services, all of the following may be considered direct SBS costs: salaries and benefits of qualified service providers (e.g., mental health, SUD, nursing, and dental providers), contracted providers who deliver Medicaid-covered services, and medical supplies and equipment used to provide Medicaid services.

Similarly, there may be school-based administrative costs that are direct costs. School-based administrative direct costs could include the salaries and benefits of personnel that do Medicaid administrative activities such as: referral, coordination, and monitoring of Medicaid-covered services; facilitating Medicaid eligibility determinations; translation and interpretation services; and transportation-related activities in support of the provision of Medicaid services.

a) Direct Cost Allocation

The following describes the regulations that govern direct cost allocation and further describes direct cost allocations.

⁹⁶ 45 C.F.R. § 75.413(a)

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Regulations in 45 C.F.R. § 75.405 state that a cost is allocable to a particular Federal award or other cost objective if the goods or services involved are chargeable or assignable to that Federal award or cost objective in accordance with the relative benefit received. Further, 45 C.F.R. § 75.405(d), defines the circumstances in which direct costs must be allocated: “[i]f a cost benefits two or more projects or activities in proportions that can be determined without undue effort or cost, the cost must be allocated to the projects based on the proportional benefit. If a cost benefits two or more projects or activities in proportions that cannot be determined because of the interrelationship of the work involved, then [. . .] the costs may be allocated or transferred to benefitted projects on any reasonable documented basis. Where the purchase of equipment or other capital asset is specifically authorized under a Federal award, the costs are assignable to the Federal award regardless of the use that may be made of the equipment or other capital asset involved when no longer needed for the purpose for which it was originally required.”

In most Medicaid settings, costs are allocated by a methodology that considers the characteristics of the specific cost that will be allocated and claimed. For example, if one room within a building is used exclusively to provide Medicaid-covered therapeutic services to students, then a reasonable direct cost allocation methodology could use the square footage of the room relative to the square footage of the entire building to allocate building costs. If the allocated cost is personnel salary, the direct cost allocation methodology would consider an allocation statistic based on how the individual spends their time using a time study (e.g., worker logs, RMTS, etc.). The results of the time study then would be applied to a specific cost pool(s) set up for providers that provide primarily direct medical services. Notably, 45 C.F.R. § 75.412, specifies that, “[t]here is no universal rule for classifying certain costs as either direct or indirect (F&A) under every accounting system. A cost may be direct with respect to some specific service or function, but indirect with respect to the Federal award or other final cost objective. Therefore, it is essential that each item of cost incurred for the same purpose be treated consistently in like circumstances either as a direct or an indirect (F&A) cost in order to avoid possible double-charging of Federal awards.”

Similar to direct cost allocation for medical service providers, a time study is often used for allocating costs associated with administrative activities. For example, time spent on coordinating Medicaid eligibility determinations, whether by direct service providers or other school staff, should be captured through a time study (e.g., worker logs, RMTS, etc.). For school personnel that only perform Medicaid administrative activities, such as conducting and coordinating Medicaid eligibility determinations, there should be a separate time study cost pool established to properly account for those individuals’ time to ensure proper allocation and to avoid over- or under-allocation of employee time of all necessary staff. As noted above, cost pools should be mutually exclusive and the same personnel or providers should not be included in multiple cost pools; this helps avoid double-counting of costs.

The time study is intended to capture the percentage of time that personnel spend on direct medical services or administrative activities. The time study percentage(s) derived from the CMS-approved time study methodology is then applied against the direct cost pools to determine the amount of total direct medical or administrative activities being performed. A second

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allocation step using a MER is used to step down costs to Medicaid. See the *Allocable Costs* section below for more information on allocating costs to Medicaid.

4. Indirect Costs

Indirect (facilities & administrative (F&A)) costs means those “costs incurred for a common or joint purpose benefitting more than one cost objective, and not readily assignable to the cost objectives specifically benefitted, without effort disproportionate to the results achieved.”⁹⁷ Indirect cost pools must be distributed to benefitted cost objectives on bases that will produce an equitable result in consideration of the benefits derived. Costs associated with individuals or activities other than those associated with enrolled, qualified direct care providers’ provision of Medicaid-covered services cannot be considered “direct” costs. Any cost that serves multiple cost objectives and cannot be readily assigned to a cost pool are considered an indirect cost.⁹⁸

5. Indirect Cost Identification Using Indirect Cost Rates

Most State Medicaid agencies, LEAs, and schools will use a designated cognizant agency unrestricted indirect cost rate (UICR) for determining their indirect costs for health care services furnished in a school-based setting. The cognizant agency by definition must be a federal awarding agency. So, the cognizant agency for LEAs and SEAs is usually ED.⁹⁹ For indirect Medicaid administrative costs for activities performed in school-based settings, CMS recognizes that ED ultimately approves the federal cognizant agency indirect rates as the federal awarding agency. LEAs and schools should identify indirect costs through application of the cognizant agency indirect rate to direct costs. Once the cognizant agency indirect cost rate is selected and used, no additional indirect costs may be applied to a cost pool. If a cognizant agency indirect rate exists, it must use this method to identify and apply indirect costs.¹⁰⁰

As part of a review of indirect costs, the LEA must certify that direct costs do not duplicate those costs reimbursed through the application of the indirect cost rate. Generally, contracted rates already have an indirect rate applied to them, meaning those contracts already include an assumption of the contractor’s overhead expenses in the contract rate for providing services, and should not have the cognizant agency indirect rate applied to them, as this would duplicate indirect costs. However, if an LEA has indirect costs that it believes would be appropriate to apply to contractor/vendor rates, CMS will look at these on a case-by-case basis. For example, if a contractor comes to a school to provide medical services, it is possible that the contract rate

⁹⁷ 45 C.F.R. § 75.2 and § 75.414

⁹⁸ Costs that may appear to be indirect may actually be direct overhead or direct general and administrative (G & A) costs based on the claiming entity’s ability to assign these costs easily and with a high degree of accuracy to a specific cost objective. Generally, overhead or G&A costs are terms that are used in connection with indirect costs; however, as demonstrated above, the classification of these costs may vary.

⁹⁹ Indirect agency cognizant rate – 45 C.F.R. Part 75, Appendix V section (F)(1)

¹⁰⁰ 45 C.F.R. § 75.402, defines “Total Cost” as “the sum of the allowable direct and allocable indirect costs less any applicable credits.” As the method of allocating indirect cost is the cognizant agency indirect cost rate, no additional indirect costs may be added to the total cost calculation. 45 C.F.R. § 75.403(d) further states that “[a] cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost.” Once a cost is assigned as a direct or indirect cost, then the methodology for allocating each must be followed consistently.

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would be paying for the provider's salary and fringe benefits, but the school would be responsible for the overhead expenses related to the direct care provided to the Medicaid eligible students and would therefore apply the UICR to these contracted costs. Conversely, if an LEA contracts with a provider to furnish SBS in a private school that has contracted the LEA to arrange for the provision of SBS, there generally would be no application of the UICR, as no indirect costs would be incurred by the LEA (the overhead expenses generally being borne by the private school). Similarly, a driver with a specialized vehicle contracted to provide transportation for students with an IEP that includes specialized transportation would not generally have the UICR applied to their direct costs because no indirect costs would be incurred by the LEA.

In rare instances, a SBS provider may not have an UICR rate assigned to them. In those instances, indirect cost identification for medical services and administrative activities for SBS providers would be determined according to federal requirements in 45 C.F.R. Part 75, Appendix VII, in the following manner:

- If a governmental department or agency receives more than \$35 million dollars in federal awards, it is required to have a Cost Allocation Plan (CAP) in place with its federal cognizant agency. This CAP should be used to identify indirect cost.
- If a governmental department or agency receives direct federal awards, but the direct federal awards are less than \$35 million, 45 C.F.R. Part 75, Appendix VII, paragraph D.1.a requires that all departments or agencies of the governmental unit desiring to claim indirect costs under federal awards must prepare an indirect cost rate proposal and related documentation to support those costs. Appendix VII, 45 C.F.R. Part 75, Appendix VII, paragraph F.3 indicates that in certain situations, governmental departments or agencies (components of the governmental unit), because of the nature of their federal awards, may be required to develop a CAP that distributes indirect (and, in some cases, direct) costs to the specific funding sources. In these cases, a narrative cost allocation methodology should be developed, documented, maintained for audit, or submitted, as appropriate, to the cognizant agency for indirect costs for review, negotiation, and approval. In the absence of a cognizant agency indirect rate to claim for indirect cost, governmental units may use methods originating from its specific HHS/Cost Allocation Services Division (CAS)-approved PACAP or its specific Local Organization CAP to identify its specific indirect cost. If the governmental unit does not have an indirect rate agreement or a department-specific CAP and it would like to claim indirect cost associated with the provision of SBS, it must secure one or the other before it can claim any indirect cost.
- If neither of the above situations apply, which is true for the vast majority of Medicaid providers, providers must follow the rules for indirect cost identification as sub-recipients of federal awards, as defined in 45 C.F.R. § 75.351. This is because they typically receive payment from their State's Medicaid agency, which is the recipient of the direct federal award. In this case, the LEA must:¹⁰¹
 - Use a CAP to identify indirect cost;

¹⁰¹ 45 C.F.R. § 75.414

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- If a CAP does not include a way to identify indirect cost, use a negotiated indirect rate; or
- Directly identify the indirect costs through a cost report

6. Allocable Costs

As defined in 45 C.F.R. § 75.2, allocation is, “the process of assigning a cost, or a group of costs, to one or more cost objective(s), in reasonable proportion to the benefit provided or other equitable relationship.” As mentioned above, direct costs are costs that benefit and can be assigned to one cost objective (e.g., salaries of personnel who provide direct medical services in schools), while indirect costs are costs that benefit multiple cost objectives and may not be assigned to a single cost objective (e.g., the overhead associated with building utilities). For purposes of SBS indirect costs, a cognizant agency (such as ED) indirect cost rate is usually assigned to schools, which is multiplied by the identified direct costs to determine the school’s total costs for a particular cost pool.

Since direct costs must be assigned to a specific cost objective, a State Medicaid agency must review the total costs associated with school personnel, including salaries, benefits, overhead, and supply costs, and assign those costs to medical and non-medical cost objectives. For SBS, services and activities recognized under the Medicaid program may be assigned to either direct service cost, meaning cost specifically associated with services provided under the approved Medicaid State plan, or Medicaid administration costs, which are costs associated with the proper and efficient administration of the Medicaid program.

Once direct costs are assigned to the SBS cost objectives, States must develop an allocation process to determine the allocable share of costs to be assigned to the Medicaid program. In many cost identification methodologies, there are two steps in the allocation methodology to Medicaid. The first step in allocating direct medical services or administrative activities costs is to attribute direct costs to a single cost objective, using a time study (e.g., worker logs, RMTS, etc.), which is generally applied statewide. The second step further allocates the costs from total direct medical services or administrative activities costs to Medicaid, usually using a MER specific to each LEA.

a) Allocations

SBS cost allocation applies to services that are furnished and activities that are performed with respect to a population of students that includes Medicaid-enrolled and non-Medicaid-enrolled students. Therefore, a Medicaid allocation ratio is applied to a provider’s time spent furnishing Medicaid-coverable services or on allowable administrative activities to determine the portion of those costs that may be claimed for Medicaid reimbursement. Note: While referred to here as the Medicaid ratio, the MER may be defined by the State to include CHIP-enrolled students as well, where applicable. There may be the need to develop a separate CHIP enrollment ratio, or other allocation methodology to differentiate the funding sources between Medicaid and CHIP.

The allocation ratio generally used for Medicaid SBS is called the MER. Notably, certain administrative activities such as outreach related to Medicaid eligibility and enrollment and

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facilitating eligibility determinations are not subject to the application of an allocation ratio because they are allowable for all students, even if they are not later determined Medicaid eligible. That is, all students are potentially eligible for Medicaid until a determination is made, and therefore the Medicaid outreach and eligibility assistance activities to all students are allowable. However, all other administrative activities, such as referral and monitoring of services, and providing translation or interpretation services, are subject to the ratio to ensure FFP is only paid for activities and services provided to Medicaid beneficiaries.

The MER identifies the percentage of Medicaid-enrolled students in each LEA or unit of government in which SBS are furnished. The MER is calculated by comparing the number of Medicaid-enrolled students to all enrolled students, or by another reasonable statistic approved by CMS, and updated on a regular basis. The number of Medicaid-enrolled students in the LEA serves as the numerator in the ratio, while the denominator represents the total number of students who attend school within the same LEA or other unit of government. Please note that CMS has determined there is effectively no material difference between the Medicaid Eligibility Ratio described in the 2003 Guide and the MER described herein. This is because activities directed to Medicaid eligible students, such as outreach and facilitating eligibility assistance, are not subject to the application of any allocation ratio and are 100 percent claimable. Therefore, we are now referring to the ratio solely as the MER. We note further that some LEAs are already using the MER for all purposes. The MER that a State uses to allocate costs to Medicaid must be defined and approved by CMS in the Medicaid State plan and, as applicable for administrative expenditures, in the PACAP/SBS Time Study Claiming Implementation Plan(s).

In the two-step allocation process mentioned above, the time study (e.g., RMTS, worker log, etc.) results are applied statewide to the cost pools that include the costs of providers and others who furnished Medicaid-coverable services and/or conducted Medicaid-allowable administrative activities. Then, these direct costs are multiplied by the indirect cost rates, generally using the cognizant agency rate, the sum total of which becomes the total allowable costs. Next, the MER is applied at the LEA level to the total allowable costs, as a second allocation statistic to calculate the portion of total direct administrative or direct medical costs that can be attributed to Medicaid, also known as the allowable Medicaid administrative costs or allowable Medicaid medical costs, respectively.

The number of Medicaid-enrolled students and the number of total students used to calculate the MER 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. In addition, the number of Medicaid-enrolled students used within the ratio must be obtained from or verified by the State Medicaid agency. This may be done by matching LEA or other school entity enrollment data to Medicaid eligibility files or other comparable CMS-approved processes. Students who are deemed presumptively eligible for Medicaid are included in the number of Medicaid-enrolled students.

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Allowable Medicaid Cost Allocation Formula Using the Medicaid Enrollment Ratio

To allocate Medicaid services that are broadly available to all students:

$$\text{Medicaid Cost} = \frac{\text{Total \# of Medicaid Enrolled Students}}{\text{Total \# of Students}} \times \text{Costs to be Allocated}$$

The MER is a ratio of Medicaid-enrolled students (per FERPA who have parental consent to release information to Medicaid) at each LEA (or other claiming entity) divided by the total number of enrolled students. The MER commonly is used to allocate the costs of Medicaid-coverable services that are broadly available to all students who attend school and not typically specified in a student's IEP, where a student has one. For services typically furnished to students with an IEP that are identified in the student's IEP, a different ratio called the IEP MER commonly is used. The IEP MER represents the number of Medicaid-enrolled students (per FERPA who have parental consent to release information to Medicaid) with an IEP in the LEA (or other claiming entity) in the numerator and the total number of students with an IEP (which should all be verifiable in an audit) in the LEA (or other claiming entity) as the denominator.

Allowable Medicaid Cost Allocation Formula Using the IEP Medicaid Enrollment Ratio

To allocate Medicaid services covered within students' IEPs:

$$\text{Medicaid Cost} = \frac{\text{Total \# of Medicaid Enrolled Students with an IEP}}{\text{Total \# of Students with an IEP}} \times \text{Costs to be Allocated}$$

The MER is not the only acceptable allocation method in cost-based reimbursement for SBS for Medicaid administrative claiming or direct service claiming. However, the MER method (including use of the IEP MER) is the Medicaid allocation method generally used by most State Medicaid agencies, with CMS approval. CMS will review and consider any reasonable allocation methodology proposed by a State as long as the allocation method can reliably allocate costs to the Medicaid program with precision.

a) Medicaid Administrative Activity Claim Example

As detailed above, the purpose of applying a MER is to determine the amount of cost associated with Medicaid-coverable services or Medicaid-allowable activities that is properly allocated to the Medicaid program. In the example provided below, the Medicaid-allowable administrative activity, "Referring students for necessary medical health, mental health, or substance use disorder coverable by Medicaid," is used to illustrate the allocation formula. Assuming medical referrals are offered to both Medicaid-enrolled and non-Medicaid-enrolled students, the costs associated with referral activities may be allocated using a calculation consisting of:

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EXAMPLE OF MEDICAID ALLOCATION

(For administrative claiming on the CMS-64, for illustrative purposes)

Total Activity Cost (from Time Study) = \$1,500

Number of Medicaid Enrolled Students in the LEA = 1,000

Number of Total Students in the LEA = 5,000

Activity = Referral, Coordination, and Monitoring of Medicaid-Coverable Services
(Proportional Medicaid / 50 Percent Federal Financial Participation matching rate for qualifying Medicaid Expenditures)

Medicaid Enrollment Ratio: Number of Medicaid Enrolled Students / Total Students = 1,000 / 5,000 = 20 percent

Total Activity Cost	\$1,500
Medicaid Enrollment Ratio (20 percent)	<u>x 0.20</u>
Allowable Medicaid Administrative Cost (Total Computable)	\$300

FFP Rate (50 percent)	<u>x 0.50</u>
FFP Available	\$150

7. Offsetting of Revenues

In general, all revenues that are received by schools that cover the cost of SBS activities are recognized and considered within the State’s cost-reporting process. For example, federal grants that contribute to costs included in the cost report should be recognized and subtracted from allowable costs. CMS typically asks the State Medicaid agency to demonstrate and/or attest that no payments have been received that already satisfy the costs being claimed for Medicaid reimbursement, including revenues from other federal grants or third-party payments. States often provide evidence for this by requiring school-based providers to maintain good general accounting principles and a clear audit record that tracks costs as well as revenues from all sources.

The following include some of the revenue offset categories which must be considered within a State’s SBS cost reporting process:

- All federal funds, along with any maintenance of effort and other State/local matching funds that may be required by the federal grant.
- All State expenditures which have been previously matched by the federal government (including Medicaid FFP, such as for Medicaid-covered services for which FFS payment already has been claimed for federal matching).

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- Purchase discounts, rebates or allowances, recoveries or indemnities on losses, insurance refunds or rebates, and adjustments of overpayments or erroneous charges must be offset against costs claimed for Medicaid FFP per 45 C.F.R. § 75.406.
 - 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.

D. CMS Review of Medicaid SBS SPAs & Cost Reports

CMS reviews and approves SPAs as needed for State Medicaid agencies to claim FFP in expenditures for SBS. SPAs must be approved before State Medicaid agencies can claim for Medicaid-covered SBS. The following provisions that should be included in the Medicaid State Plan for SBS when using cost or cost-based methodologies:

- List of 1905(a) services that will be provided in the school setting with statement on coverage attestation, similar to this: “All costs described within this methodology are for Medicaid services provided by qualified personnel or a qualified health care professional that have been approved under Attachment 3.1- A/B of the Medicaid state plan.”
- Comprehensive direct payment methodology (see list of basic components below).
- Cost report package (*see* below- this is separate from the SPA) showing consistency with the comprehensive direct payment methodology during a walk through with the State Medicaid agency and CMS.
- As applicable, explanation of the time study used to allocate costs to Medicaid, and the relevant cost pools for direct services, and how the allocation statistics are applied-checked for consistency with the proposed Cost Report.
- As applicable, explanation of and definitions of any Medicaid Enrollment Ratios used to allocate costs to Medicaid (and how they are applied – State level, LEA level, etc.).
- For specialized transportation, comprehensive direct payment methodology for IDEA students and how these are allocated using one-way trips.
- Any relevant definitions and other information as needed.

CMS reviews a State Medicaid agency’s proposed FFS Medicaid cost report template and cost report instructions prior to approving proposed SPAs to ensure these materials comport with the Medicaid State plan cost-based payment methodology and with all applicable federal requirements. However, it is incumbent upon States to ensure that reported costs and associated claims for FFP are accurate and represent only costs associated with the provision of Medicaid-covered services. Costs that are claimed improperly may be subject to financial reviews and/or audit findings and place States at financial risk of liability to repay the federal share of any identified overpayments.

State Medicaid agencies should work with the LEAs to develop a comprehensive cost-reporting process to be used for claiming FFP associated with SBS. The methodology and cost-identification process must be described in detail in the Medicaid State plan. The cost report and instruction documents must include, but may not be limited to:

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- A list of the types of providers qualified to provide services in schools;
- an interim payment methodology;
- A statement regarding the source of the financial data used in the cost report (e.g., from the entity's audited financial statements);
- Definitions of the direct costs that may be claimed for Medicaid reimbursement;
- A description of the cognizant agency indirect cost rate (or in the absence of a cognizant agency rate, a description of a reasonable method for determining indirect costs);
- Identification of the cost pools used for direct medical claiming;
- A description of any time study that is used and how it is applied to costs;
- Direct cost identification procedures, including use of a cost report;
- The allocation statistics used to allocate costs to Medicaid and information about how the statistics are calculated and how they are applied to step-down a cost pool to the portion properly allocated to Medicaid;
- Any specialized transportation cost methodology under IDEA (optional); and
- The manner and timing of the reconciliation of interim payments to final costs as documented on the cost report.

When using a reconciled cost methodology, LEAs are required to use a reasonable cost reporting methodology to identify allowable costs for SBS, and should submit a uniform SBS cost report to the State Medicaid agency to document the costs of providing Medicaid-covered services as specified in the Medicaid State plan. While CMS will assist State Medicaid agencies in developing SBS cost report documents and instructions if the State Medicaid agency has questions regarding federal requirements, CMS does not explicitly approve them. State Medicaid agencies and LEAs must ensure costs are calculated appropriately and should adhere with general accepted accounting principles and all applicable federal cost principles in determining costs allocated to Medicaid.

1. Basics of Medicaid SBS Cost Reports

To determine the portion of the actual, incurred cost of furnishing SBS that can be certified to the State Medicaid agency for reimbursement, CMS recommends State Medicaid agencies use a uniform cost report for school-based providers, as discussed above.

To ensure the proper identification of costs, most school-based providers use audited financial statements as the first step to develop their cost reports. The audited financial statements will include an adjusted trial balance. This adjusted trial balance lists all the expenses incurred and the applicable revenues received by the SBS provider. These balances are then transferred to the cost report to be allocated to the allowable medical services and then allocated to the Medicaid program with Medicaid's portion of allowable cost clearly identified.

The basic components of reconciled cost methodologies and cost reporting procedures include, but may not be limited to, the following:

1. *An interim rate concept* – An interim rate concept is an amount which is paid out for claims for services during a cost reporting year. Interim rates are often based on a

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provider's prior year cost and utilization, or on the Medicaid fee schedule for the relevant service, and may be calculated at an appropriate unit of service for covered SBS (e.g., calculated on a per day or per visit unit of service).

2. *A comprehensive cost identification and allocation methodology* – The State must develop a cost pool identification and allocation methodology, as detailed through a cost report and associated instructions, that meets the requirements of 45 C.F.R. Part 75, described in detail in a proposed Medicaid SPA that meets the requirements of 42 C.F.R. Parts 430 and 447. The cost report must appropriately identify and allocate 100 percent of the direct and indirect costs associated with the provision of Medicaid-covered SBS, including the following:
 - a. A methodology that identifies direct cost pools associated with services provided to students by qualified practitioners. Cost pools should be identified according to the provider type.
 - b. A cost allocation methodology that applies a reasonable allocation method, such as a RMTS, to allocate portions of time that the qualified practitioners spent providing covered direct services to students.
 - c. A cognizant agency indirect cost rate, or other indirect cost methodology, to identify the portion of overhead associated with the delivery of health care services that is applied to direct cost.
 - d. A MER (or other acceptable allocation statistic) to determine Medicaid's portion of direct and indirect costs that may be claimed for Medicaid reimbursement.
3. *Direct Cost Considerations* – Direct cost is composed primarily of practitioners' salary and fringe benefit costs. Direct cost may include other, non-practitioner-related costs for supplies and other items necessary to deliver care (e.g., medical supplies).
4. *Direct Services Provided via a Contract in Schools or Private Schools* – Some schools arrange for services to be provided via contract with an outside organization or providers in the community.
 - a. The contractual amount paid for services delivered either on-site or off-site are generally considered to be the full cost of providing medical services in schools and may not be reported at a rate increased by the Cognizant Agency Indirect Rate, to the extent that the services occurred off-site. See section V.C.5 of this guide for more information.
 - b. LEAs may contract with private schools to provide or arrange for services to be furnished to students of the private school, but the reported cost of such services to the LEA is limited to the costs incurred in furnishing or arranging the contracted services and may not be increased by the Cognizant Agency Indirect Cost Rate or through any other means.
5. *Indirect Cost* – Indirect costs generally are identified using the UICR assigned by ED. When the UICR is used, no additional indirect cost is allowed beyond the UICR. In rare instances, like a new school opening for which there is not yet an applicable UICR, there may be other ways to calculate the indirect costs; in these cases, States should review the

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Indirect Cost Identification Using Indirect Cost Rates section for additional options for allowable indirect cost identification processes.

6. *An allocation of costs to the Medicaid program using an allocation statistic, which could include:*
 - a. For Medicaid-covered services typically identified in an IEP (i.e., the IEP MER ratio):
 - i. Medicaid-enrolled students with an IEP to total students with an IEP, or
 - ii. Medicaid-enrolled students to total students (i.e., use of the MER instead of a separately calculated IEP MER; this ratio may be chosen for ease of administration)
 - b. For Medicaid-covered services outside of an IEP (i.e., the “free care” MER ratio):
 - i. Medicaid-enrolled students to total students
7. *A Certification Statement* – A form where the portion of the public school or LEA’s costs properly allocated to Medicaid is certified by the public school or LEA to the State Medicaid agency for use as the non-federal share of Medicaid expenditures. The amount that may permissibly be certified by a public school or LEA as a CPE is the portion of the incurred cost that is properly identified and allocated to Medicaid via the school-based provider’s cost report.
8. *A Detailed Cost Reconciliation Process* – The State Medicaid agency must develop a cost reconciliation process which will define timelines for the following processes:
 - a. Cost report submission
 - b. State desk review and audit processes
 - c. Reporting to the total amount due to or from the provider (or, as applicable, the school, LEA, or school district acting as the billing entity) based on the difference between the total cost incurred properly allocated to Medicaid and the total Medicaid interim payments made
 - d. Settling over or under payment with the provider or, as applicable, the school, LEA, or school district acting as the billing entity)
9. *A Detailed Cost Report Package and Instructions* – For the benefit of the schools and LEAs, States are strongly encouraged to develop a detailed cost reporting package and instructions through which providers can report the necessary cost identification and allocation details described above.

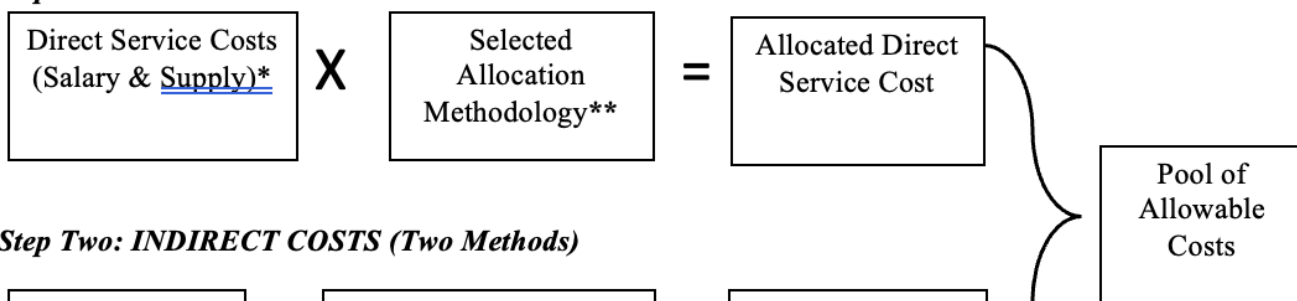
2. Example of Allocating Costs to Medicaid

Below is a simple example of the cost allocation process. In the example below, the allocation process steps down identified costs from direct services costs (from an identified cost pool) in step one and then adds indirect costs (generally using the cognizant agency rate) in step two, for a total pool of allowable costs. The allocation methodology in SBS is generally a time study (e.g., worker log, RMTS, etc.) that steps costs down from the identified total direct costs for personnel and materials to the isolated direct medical costs related specifically to the provision of medical services to students. The final allocation in step three would be from medical costs to

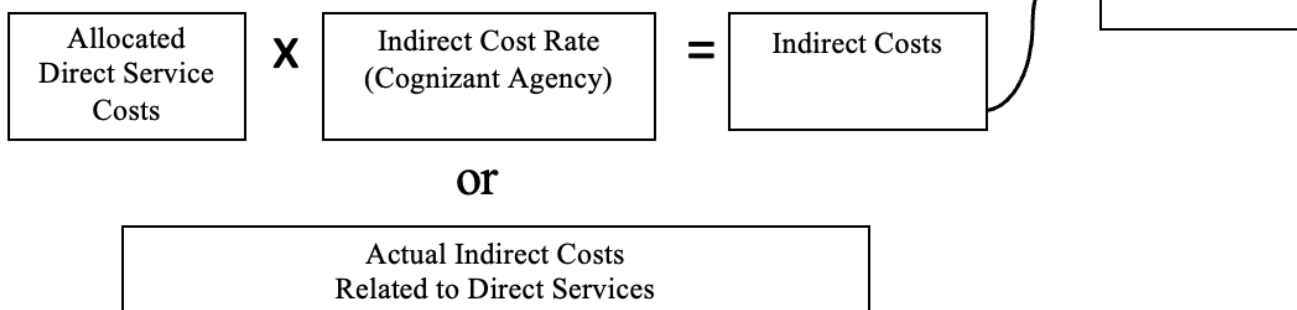
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Medicaid costs by applying a MER where applicable.

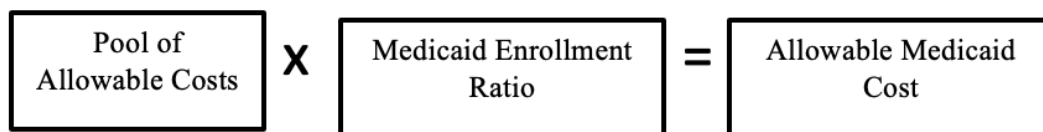
Step One: DIRECT COSTS



Step Two: INDIRECT COSTS (Two Methods)



Step Three: Allocating Allowable Costs to Medicaid



**Direct Service Salaries and Medical Supplies must be consistent with service providers described in Att. 3.1 of the State Plan.*

***Allocation Methodologies for Direct Costs Can include, but are not limited to: Random Moment Time Studies, Employee Time Sheets, etc.*

Using the above flow chart and basic cost report features, the following is an example of a general allocation methodology to determine the portion of an entity's cost allocable to the Medicaid program:

Prior to beginning to work through cost allocation, a cost-reporting process starts with the school, LEA, or school district identifying 100 percent of all costs incurred by the LEA (or other entity) related to the provision of medical services. Costs are then isolated into allowable direct services costs, allowable indirect costs, and unallowable costs. Costs must be offset by any non-Medicaid federal grant awards or third-party payments otherwise received for the services.

Step 1 – Once allowable direct service costs are isolated, that direct service cost pool is multiplied by an allocation statistic, as applicable, to further isolate direct costs specifically related to the provision of direct medical services. That allocation statistic may be based on a time study (e.g., RMTS, worker log, or other such statistic) that is reasonably related to the cost

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being allocated. If, for example, a provider spends 100 percent of their time performing direct medical services, then 100 percent of that individual's salary would be included as a direct cost, and there would not be a need for a time study for this provider. Also, some contractors hired to perform only direct medical services would not need to be included in a time study if 100 percent of their time is spent performing direct medical services. The final allocated direct cost is the total amount of direct cost related to the provision of medical services.

Step 2 – Using the identified indirect cost methodology, the total indirect cost is identified. In the example provided, a cognizant agency indirect cost rate is used. To identify the indirect cost, multiply the above identified total direct cost by the UICR. For schools, to the extent that it is available, the ED cognizant agency indirect cost rate must be used. The product of multiplying the total direct cost by the indirect cost rate is the total allowable indirect cost, again, for all direct medical services provided in the school.

The sum of the total allowable direct services costs and the total allowable indirect costs is the total allowable direct cost pool.

Step 3 – The next step is the allocation of costs to the Medicaid program. Applying a MER where applicable, or other allocation ratio as approved by CMS, the school would multiply the total allowable direct cost pool by the allocation ratio to determine the total allowable Medicaid cost for direct medical services. This number represents the total computable amount that is eligible for FFP.

After determination of final costs, the total interim payments for services provided during the fiscal year, as determined by the State Medicaid agency, are compared to the total allowable cost of direct medical services attributed to Medicaid, and the difference between those two amounts represents the over- or under-payment due to or from the school for the services provided during the year.

3. Interim Payments & Final Cost Reconciliation in Reconciled Cost Methodologies

THINGS TO CONSIDER:

- *New flexibilities for interim payments: no federal requirements to document claimed services in the States' Medicaid Management Information System (MMIS) or to fill out the CMS 1500 Professional Paper Claim Form- service level documentation will still be needed for audits.*
 - *Several examples from CMS approved interim payments are included here: 1/12th methodology, quarterly interim rates, lesser of billed charges or FFS rates, and FFS rates.*
 - *New interim rate flexibilities proposed here include: roster billing, per child per month rates, average cost per service rates, and bundled rates.*
-

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During the cost report period, State Medicaid agencies pay school districts providing SBS to Medicaid-enrolled students on an interim basis using interim rates, when using CPEs and capturing the costs of providing SBS. Interim rates provide cash flow to offset the ongoing cost of providing or arranging services for students prior to cost reconciliation and settlement procedures. State Medicaid agencies subsequently reconcile interim payments to costs using an annual cost report.

Typically, SBS payment methodologies include interim payments for Medicaid-covered services that are based on prior year costs or FFS rates (i.e., the rates paid under the Medicaid program’s fee-for-service delivery system for services furnished in non-school settings), and a final reconciliation process occurs once the cost reports are reviewed and accepted by the State Medicaid agency.

There are multiple ways that State Medicaid agencies can structure interim payments to LEAs and schools. For example, LEAs/schools can bill State Medicaid agencies for services provided and State Medicaid agencies can pay “interim rates,” such as the FFS rates paid to other providers.¹⁰² Alternatively, a State Medicaid agency could make monthly or quarterly interim payments to the LEAs/schools based on the prior year costs.

Below, Table 1 offers some examples of existing interim rate methodologies that States use for interim payment. Table 2 then shares new interim rate methodologies that States could consider using that CMS is discussing for the first time in this guide. For all new flexibilities shared in this guide, please see *Appendix C: Overview of New Policy Flexibilities Described in this Guide*.

Regardless of the methodology or examples given here, SBS providers must maintain service level documentation for audit purposes per 45 C.F.R. § 75.508(d).

Table 1: Existing Interim Rate Methodologies in Reconciled Cost Methodologies

Interim Rate Types	Explanation of the Sample Methodology
<p>Monthly Interim Rates</p> <p><i>1/12th Methodology</i></p> <p><i>States that currently use this methodology include: Colorado Utah</i></p>	<p>Participating LEAs are paid through interim payments based on a monthly rate calculated according to a one-twelfth methodology. The monthly rate is based on the LEA’s actual, certified costs identified in their most recently filed annual cost report from a prior fiscal year (usually the previous year). For a new participating LEA, the monthly rate is calculated based on statewide historical data of similar LEAs. The interim payments are calculated prior to the school year beginning and are divided into 12 equal monthly installments per student, to be paid monthly during the school or calendar year for each student who receives a service within a month. Some States offer an 80-90 percent of the one-twelfth methodology in order to avoid over-paying LEAs and having to collect overpayments at the end of the year.</p>

¹⁰² FFS rates can be based on factors like the cost of providing the service, a review of what commercial payers pay in the private market, and a percentage of what Medicare pays for equivalent services.

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	Although LEAs are not paid based on individually submitted service claims, the LEAs must maintain service-level documentation for direct care services that they provide to Medicaid-enrolled students. The documentation process is used to ensure that the LEA is maintaining auditable documentation of Medicaid-covered services provided to enrolled students.
<p>Quarterly Interim Rates</p> <p><i>States that currently use this methodology include: Nebraska</i></p>	Each school district/LEA completes a quarterly cost report to calculate allowable interim payments. The primary purpose of the cost report process is to document the provider’s total Medicaid allowable costs of delivering Medicaid coverable services using an allowable cost allocation methodology.
<p>Lesser of Billed Charges or State FFS Payment Rate</p> <p><i>States that currently use this methodology include: Arizona</i></p>	On an interim basis, LEAs will be paid the lesser of the rate contained in the State’s FFS schedule or the amount billed by the LEA.
<p>FFS Rates (by HCPCS or CPT Codes)</p> <p><i>States that currently use this methodology include: Illinois</i></p>	LEAs are paid using a fee schedule where the units of service are defined by each HIPAA-compliant Current Procedural Terminology (CPT) or Health care Common Procedure Coding System (HCPCS) code or Code on Dental Procedures (CDT). Direct medical services may be encounter-based or in 30, 15 or 5- minute unit increments. Note CMS does not require the use of HCPCS CPT, or CDT codes, but States may use these for accounting for SBS.

In addition to the above-approved methodologies, State Medicaid agencies may also consider the following additional, more flexible options for setting interim payment rates. With regard to these interim payment methodologies, there would be no need to submit service claims in the States’ MMIS or to fill out the CMS 1500 Professional Paper Claim Form. However, service-level documentation should be properly maintained as part of a State Medicaid agency’s program integrity efforts. Additionally, we currently do not expect the below-described methodologies to be appropriate for other reconciled cost-based reimbursement methodologies outside the context of SBS. CMS was tasked in the BCSA to specifically ease administrative burden for LEAs,¹⁰³ which are non-traditional settings for the delivery of Medicaid-covered services and may have limited resources relative to more traditional Medicaid providers for billing health care payers. Accordingly, although we believe the below-described methodologies are responsive to the

¹⁰³ Bipartisan Safer Communities Act, Section 11003(a)(1)(B)(iii). Supporting Access to Health Care Services in Schools. See <https://www.congress.gov/117/plaws/publ159/PLAW-117publ159.pdf>

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statutory directive in the BCSA and would be sufficient to comply with applicable federal requirements and maintain program integrity in the context of school-based services, CMS would expect to issue additional guidance before expanding these methodologies beyond the SBS context.

Table 2: Additional Interim Rate Methodologies in Reconciled Cost Methodologies, First Discussed in this 2023 Guide

New Flexible Interim Rate Methodology	Description of the Potential Methodology
Roster Billing	Providers of SBS (e.g., occupational therapists, physical therapists, speech therapists, nurses, etc.) can create and multiply a pre-determined rate based on some percentage of previous years' costs or the State FFS rate for similar services, etc., on a quarterly or monthly basis, by the number of Medicaid-enrolled students that receive covered services within the service period. These quarterly/monthly payments would then be reconciled to actual cost at the end of each year.
Cost-based Monthly Interim Rate or Per Child, Per Month Rates	Providers of SBS can create a cost-based rate that can be, for example, 1/12th of the provider's previous year's actual cost, which would be paid out each month on a Per Child, Per Month basis, based on the rendering of Medicaid service to a student. Please note that this not a capitated payment; a service would need to be rendered to trigger payment on a Per Child, Per Month basis.
Average Cost Per Service Monthly Interim Rate	State Medicaid agencies could create an average per-encounter rate that is based on the services the State Medicaid agency anticipates will be provided on average in the encounter by an LEA/school-based provider. For example, billing could be based on an average calculation of expected costs per visit for several different types of services (e.g., occupational therapists, physical therapists, speech therapists, nurses, etc.).
Bundled Interim Payments	A 1999 SMDL regarding bundled rates for SBS stated that we would not approve the use of bundled rates for SBS. ¹⁰⁴ To clarify, this 1999 SMDL only applies to rates that are not cost-based or ultimately reconciled to cost. Bundled fee schedule rates that are not reconciled to actual cost or based on actual cost are not appropriate for the reasons stated in the 1999 SMDL; however, if a State/school-based provider uses bundled interim rates, these interim rates would be permissible as long as the bundled interim rates are reconciled to actual cost.

¹⁰⁴ See <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD052199.pdf>

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For State Medicaid agencies that opt to pay for SBS through managed care arrangements, if the State Medicaid agency seeks to contractually require MCPs to pay school-based providers in a certain manner, such as to align with the monthly payment methodology discussed above (see Cost-based Monthly Interim Rate or Per Child, Per Month Rates) rather than a per-claim payment, then the State must adhere to the federal requirements for State-directed payments in accordance with 42 C.F.R. § 438.6(c), which may include written prior approval by CMS. State Medicaid agencies that elect the Per Child, Per Month payment approach may want to consider this approach to ensure consistency with the FFS flexibility and a comparable level of administrative ease.

Please note, the methodology described is a Per Child, Per Month payment that is paid after a service is rendered to a student for the month. Payment methodologies that require MCPs to make interim payments that are then later reconciled to cost have historically presented significant challenges for States to both implement and ensure compliance with the regulatory requirements for State directed payments (see 42 C.F.R. § 438.6(c)).

As LEAs, SEAs, State Medicaid agencies, CMS, and ED implement the billing flexibilities for Medicaid-covered services provided in schools, we are cognizant of the potential for data loss that may be associated with the flexibilities. Collection of basic data metrics (e.g., the number of students receiving SBS) is crucial for the Medicaid program in order to monitor trends in care and support performance improvement across physical health, mental health, and SUD services. Regardless of the delivery setting, it is important that CMS, States, and stakeholders have visibility into essential EPSDT services being provided to students and the quality of those services.

To ensure that States and CMS have information available to understand that quality care is delivered in schools to Medicaid-eligible students, CMS will provide national guidance to capture a consistent, simplified set of metrics while avoiding placing additional administrative burden on schools. Through collaboration in the SBS TAC, we will further define these reporting parameters and provide additional guidance on options for LEAs to implement billing flexibilities, while maintaining the necessary supporting documentation for States and Federal entities to assess access, quality of care, and health equity.

4. Timely Claims Filing Requirements

To receive FFP for Medicaid and CHIP expenditures, including expenditures for SBS, State Medicaid/CHIP agencies must comply with section 1132 of the Act and implementing regulations at 45 C.F.R. Part 95 Subpart A by filing claims for FFP within the two-year statutory time limit (or by meeting a statutory exception to the limit). There are four exceptions to the timely claims filing limits: claims for an adjustment to prior year costs, claims resulting from an audit exception, claims resulting from a court-ordered retroactive payment, and claims for which the Secretary decides there was good cause for the State's Medicaid/CHIP agency not filing within the time limit.¹⁰⁵

¹⁰⁵ 45 C.F.R. §§ 95.7, 95.19.

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Examples of State Claims Based on Interim Payment/Cost Reconciliation (for Public Providers):

January 1, 2019	School provides a service to Medicaid-enrolled student
April 1, 2019	School submits a claim to State for interim payment
May 15, 2019	State makes an interim payment to the school
June 30, 2020	School submits a cost report to State for 2019
March 31, 2021	Last day by which State can submit claim to CMS for FFP (unless the state demonstrates it meets a statutory exception to the two-year time limit)

State Medicaid agencies with approved Medicaid State plan methodologies that pay providers by reconciling an interim payment rate to actual cost might fall under the exception to the two-year limit relating to an “adjustment to prior year cost” in 45 C.F.R. § 95.19. The term “adjustment to prior year cost” is defined in 45 C.F.R. § 95.4 as “an adjustment in the amount of a particular cost item that was previously claimed under an interim rate concept and for which it is later determined that the cost is greater or less than that originally claimed.” However, we note that States must make their best effort to finalize their claims for FFP within the generally applicable time limit. Normal cost reporting cycles and reasonable administrative time frames to conduct cost reconciliations are generally sufficient to support a request for an exception to the timely filing limit under 45 C.F.R. § 95.19(a), so long as the adjustment is to costs for payments under an interim rate concept. Some States have included a two-year timeframe in their Medicaid State plan for the cost reconciliation process, which is acceptable, but not required. If State Medicaid agencies elect to include a reconciliation time frame, State Medicaid agencies should consider clarifying in their Medicaid State plan that the timeframe may be exceeded in the event of an audit or desk review or other unforeseen or unavoidable circumstances, to ensure that the State Medicaid agency does not run afoul of their own limitations in their Medicaid State plan.

As a reminder, for CPE-supported payments in which the provider is the certifying entity, the actual cost incurred in providing the service is the allowable expenditure and serves as the basis for any FFP claimed. In this situation, therefore, the date of the expenditure for purposes of the two-year time limit is the date of service, not the date of an interim payment to providers.¹⁰⁶ Additionally, claims relating to Medicaid State plan-approved, CPE-supported interim payments should be claimed at applicable federal matching rate in effect on the date of the Medicaid service provided.

¹⁰⁶ The State Medicaid Manual generally provides that an “expenditure occurs when cash or its equivalent is actually paid in the current quarter by an agency of the State.” SMM § 2560.4.G.1 (CAF, Vol. 1, at 32). However, the SMM distinguishes between the treatment of expenditures to public and non-public providers. It states that an expenditure is made to a public provider “when it is paid or recorded, whichever is earlier, by any State agency.”

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Example of State Claims for Payments not Based on Interim Payment/Cost Reconciliation:

January 1, 2019	School provides a service to Medicaid-enrolled student
April 15, 2019	School submits a claim to the State Medicaid Agency
April 30, 2019	School records the expenditure and the State pays the school based on the claim
June 30, 2021	Last day by which State can submit claim FFP to CMS (unless the State demonstrates it meets a statutory exception to the two-year time limit)

5. Contingency fee-based contracts

Many school districts or LEAs have chosen to use contracted services of professionals and consultants. 45 C.F.R. § 75.459(a) states:

Costs of professional and consultant services rendered by persons who are members of a particular profession or possess a special skill, and who are not officers or employees of the non-Federal entity, are allowable, subject to paragraphs (b) and (c) of this section when reasonable in relation to the services rendered **and when not contingent upon recovery of the costs from the Federal Government.** (Emphasis added.)

Medicaid claims for the costs of administrative activities and direct medical services may not include fees for contractor services that are based on, or include, contingency fee arrangements. Thus, if payments to contractors by schools are contingent upon payment by Medicaid, those payments may not be considered in determining the LEA's costs to be claimed for FFP. Further, as discussed in HHS Office of Inspector General (OIG) Compliance Program Guidance documents, percentage billing arrangements may increase the risk of upcoding and similar abusive billing practices.¹⁰⁷ Such arrangements may implicate, and depending on the facts and circumstances, could violate the anti-kickback statute, section 1128(b) of the Act.

State Medicaid/CHIP agencies or schools may directly contract with professionals and consultants to perform administrative activities such as Medicaid and CHIP 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.

6. State Plan Methodology Cost Reporting Examples

CMS has approved a number of SPAs that implement reconciled cost methodologies in the Medicaid State plan for payment for SBS. CMS has shared the Colorado Medicaid State plan

¹⁰⁷ See <https://oig.hhs.gov/documents/compliance-guidance/805/thirdparty.pdf> (“The OIG has a longstanding concern that percentage billing arrangements may increase the risk of upcoding and similar abusive billing practices.”) and <https://oig.hhs.gov/documents/compliance-guidance/801/physician.pdf> (“Although percentage based billing arrangements are not illegal per se, the Office of Inspector General has a longstanding concern that such arrangements may increase the risk of intentional upcoding and similar abusive billing practices.”).

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SBS payment methodology as a good example of a reconciled cost methodology.¹⁰⁸ The approved Colorado State plan includes all of the elements described within this section. Colorado’s methodology defines: the types of qualified providers that furnish covered services in schools; direct costs; indirect costs; time study-based allocation methodologies; allocation to Medicaid using a MER; an interim rate methodology; and final cost settlement including the timing of the settlement process. The methodology also includes a discussion of how and where the State retrieves the documentation related to their MERs. Colorado’s methodology is an example that other States can use to inform the development of an SBS payment SPA that uses a reconciled cost reimbursement methodology. However, Colorado is not alone in the list of States that have implemented a reconciled cost methodology for Medicaid SBS. At the time of this guidance issuance, the most recently approved SPAs include:

State and SPA Number	Approval Date	Link to Approved SPA (current URL)
AZ 21-0006	10/25/2021	https://www.medicaid.gov/Medicaid/spa/downloads/AZ-21-0006 https://www.medicaid.gov/Medicaid/spa/downloads/AZ-21-0006
GA 17-0014	07/14/2021	https://www.medicaid.gov/medicaid/spa/downloads/GA-17-0014.pdf
KY 20-0008	05/20/2021	https://www.medicaid.gov/Medicaid/spa/downloads/KY-20-0008.pdf
OK 20-0021	06/26/2020	https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OK/OK-20-0021.pdf
UT 21-0019	08/15/2022	https://www.medicaid.gov/medicaid/spa/downloads/UT-21-0019.pdf
WA 20-0004	02/11/2020	https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-20-0004_0.pdf

E. Administrative Claiming for SBS

THINGS TO CONSIDER:

- *Medicaid and CHIP can pay schools for the costs of administrative activities that support the provision of medical services covered under the Medicaid or CHIP State plan including outreach and enrollment, translation, transportation (when not provided as an optional medical service), referral and coordination of care, and Medicaid or CHIP-related training.*
- *School districts must enter into interagency agreements with State Medicaid agencies to conduct Medicaid administrative activities. 45 C.F.R. § 95.507(b)(6).*
- *State Medicaid agencies that intend to claim for allowable administrative activities must have an approved PACAP as well as an SBS Claiming Time Study Implementation Plan. 45 C.F.R. § 95.517; 45 C.F.R. § 75.430(i)(5).*

¹⁰⁸ Colorado SPA 19-0021. See <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-19-0021.pdf>. Approved February 11, 2020.

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- *Amounts claimed for administrative activities are based on the time study claiming methodology. States do not reconcile to costs for administrative activity claiming.*
 - *This is because administrative claiming is based on activities that have already occurred (and costs that have already been incurred) by the time of the claiming, whereas direct service claiming is based on interim bills which may not accurately reflect the costs incurred, such that a cost report reconciliation is needed.*
-

1. Allowable Administrative Activities

School or school district employees may perform administrative activities that directly support the Medicaid and CHIP programs. Some or all of the costs of these administrative activities may be reimbursable under Medicaid or CHIP; however, an appropriate claiming mechanism must be used. A 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.

Below are the principles States should follow for determining allowable administrative costs for which a State may claim Medicaid administrative expenditures. Note: many of these principles were stated in the December 20, 1994, SMDL on administrative claiming. See <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD122094.pdf>.

- Must be directly related to the proper and efficient administration of the State Medicaid program (section 1903(a)(7) of the Act and implementing regulations at 42 C.F.R. §§ 430.1, 433.15(b)(7)). Allowable administrative activities do not include gaining access to or coordinating non-Medicaid-covered services even if such services are health-related and provided to Medicaid beneficiaries.
- Must be included (by reference) in the PACAP that is approved by CMS and the HHS Program Support Center Division of CAS per Subpart E of 45 C.F.R. Part 95 (requirements for PACAPs are discussed above in subsection D of this section).
- Must be supported by adequate documentation. (45 C.F.R. § 75.403(g)).
- Cannot reflect any direct or indirect activities related to providing a direct medical service.
- Cannot be an integral part or extension of a direct medical service, such as patient follow-up, patient assessment, patient education, counseling (including pharmacy counseling), or other physician extender activities.
- May not generally include any cost of general public health initiatives that are made available to all persons, unless the activities related to assisting Medicaid-eligible students are specifically identified.
- May not include any cost of activities related to the operation of a provider facility, such as the supervision and training of providers. Such services are properly paid for as part of the payment made for the medical or remedial service. Because Medicaid providers have

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agreed to accept service payment as payment in full, such providers may not claim an additional cost as administrative cost under the Medicaid State plan.

- May not include activities related to the operation of an agency whose purpose is other than the administration of the Medicaid program, unless that agency directs some fraction of its efforts to Medicaid-allowable activities, and accurately identifies that fraction.

Examples of Allowable Medicaid and CHIP Administrative Activities

- Medicaid and CHIP Outreach:
 - Informing Medicaid- and CHIP-eligible and potentially Medicaid- or CHIP-eligible students and families about the benefits and availability of services covered by Medicaid and CHIP, including services that may be covered under the EPSDT benefit.
 - Developing and/or compiling materials to inform individuals about the Medicaid and CHIP programs, including EPSDT, and how and where to apply for and obtain those benefits. As appropriate, outreach materials should have prior approval of the State Medicaid/CHIP agency.
 - Distributing literature about the benefits, eligibility requirements, and availability of the Medicaid and CHIP programs, including EPSDT.
- Facilitating Medicaid and CHIP Eligibility Determinations:
 - Verifying an individual's current Medicaid or CHIP eligibility status for purposes of the Medicaid and CHIP eligibility process.
 - Explaining Medicaid and CHIP eligibility rules and the Medicaid and CHIP eligibility processes to prospective applicants.
 - Assisting individuals or families with completing a Medicaid and CHIP eligibility application.
 - Gathering information related to the application and eligibility determination for an individual, including resource information and TPL information, as preparation for submitting a formal Medicaid and CHIP application.
 - Providing necessary forms and packaging all forms in preparation for the Medicaid or CHIP eligibility determination.
 - Referring an individual or family to the local assistance office or online to complete an application for Medicaid or CHIP benefits (Note: assisting with applying for Marketplace or other commercial coverage is *not* an allowable expense).
 - Assisting the individual or family in collecting/gathering required information and documents for the Medicaid and CHIP application.
- Transportation-Related Activities in Support of Medicaid and CHIP Services:
 - Scheduling or arranging transportation to Medicaid- or CHIP-covered services. Note, when the State claims FFP for necessary transportation as an optional medical service, the State must not also claim the same transportation expenditures as an administrative activity, which would result in duplicative payment.
- Translation and Interpretation Services Related to Covered Services:
 - Arranging for or providing translation or interpretation services (oral and signing) that assist the individual to access and understand necessary care or treatment

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- covered by Medicaid so long as the cost is not already included in the rate paid to providers.
- Developing translation materials that assist individuals with accessing and understanding the care and treatment covered by Medicaid.
- Program Planning, Policy Development and Interagency Coordination Related to Medicaid and CHIP:
 - Identifying gaps or duplication of Medicaid and CHIP-covered services and developing strategies to improve the delivery and coordination of covered services.
 - Developing strategies to assess and/or increase the capacity of Medicaid and CHIP programs to meet changing needs.
 - Monitoring the claiming entity's provision or arranging of, and billing for, Medicaid and CHIP-covered services (Note: Medicaid billing alone is an ancillary service to the direct service, not an administrative expense).
 - Analyzing Medicaid and CHIP data related to a specific program, population, or geographic area.
 - Working with other agencies and/or providers that provide Medicaid- and CHIP-covered services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid- and CHIP-eligible individuals and to increase provider participation.
- Medicaid- and CHIP-Related Training:
 - Participating in or coordinating training seeking to improve the health care delivery system of Medicaid- and CHIP-covered services with respect to schools.
 - Participating in or coordinating training that enhances early identification, intervention, screening, and referral of students with special health needs to Medicaid- and CHIP-covered services (e.g., EPSDT services).
 - Participating in training on administrative requirements related to Medicaid and CHIP-covered services (e.g., conditions of coverage for certain services).
- Referral, Coordination and Monitoring of Medicaid and CHIP-Covered Services (distinct from case management activities covered as a medical service):
 - Making referrals for and/or coordinating services covered by Medicaid and CHIP, including evaluations.
 - Arranging for any Medicaid- or CHIP-covered services that may be required as the result of a specifically identified health condition.
 - Providing follow-up contact to ensure that a student has received the prescribed services covered by Medicaid or CHIP.
 - Coordinating the delivery of community-based services for a student with special/severe health care needs.
 - Coordinating the completion of the prescribed services, termination of services, and the referral of the student to other Medicaid or CHIP service providers as may be required to provide continuity of care.
 - Providing information as appropriate to other staff on the student's health services and plans.
 - Coordinating service provision with MCPs as appropriate.

2. More on Outreach and Enrollment Support Through Partnerships with Schools

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State Medicaid/CHIP agencies may conduct Medicaid and CHIP outreach and enrollment support to families through partnerships with schools, and may claim FFP for those expenditures. Sections 2102(c)(1) and 2105(a)(1)(D) of the Act permit State Medicaid/CHIP agencies to use Title XXI funds for outreach to individuals that are eligible for Medicaid or CHIP. Outreach efforts that target Medicaid or CHIP enrollment may be matched by either Title XIX funds, as permitted by section 1903(a)(7) of the Act) or Title XXI funds pursuant to sections 2105(a)(4) and/or 2113 of the Act. However, State Medicaid/CHIP agencies must report expenditures for these outreach activities only once under either Title XIX or Title XXI. State Medicaid/CHIP agencies may not report duplicative expenditures for joint Medicaid and CHIP outreach activities under both funding authorities.

The Connecting Kids to Coverage National Campaign is another resource to assist States and community partners with outreach efforts in schools.¹⁰⁹ One of the Campaign's key initiatives focuses on outreach during back-to-school time, as well as school-based outreach.¹¹⁰ As part of this initiative, the Campaign develops a broad array of materials that States and their school partners may disseminate in schools to reach families with students potentially eligible for Medicaid or CHIP. The Campaign materials contain information about Medicaid and CHIP eligibility requirements, covered Medicaid and CHIP benefits for eligible students, and where families can apply for coverage. States and their school partners may submit a request to customize¹¹¹ these materials to tailor them for specific target audiences. The Campaign website also provides an outreach tool library¹¹² that allows users to filter materials by specific audience, including educators, and type of resource.

3. Unallowable Activities

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 and CHIP, duplicate payments are **not** allowable. That is, State Medicaid/CHIP agencies 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 Medicaid/CHIP agency must provide assurances to CMS of non-duplication through the administrative claiming process. Furthermore, in no case should a program or claiming unit in a local jurisdiction be reimbursed more than the actual cost that program or claiming unit incurred for the allowable activities, including payments from all State, local, federal, and any other payers. CMS will work with State Medicaid/CHIP agencies as needed to determine which activities may be claimed as Medicaid and CHIP administrative costs.

Examples of activities that are not likely eligible for FFP as Medicaid and CHIP administrative expenditures due to the likelihood of duplicative payments include:

¹⁰⁹ See <https://www.insurekidsnow.gov/campaign-information/index.html>

¹¹⁰ See <https://www.insurekidsnow.gov/initiatives/back-school-school-based-outreach/index.html>

¹¹¹ See <https://www.insurekidsnow.gov/sites/default/files/2022-04/materialscustomizationguide-english-apr-2022.pdf>

¹¹² See <https://www.insurekidsnow.gov/outreach-tool-library/index.html>

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- Activities that are integral parts or extensions of direct medical health services, including but not limited to behavioral health services (Medicaid/CHIP or non-Medicaid/CHIP) such as patient follow-up, patient assessment, patient education, or counseling. In addition, the cost of any consultations between medical professionals is already reflected in the payment rate for medical assistance services and may not be claimed separately as an administrative cost. Referral coordination and monitoring of services are recognized administrative activities, however, medical consultations are part of the direct service.
- Activities that have been, or will be, paid for as a medical assistance service, such as necessary transportation where the State ensures necessary transportation as an optional medical service, or as a service of another (non-Medicaid/CHIP) program.
- Activities that already have been claimed as a Medicaid/CHIP administrative cost.
- Activities that are included as a part of a managed care capitation rates and are paid by a MCP payment (these activities may not also be claimed for payment directly by the State Medicaid/CHIP agency).

Additional Examples of Unallowable Medicaid Administrative Activities

- Non-Medicaid/CHIP outreach.
- Facilitating eligibility determinations for non-Medicaid/CHIP public assistance programs (e.g., Temporary Assistance for Needy Families, or TANF).
- Transportation for non-Medicaid/CHIP covered services.
- Translation and interpretation services related to non-Medicaid/CHIP covered services.
- Non-Medicaid/CHIP related training.
- Referral, coordination, and monitoring of non-Medicaid/CHIP-covered services.

State Medicaid agencies should consult with CMS as early as possible in the development of their school-based services payment methodologies in order to have such methodologies and the associated time study codes reviewed and approved by CMS prior to submitting any necessary SPAs and claims for FFP, and prior to submitting their PACAP amendments to CAS (see *Requirements for PACAPs for Determining Allocable Share of Medicaid Administrative Costs*). This will help ensure that such amendments are approved on a timely basis and that subsequent claims are in accordance with all applicable federal requirements.

4. Coordination of Activities

Allowable administrative activities must be necessary for the proper and efficient administration of the Medicaid or CHIP State plan. Therefore, it is important in the design of school-based administrative claiming processes that the school does not perform activities that are already being performed by other entities or through other programs.

To ensure appropriate coordination among providers in accordance with 42 C.F.R. §§ 438.208 and 457.1230(c), States can include relevant requirements in their Medicaid and CHIP managed care contracts. In addition, since schools are required under IDEA to provide services listed in a student's IEP, many Medicaid and CHIP managed care contracts contain provisions that specifically exclude these services from the capitation rate paid to cover the costs of providing

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other medical services to Medicaid and CHIP eligible students, leaving the State Medicaid/CHIP agency responsible for payment for the carved-out covered services.

The following are examples of activities that should be coordinated:

- Activities performed by MCPs for Medicaid or CHIP beneficiaries, such as case management functions. To avoid duplication of these functions by school personnel, coordination mechanisms should be established between the schools and other relevant entities, such as the MCP(s) in which students are enrolled and the State Medicaid/CHIP agency.
- Activities involved with the establishment of payment rates and rate-setting mechanisms. State Medicaid/CHIP agencies and schools need to coordinate with respect to their activities, especially payments to providers, third party payers, and rates 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, MCP payment rates may need to be adjusted to reflect the activities and services being furnished in the school setting.
- Activities that are conducted by another governmental component. For example, if EPSDT-related educational materials, such as pamphlets and flyers, have already been developed by the State Medicaid/CHIP agency, it is not necessary for them to also be developed by schools. In order to avoid such potential inefficiencies in the allocation of Medicaid and CHIP programs and school resources, school districts/schools should coordinate and consult with the State Medicaid/CHIP agencies to determine appropriate activities for each to undertake related to SBS (including but not limited to matters related to the EPSDT benefit) and to determine the availability of existing materials.¹¹³

5. Interagency Agreements

a) General

Administrative 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 SEA and/or the school district or local entity that may be conducting Medicaid-allowable administrative activities, must be in place in order to claim federal matching funds in accordance with 45 C.F.R. § 95.507(b)(6).

The State Medicaid agency is the only entity that may submit claims to CMS to receive FFP for allowable Medicaid expenditures. This requirement necessitates that every participating agency

¹¹³ Medicaid administrative activities can be performed by the State Medicaid agency, but also by many other entities, such as local governmental entities or State sister agencies. These entities should not perform and claim for activities that are duplicative of other Medicaid activities that are already occurring. This calls for close coordination between the claiming entities and the State Medicaid agency. Lack of coordination concerning activities could result in duplication of effort, as well as inappropriate classification or shifting of cost.

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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 the staff conducting administrative activities at the school are all employed or contracted for this purpose by the school district, and that school district is party to the interagency agreement with the State Medicaid agency.

Some States recognize consortia arrangements for purposes of claiming Medicaid administrative expenditures, for which 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 LEAs, or school districts, as appropriate. The State Medicaid agency should remain apprised of any changes in the participation terms or membership of a consortium with which it has entered into an interagency agreement.

Interagency agreements may only exist between governmental entities and cannot extend to private contractors or consultants. If a school district hires a private consultant to manage its administrative claims, the private consultant would not be a party to the interagency agreement. However, the parties to the interagency agreement can engage private contractors to perform functions in connection with the interagency agreement, provided this is not prohibited under the terms of the interagency agreement itself.

In entering into interagency agreements, State Medicaid agencies should be mindful of their responsibility to administer or supervise the administration of the State Medicaid plan.¹¹⁴ Additionally, State Medicaid agencies should take care to observe all requirements of State law regarding interagency agreements and, as applicable, contracts. Although CMS is not able to counsel State Medicaid agencies on requirements of their State’s laws, we are aware that 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:

- The specific services being purchased, including:
 - Activities or services each party to the agreement will offer or perform, and under what circumstances.
 - Defined oversight activities and responsibilities.
- The basis upon which the billing will be made by the provider agency (e.g., time reports, etc.), including:
 - When CMS has approved specific administrative claiming time study activity codes.

¹¹⁴ 42 C.F.R. § 430.10.

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- The specific payment methodology, which may include a standardized claim form, the mechanism for filing the claim.
- A stipulation that the billing will be based on the actual cost incurred, including (Note: this statement would not be required if the costs involved are specifically addressed in a State-wide or local-wide cost allocation plan, or umbrella/department cost allocation plan.):
 - Relevant information about any payments and/or non-federal share financing mechanisms.
 - When CMS has approved a specific methodology for computation of the claim, the interagency agreement should include or reference.

Useful information to include in inter-agency agreements:

- Methods for payment.
 - Processes for exchange of necessary reports and documentation.
 - Identification of liaison(s) between the parties, including designation of State and local liaison staff.
 - A description of any cooperative and collaborative relationships between relevant entities at the State and local levels.
6. Requirements and/or procedures for maintenance of records, participation in audits, designation of local project coordinators, training timetables and criteria, and submission of fiscal information are all likely to be important elements of an interagency agreement.

Although prior approval by CMS of an interagency agreement is not required, State Medicaid agencies are encouraged to consult CMS during the development of their model interagency agreements intended for use with respect to Medicaid administrative claiming. CMS is available to review interagency agreements, and may request to do so as necessary to ensure that expenditures claimed for FFP are for activities necessary for the proper and efficient administration of the Medicaid State plan.

7. Increased Federal Match for Claiming of Specific Administrative Services

a) Claiming for Administrative Expenditures for Family Planning Services

The increased family planning matching rate of 90 percent is available under Medicaid only for the “offering, arranging and furnishing” of family planning services and supplies.¹¹⁵ This increased rate is available with respect to expenditures for personnel who administer as well as directly provide certain family planning services and supplies, when the provider offers, arranges, and furnishes them.¹¹⁶ Schools that offer and/or arrange for family planning services and supplies, but do not actually furnish them, may claim expenditures for administrative

¹¹⁵ See Section 1903(a)(5) of the Act.

¹¹⁶ See 42 C.F.R. § 432.50(b)(5) as referenced by 42 C.F.R. § 433.15(b)(2).

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activities related to Medicaid-covered family planning services and supplies at the 50 percent administrative match, but not at the increased 90 percent FFP matching rate. There are specific ways for a school to account for offering and/or arranging for family planning services versus actually providing the services. This guidance has a lengthy discussion of such coding in the Appendix. Arranging for the activity would be reported under Administrative Activity Code 9.b., “Referral, Coordination, and Monitoring of Medicaid Services” in the example activity code set referenced in this guidance. Payment for some or all of the costs of arranging family planning services and supplies may also be available under Medicaid as a direct service. If included in a direct service claim, these costs are not allowable as administrative expenditures; they would be reported instead under time study Code 4., “Direct Medical Services.” (See *Activity Codes* in Appendix).

b) Claiming for Administrative Expenditures for Translation or Interpretation Services

Sections 1903(a)(2) and 2105(a)(1) of the Act provide an increased federal matching rate for expenditures for translation or interpretation services provided to eligible individuals for whom English is not their primary language. Specifically, the increased translation/interpretation match for administrative expenditures for translation or interpretation services is available in connection with the “enrollment of, retention of, and use of services” under Medicaid or CHIP. The increased matching rate is available for expenditures for translation or interpretation services for any individual whose primary spoken or written language is not English. This includes individuals whose primary spoken or written language is American Sign Language or Braille, since these languages are considered distinct and separate languages from English, as noted in the 2010 State Health Official letter on federal matching funds for translation and interpretation services (SHO #10-007¹¹⁷).

The increased federal matching rate for translation or interpretation services differs for Medicaid and CHIP. For Medicaid, the increased match is 75 percent of allowable expenditures. For CHIP, the increased match is 75 percent, or the State’s enhanced FMAP plus 5 percent, whichever is higher. However, the increased translation/interpretation match is only available for eligible Medicaid administrative expenditures, not for the expenditures claimed for benefits.

In order to obtain the increased translation/interpretation federal matching rate, State Medicaid agencies and providers may:

- Enter into a contract or employ staff that provide solely translation or interpretation functions and claim related costs as administrative activities; and/or
- Pay for translation or interpretation activities as directly administrative expenditure, separate from the medical service (subject to managed care payment requirements discussed below).

Under Medicaid, if translation or interpretation services are provided by a contracted MCP and paid for through a capitated payment from the State, related costs in that rate are not eligible for

¹¹⁷ See <https://www.medicaid.gov/federal-policy-guidance/downloads/sho10007.pdf>

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the increased translation/interpretation match rate because the capitated payment is a benefit expenditure, not an administrative expenditure. This is consistent with Medicaid managed care regulations at 42 C.F.R. § 438.812(a), which specify that payments made under a managed care contract are considered “medical assistance services” and are matched only at the FMAP rate. However, States have the option to carve out translation or interpretation services from the capitated rate and contract separately for such services as an administrative activity.

Activities for which the increased translation/interpretation match is available include (but may not be limited to) translating forms, web sites, and enrollment and outreach materials into languages other than English, and making translation or interpretation services available in order for Medicaid-eligible students to enroll in the program, maintain eligibility, and access covered services. Any expenditures claimed by the State as Medicaid administrative expenditure, including translation or interpretation services, must be necessary for the proper and efficient administration of the Medicaid State plan as specified in section 1903(a)(7) of the Act. CMS is available to help State Medicaid agencies determine if proposed translation or interpretation activities would be matched at the increased translation/interpretation administrative federal matching rate.

By contrast, translation and interpretation services under CHIP can be covered as “child health assistance” at section 2110(a)(27) of the Act and are eligible for the full enhanced FMAP. Under CHIP managed care, these translation services would be considered part of “child health assistance” and included in the CHIP capitated rate.

8. Requirements for PACAPs for Determining Allocable Share of Medicaid Administrative Costs

The PACAP, a document that allocates costs across federal grant awards, contains narrative statements about functions performed by the agency as well as financial documentation, methodologies, claiming mechanisms, interagency agreements, and other relevant information and materials that will be used when claiming and appropriately allocating costs. Requirements for the development, documentation, submission, negotiation, and approval of PACAPs are in 45 C.F.R. Part 95, Subpart E. In accordance with these federal regulations, a PACAP must be submitted or updated by States and reviewed and approved by HHS/Program Support Center/CAS before FFP is available for administrative claims in the Medicaid program. 45 C.F.R. § 95.517(a) indicates that a State Medicaid agency must claim FFP for costs associated with a program only in accordance with its approved cost allocation plan. However, if a State Medicaid agency has submitted a plan or plan amendment for a State agency, it may, at its option, claim FFP based on the proposed plan or plan amendment, unless otherwise advised by the CAS. However, where a State Medicaid agency has claimed costs based on a proposed plan or plan amendment, the State Medicaid agency, if necessary, shall retroactively adjust its claims in accordance with the plan or amendment as subsequently approved by the Director, CAS. The State may also continue to claim FFP under its existing approved cost allocation plan for all costs not affected by the proposed amendment. CAS reviews State PACAPs and grantee indirect cost rate proposals to ensure rates comply with all applicable federal requirements and grant terms.

For purposes of school-based administrative activities, a State Medicaid agency must submit a

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PACAP before claiming FFP for school-based administrative claiming, if it chooses to use schools to perform allowable Medicaid administrative activities. The PACAP must provide, in accordance with the approved interagency agreements, for reimbursement of the administrative activities performed in the school setting for which claims will be made by the LEAs, school districts, and schools to the State Medicaid agency. It must also make explicit reference to the methodologies, claiming mechanisms, interagency agreements, and other relevant information and materials 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 cost allocation methodology, States may need to amend the PACAP if the State seeks to make programmatic changes that would not be compatible with the approved PACAP. States should consult with CMS in the development of time study and allocation methodologies used for their school-based administrative claiming processes.

The school-based administrative claiming process must be supported by a system that has the capability to isolate the costs directly related to the administration of the Medicaid program from all other costs incurred by the school and for which the State Medicaid agency will claim FFP as administrative expenditures. Such costs must comply with the cost allocation principles described in 45 C.F.R. Part 75, Subpart E and 2 C.F.R. Part 200, which require that costs be “reasonable” and “allocable” to the Medicaid program. 45 C.F.R. §75.404-406. Claims for the school district’s indirect costs are automatically allowable (*prima facia*) when the entity has an indirect cost rate approved by the cognizant agency (such as ED) and costs are claimed in accordance with the rate.

Although CMS is not the HHS component responsible for approval of the PACAPs, CMS works directly with CAS in the PACAP review and approval process. CAS will not approve such PACAPs without CMS review and approval of the methodologies referenced in the PACAP. Therefore, the referenced elements must be reviewed and approved by CMS before States implement a school-based administrative claiming process and claim related FFP.

9. SBS Claiming Time Study Implementation Plans

CMS requires the State Medicaid agency to submit an SBS Claiming Time Study Implementation Plan (also called the Medicaid Administrative Claiming Plan) that provides a comprehensive description of the mechanisms and processes for claiming Medicaid administrative costs and for conducting a time study for administrative and direct services costs. See 45 C.F.R. § 95.507(a)(4); (b)(4); and (b)(9). An SBS Time Study Claiming Implementation Plan details the SBS activities, including both administrative activities and direct medical services, performed by LEAs and the methods used to allocate SBS activities and services to the Medicaid program. The SBS Time Study Implementation Plan contains the elements needed to approve in order for States to initiate SBS claiming.

The SBS Time Study Implementation Plans generally implement the SBS State plans and PACAPs and describe the specific Medicaid costs and allocation principles that are used for purposes of Medicaid claiming. States should submit their SBS Time Study Implementation Plan(s) to CMS for review and approval prior to implementation. CMS collaborates with States to determine the appropriate implementation or effective date for the submitted SBS Time Study

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Implementation Plan. To the extent the SBS Claiming Time Study Implementation Plan is necessary to support or fully document the PACAP (including any necessary PACAP amendment), it must be approved by CMS before FFP is available. CMS works with States to determine the most appropriate effective date, consistent with all applicable federal requirements.

The CMS-approved SBS Time Study Implementation Plan can be submitted along with a PACAP amendment and/or SBS payment SPA, as applicable, and must be included with those submissions where necessary to support or fully document the PACAP amendment or SPA submission.

The SBS Claiming Time Study Implementation Plan should include the following elements:

1. **Description of Administrative and Direct Services Payable by Medicaid:** Other State and local agencies (e.g., State and local health departments and mental health and SUD authorities) may perform the same activities and/or services that are provided in the school setting. Similarly, Medicaid MCPs may cover the same services for school-aged students.¹¹⁸ The State should provide a description of the current administrative activities performed by these other entities and their relationship to the Medicaid activities performed in the schools, as well as direct services payable by Medicaid. For example, a chart or matrix could be used to identify activities for which each agency currently receives FFP to ensure no duplicative payment.
2. **Interagency agreements:** An interagency agreement must be in place between the State Medicaid agency, the SEA and/or the school district or local entity conducting the activities. Requirements and elements of interagency agreements are discussed in *Interagency Agreements* section guide. The State should submit copies of the Interagency agreements with its SBS Claiming Time Study Implementation Plan.
3. **Description of Cost Pools:** Cost pools should be mutually exclusive and internally homogenous. Time studies often have multiple cost pools to account for different types of staff (e.g., direct medical staff and administrative activities staff). See discussion of *Cost Pools*.
4. **Source of Non-Federal Share:** The SBS Claiming Time Study Implementation Plan should set forth the source of the non-federal share. The claiming plan should describe how the availability of sufficient non-federal funds to support Medicaid expenditures will be documented. The description should demonstrate that the non-federal share to be used to support the expenditures is not already committed for another use, such as non-federal share under another federal grant program, and is derived from permissible sources. Federal funds may not be used as non-federal share to draw down additional federal matching funds, except as permitted by federal law.¹¹⁹

¹¹⁸ See the Managed Care discussion in Section IV.

¹¹⁹ 42 C.F.R. § 433.51(c).

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5. **Sample Design.** A description of the sample design must be included in the SBS Claiming Time Study Implementation Plan (for more on RMTS, please see section: *Random Moment Time Study*). This description must include:
- a. Sampling Plan Methodology
 - i. Sample frame: pursuant to 45 C.F.R. § 75.430, the sampling universe must include all employees together with their job descriptions whose salaries and wages are to be allocated based on the sample results, the entire time period must be covered, and the results must be statistically valid and applied to the period being sampled, including job classifications eligible to be sampled and the description of the random selection process
 - ii. Sample size based on a 95 percent confidence level and 5 percent error rate
 - iii. Description of non-response protocol
 - iv. A set of approved Time Study Implementation Plan activity codes that capture 100 percent of activities performed and clearly distinguish direct services from administrative activities, and Medicaid functions from non-Medicaid functions should be detailed in the Implementation plan.
 - v. Selection of RMTS participants and assignment of random moments
 - vi. Methods used to obtain worker observations
 - 1. Prior notification protocol
 - 2. Maximum response time allowed
 - b. Period of Observations (i.e., intervals)
 - i. Start and end dates of the time study
 - ii. Treatment of Summer period
 - c. Time Study Documentation Requirements
 - d. Training Process and Materials for Study Participants. The plan should include training schedules for both time study participants and time study coordinators. The training must include all aspects of the sampling process, potentially time study codes, and the appropriate documentation guidelines for participants.
 - e. Oversight and Monitoring Process
 - i. Validation protocol: 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. State and/or claiming entity are expected to have a system of controls in place to ensure the effectiveness and efficiency of operations, reliability of financial information, and compliance with applicable laws and regulations.
 - ii. Monitor worker responses: State Medicaid agencies should sample an appropriate number of responses (5-10 percent of the moments) each time study period as CMS has approved Time Study Implementation Plans that included monitoring sample reviews of 5-10 percent of sampled moments. A suitable method would trace the responses to supporting documentation, such as leave approvals, worker schedules, activity logs, etc.,
 - iii. States may identify the limited circumstances under which changes or corrections to an observation may be needed, e.g. if a worker is on paid

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time off and cannot respond to their moment, the time study coordinator, after viewing leave records, would change that nonresponse to code such activity properly and include it as a valid response

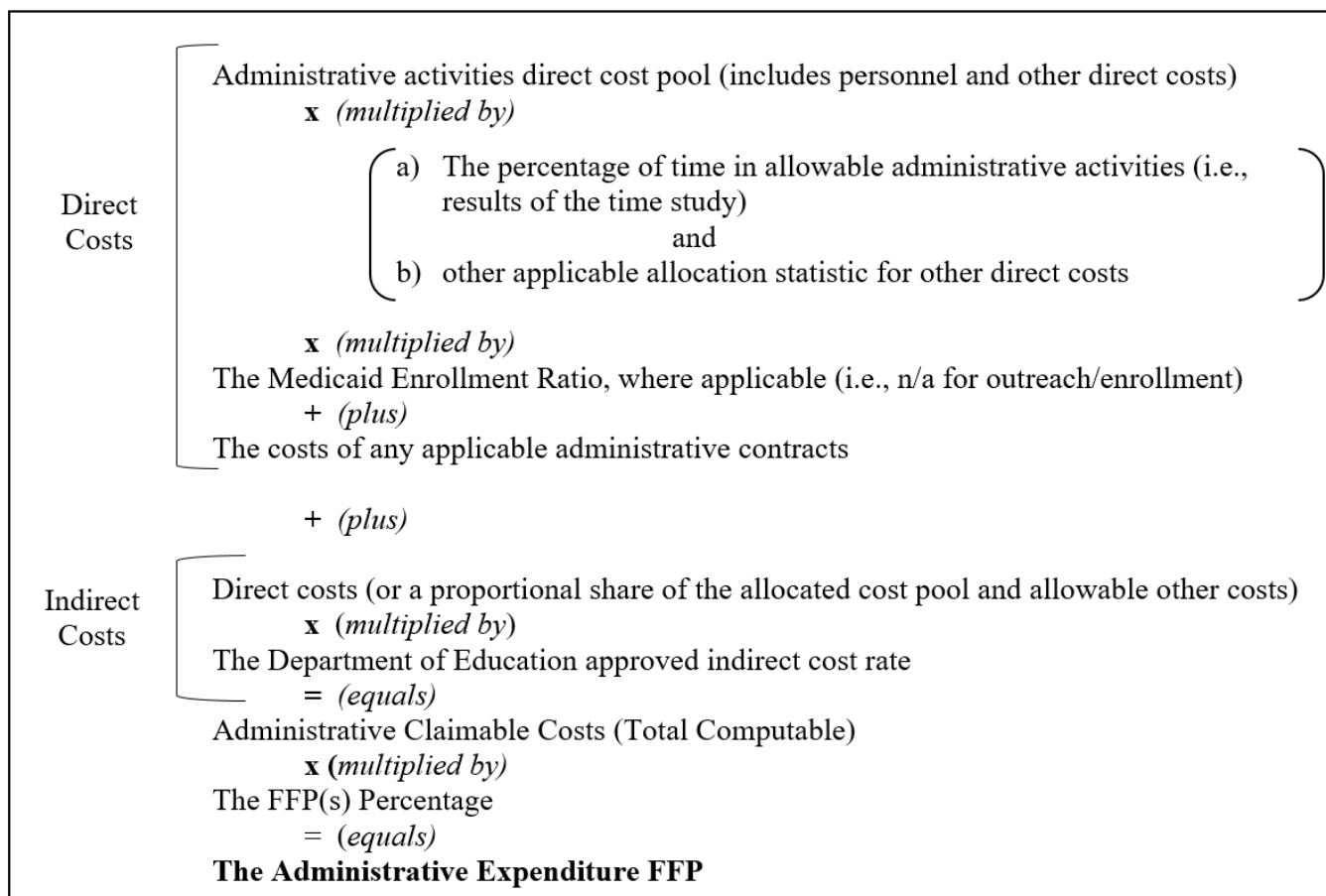
6. **Treatment of Indirect Costs:** The State Medicaid agency must indicate whether indirect costs will be claimed. For school-based claiming, indirect costs are typically claimed through the use of an indirect cost rate approved by the cognizant agency responsible for approving such rates. With respect to school-based costs, the cognizant agency is ED 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.
7. **Monitoring Process:** The State Medicaid agency must establish an oversight process for monitoring LEAs, which 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.

10. Claim Calculation

The amount of FFP that a State can claim to CMS based on an LEAs' quarterly administrative expenditures is calculated by applying the allocation statistics to the personnel cost pools (allocated using the time study) and other direct cost pool charges as allocated by an applicable methodology (e.g., computers, supplies) for administrative activities that were conducted during the quarter. For expenditures claimed as administrative activities, unlike SBS medical services, there is not a cost report process as described above in Section *CMS Review of Medicaid SBS SPAs & Cost Reports* of this guidance. There is no formal reconciliation process because administrative costs are fully recognized through the time study codes as having been performed and allocated during the quarter for which the claim for FFP is submitted, and there are no interim payments to reconcile to actual costs incurred.

The formula for this calculation may be described as follows. This is an example for administrative claiming which can be adapted to an LEA or State's specific circumstances.

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F. Documentation Expectations and Requirements for Covered Medicaid Services

1. Introduction and Documentation Guidance to LEAs

THINGS TO CONSIDER:

- *CMS and ED documentation requirements are outlined to help State Medicaid agencies and LEAs streamline documentation for claims.*
- *There are no applicable federal requirements for procedure or diagnosis codes (e.g., HCPCS, CPT, CDT, ICD-10, etc.); however, States may have their own requirements.*
- *Several best practices for documenting Medicaid services, cost reporting, and time studies are presented.*

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Documentation Requirements in the Context of SBS

In general, providers must maintain documentation that covered Medicaid services have been provided to beneficiaries to support the provider’s claim for Medicaid payment.¹²⁰ However, many school-based settings are not traditional health care providers with a sophisticated billing infrastructure in place. A number of OIG audits have noted that States’ methodologies did not capture information that would allow the States to support cost allocations.¹²¹ To prevent these types of findings, be sure to state clear and consistent billing requirements in State provider billing manuals. While this section details the current documentation requirements to support the claiming of FFP, there is a need for collaboration among State Medicaid agencies, SEAs, and LEAs to determine documentation and retention policies that are suitable to satisfy applicable legal requirements and withstand audits without unnecessarily impeding service delivery. For example, there may be overlap between medical service documentation and educational documentation that could be consolidated or reconciled into a more efficient documentation process that meets medical (including billing) and educational purposes.

With regard to documentation required to support claims for FFP, CMS also realizes there should be collaboration between CMS and ED to eliminate any unnecessarily duplicative federal documentation requirements. We understand additional guidance that details CMS and ED documentation expectations regarding supporting documentation when audits are conducted may be helpful to State Medicaid agencies, SEAs, and LEAs. We plan to address these issues through the forthcoming TAC, and additional guidance.

Below is a chart that outlines the required documentation to claim FFP for services provided to Medicaid-enrolled students. This table details whether the data is required by the Medicaid program and/or ED. The purpose of the table is to help State Medicaid agencies and LEAs identify the required documentation for each program. Note that State Medicaid agencies may require additional data in addition to what is listed below:

Required Documentation	Required by CMS	Required by IDEA
Date of service	✓	X
Name of recipient	✓	✓ ¹
Medicaid identification number (of student)	✓	X
Provider agency and person providing the service	✓	✓ ²
Nature, extent, or units of service	✓	✓ ³
Place of service	✓	✓ ⁴
Eligibility for IDEA services	X	✓ ⁵

¹²⁰ 42 C.F.R. § 431.107(b).

¹²¹ See New York Improperly Claimed \$439 Million In Medicaid Funds for Its School-Based Health Services Based on Certified Public Expenditures, 07-20-2021; A-02-18-0101; See <https://oig.hhs.gov/oas/reports/region2/21801019.asp> ; New Jersey’s Medicaid School-Based Cost Settlement Process Could Result in Claims That Do Not Meet Federal Requirements, 03-08-2022; A-02-20-01012; See <https://oig.hhs.gov/oas/reports/region2/22001012.asp>

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X= No specific program requirement

1 An IEP is defined as a written statement for a child with a disability that is developed, reviewed, and revised in accordance with IDEA's IEP requirements. See 34 C.F.R. § 300.22

2 IDEA requires that each provider is informed of: (i) his or her specific responsibilities related to implementing the child's IEP; and (ii) the specific accommodations, modifications, and supports that must be provided for the child in accordance with the IEP. See 34 C.F.R. § 300.323(d)(2)

3 IDEA requires IEPs to include anticipated frequency, location, and duration of services and modifications. See 34 C.F.R. § 300.320(a)(7)

4 IDEA requires IEPs to include anticipated frequency, location, and duration of services and modifications. See 34 C.F.R. § 300.320(a)(7)

5 LEAs must convene a meeting to develop an IEP for a child within 30 days of a determination that the child needs special education and related services; and as soon as possible following development of the IEP, special education and related services must be made available to the child in accordance with the child's IEP. See 34 C.F.R. § 300.323(c)

Overview of Medicaid Documentation Requirements

In general, any claim for FFP to the federal government must be adequately supported by underlying documentation that allows CMS and relevant oversight bodies to verify the expenditures associated with the claim. Regulations at 42 C.F.R. § 431.107(b) require that a Medicaid State plan must provide for an agreement between the State Medicaid agency and each provider or organization furnishing services under the plan in which the provider or organization agrees to keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries. In addition, the State Medicaid agency must maintain an accounting system and supporting fiscal records to ensure that claims for federal funds meet applicable federal requirements and retain the records for three years from the date of submission of the final expenditure report or longer if the audit is not resolved (see 42 C.F.R. § 433.32). Moreover, 45 C.F.R. § 75.302 Financial management and standards for financial management systems, sets forth broad record-keeping and reporting responsibilities for entities that receive federal awards. Documentation of the services performed is also necessary for internal and external audits, and State laws or regulations may have additional requirements beyond those imposed by the federal government.¹²²

As Medicaid documentation requirements are broadly applicable to all service providers, SBS providers must establish and retain service-level information that demonstrates Medicaid-enrolled students actually received the covered services for which the provider is reimbursed. To the extent States move away from requirements for providers to bill for individual claims in school-based settings, it is particularly important to retain robust service-level documentation in the event of an audit, as the specifics of a Medicaid claim for a covered service will not be available within a billing system if such claims are not submitted to such a system. Note that all interim claim methods and time study responses must provide enough information to locate this service-level documentation.

This section details federal documentation requirements related to the following:

1. Documentation to support the billing of a Medicaid direct medical service claim

¹²² 42 C.F.R. § 447.202, requiring that the State Medicaid agency must assure appropriate audit of records if payment is based on costs of services.

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2. Documentation associated with cost reporting
3. Documentation to support time study (e.g., RMTS)

The section will provide a general overview of documentation needed to support audits. Finally, the section will conclude with an overview of CMS flexibilities for documentation in the context of SBS.

2. Documentation to support Medicaid direct medical service claims

Section 2500.2 of the State Medicaid Manual (SMM) instructs States to report only expenditures for which all supporting documentation, in readily reviewable form, has been compiled and which is immediately available when the claim is filed.

Below is detail of the minimum documentation requirements for Medicaid claims. The supporting documentation file for each claim of FFP must include the following detail:

Pursuant to the SMM, Section 2500.2, supporting documentation must include at a minimum the following:

- Date of service
- Name of recipient
- Medicaid identification number
- Name of provider agency and person providing the service
- Nature, extent, or units of service
- Place of service

There are no federal requirements for procedure or diagnosis codes (e.g., HCPCS, CPT, CDT, ICD-10, etc.); however, States may have their own requirements.

Special Considerations for Documentation to Support Billing of a Direct Service:

For services provided under IDEA Part B, State Medicaid agencies and LEAs may have to maintain records of an up-to-date IEP documenting the frequency, location, and duration of services that the school-based provider provided pursuant to the IEP, as part of their billing documentation and to support costs as part of their allocations if using the IEP MER.

With regard to specialized transportation services provided under an IEP, State Medicaid agencies and LEAs must maintain documentation of the student's need for specialized transportation in their IEP.

Below is a list the types of documentation and materials that may be able to be used or combined to meet the minimum documentation requirements for claims described above and should help State Medicaid agencies and LEAs to meet the various documentation requirements needed to create a proper audit trail. State Medicaid agencies and LEAs may be able to use these types of documentation (see below), alone or considered together, to establish all elements described

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above as the minimum required documentation set. Please contact your State Medicaid agency to ensure the requirements for documentation are met in your State.

Types of Documentation

- Attendance records
- Prior authorizations
- Provider Agreements
- Evidence of provider licensure/certification
- Medical Records
- Clinical notes of services provided
- Transportation logs
- Payroll records

Best Practices and Approaches for Meeting Documentation Requirements for Direct Services:

To ensure clear and consistent billing and documentation standards and to help alleviate burden on school-based providers, States should:

- Review and update their provider billing manuals, ensuring billing and documentation requirements for providers are clear and concise, and reasonably can be met by providers furnishing SBS.
- Conduct front-line training to SBS providers on Medicaid documentation standards and audit processes.
- Ensure LEAs have adequate funding to support necessary Medicaid billing infrastructure and training. When such investments and activities are undertaken as allowable Medicaid administrative activities, federal matching funds are available.
- Consider increasing Medicaid payment rates for services provided in school-based settings to account for higher overhead costs associated with services provided in school settings, including staffing and training needs at the LEA or school.
- Track services provided in school-based settings using MMIS. These claims are important to document that covered services were actually delivered to an eligible beneficiary and can be used to trigger interim payments to LEAs under a cost reconciliation payment methodology.
- Work directly with CMS and ED, through the forthcoming TAC, to ensure State documentation requirements align with applicable federal documentation requirements.

3. Documentation associated with Cost Reporting

Providers paid using a cost-based payment methodology must maintain sufficient financial records to enable proper determination of costs payable under the program, including, as applicable, to support cost allocation using statistically sound methods. Below are the types of documentation that may be needed to meet requirements for States and LEAs that use cost-based reimbursement methodologies:

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Documentation Associated with Cost Reporting

- A finalized uniform cost report
- A copy of the CPE form (for CPE-supported expenditures)
- Cost report instructions
- Documentation of the time study methodology
- Sign-in sheets from training sessions for time studies
- Time study source documents including time study logs
- Copies of any manuals related to the time study, CAP, procedures associated with Medicaid SBS payment
- Documentation to support a Medicaid Enrollment Ratio

4. Documentation to Support RMTS

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 LEAs must maintain to support claims of payment submitted to the State Medicaid agency. The documentation for administrative activities and direct medical services must clearly demonstrate that the activities or services directly benefit the Medicaid program. In accordance with the statute, the regulations, and the Medicaid State plan, the State Medicaid agency is required to maintain/retain adequate source documentation to support Medicaid claims of FFP.¹²³ Specifically:

- Records must be made available for review by State and federal staff upon request during normal working hours.
- State Medicaid agencies are responsible for ensuring that the applicable policies are applied uniformly throughout the State and that claims submitted to CMS conform with such requirements.
- Documentation maintained in support of claims for FFP must be sufficiently detailed to permit CMS to determine whether the activities are necessary for the proper and efficient administration of the Medicaid State plan.

Best Practices regarding Documentation of Random Time Study Moments: Documentation of aspects the RMTS (and other time studies) is critical as described below. To verify the propriety of claims, documentation to support random moment sampling should include, but may not be limited to:

¹²³ See, for example: sections 1902(a)(4) and 1902(a)(6) of the Act and 42 C.F.R. § 431.17; see also 45 C.F.R. § 75.400(d) and 42 C.F.R. § 433.32(a,) which require source documentation to support accounting records, and 45 C.F.R. § 75.430(i) and 42 C.F.R. § 433.32(b) and (c), which detail retention periods for records.

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Documentation to Support Random Moment Sampling

- Sample universe determination
- Sample selection
- Sample results
- Sampling forms
- Cost data for each school district
- Summary sheets showing how each school district's claim compiled the computation of the universe
- Detail of sampling techniques used
- Data and analysis used to compute sample size
- Sample selection procedures (to include the seed number used to generate random moments)
- Definitions
- Any other forms needed to verify steps within the overall process

Samples that cannot be replicated by an independent third party are not be considered valid for purposes of using them as a basis for claiming FFP.

The State Medicaid agency or LEA must maintain documentation that clearly indicates how the time study results are determined. Accordingly, the time study methodology and instructions, as well as all records and information that support the administration and results of the study to support the claims submitted by the State Medicaid agency must be retained. Some State Medicaid agencies currently include an area on time study forms for a brief narrative description of the Medicaid activity, function, or task being performed to meet this requirement, as well as recording the case number or beneficiary name where applicable. Please see section, *Random Moment Time Study*, for further detail on RMTS.

5. Documentation for Audit Support

LEAs should produce, maintain, and furnish the following types of documents, as applicable, to aid in any Financial Management Review or audit in order to be able to provide evidence that supports a health service activity or an administrative activity as identified by a moment in a time study:

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Documentation Materials to Support Audits/Financial Management Reviews

- Prior Authorizations
- Beneficiary's medical record
- IEP
- Prescriptions/referral for IEP services
- Documentation of the service performed on the date of service including clinical notes signed and dated by provider (including service claims)
 - a. Service and diagnostic codes, start and finish time of the service
- Documentation regarding where the service was provided and who provided the service
- Medical provider qualifications associated with licensing and certification
- School attendance records for the date of service on the claim
- Transportation logs
- Payroll records associated with school personnel providing services
- Copies of contracts with medical providers
- National Provider Identification

6. Documentation Flexibilities

SBS providers have raised concerns over creating and maintaining documentation to support billing for Medicaid-covered services. In collaboration with ED and through the TAC, CMS intends to further review policies and procedures to address concerns school-providers have regarding billing and documentation. In the interim, the below represents potential billing and documentation flexibilities that providers may explore.

a) Privacy Issues under IDEA and FERPA

One recurring item raised by SBS providers is the challenge schools face with furnishing documentation to support the rendering of Medicaid services, while also ensuring compliance with privacy provisions under IDEA and FERPA.

De-identified or Masked Data:

In order to meet the documentation requirements applicable to Medicaid and to be prepared for audit, school-based providers can furnish de-identified or masked data, which has been redacted or conceals PII. To the extent possible, and to aid in relieving school-based providers of administrative burden, State Medicaid agencies that do not allow providers to use de-identified data to support payment for services should consider amending their policies to do so. If States need assistance with this matter, support can be sought via CMS and ED. As referenced above, this does not supersede existing policies on the Minimum Documentation Requirements in Medicaid.

Privacy under FERPA and IDEA and Education Records

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Part B of IDEA protects the personally identifiable information in the education records of students with disabilities and all participating agencies, including LEAs must comply with IDEA's privacy protections. Similarly, FERPA protects education records, which are defined as records that are directly related to a student and maintained by an educational agency or institution or by a party acting for the agency or institution. An educational agency or institution generally means a school district, a public elementary or secondary school, or an institution of postsecondary education such as a college or university. The law applies to all schools that receive funds under an applicable program of ED.

The FERPA regulations at 34 C.F.R. § 99.3 define PII as including but not limited to: the student's name; the name of the student's parent or other family members; the address of the student or student's family; a personal identifier, such as the student's social security number, student number, or biometric record; other indirect identifiers, such as the student's date of birth, place of birth, and mother's maiden name; other information that, alone or in combination, is linked or linkable to a specific student that would allow a reasonable person in the school community, who does not have personal knowledge of the relevant circumstances, to identify the student with reasonable certainty; or information requested by a person who the educational agency or institution reasonably believes knows the identity of the student to whom the education record relates. IDEA Part B regulation defines PII at 34 C.F.R. § 300.32 similarly and includes a "list of personal characteristics or other information that would make it possible to identify the child with reasonable certainty."

Under FERPA and IDEA, a school generally may not disclose PII from the education records of a student who is under 18 and not in attendance at an institution of postsecondary education to a third party unless the student's parent has provided prior written consent with some limited exceptions. For example, in terms of de-identified records and information, a school may release the records or information without the prior written consent of the parent after the removal of all PII, provided that the educational agency or institution or other party has made a reasonable determination that a student's identity is not personally identifiable, whether through single or multiple releases, and must take into account other reasonably available information. In addition, IDEA at 34 C.F.R. § 300.622 incorporates the FERPA exception to the general consent requirement that would permit the disclosure of PII from education records to authorized representatives of, among others, State and local educational authorities, such as a State department of education, in connection with an audit or evaluation of Federal- or State-supported education programs, or for the enforcement of or compliance with Federal legal requirements that relate to those programs. The relevance of the audit and evaluation exception would be contingent upon various State-specific elements, and States considering this approach should contact ED's Student Privacy Policy Office for assistance as well as their ED-OSEP State contact for their IDEA grant.¹²⁴

General Ratio to Allocate Cost:

Concerns with complying with FERPA and IDEA's privacy requirements generally occur when school-based providers are asked to furnish documentation to support the MER. See the cost

¹²⁴ Link to ED's Student Privacy Policy Office: <https://studentprivacy.ed.gov> Link to ED-OSEP's state contacts at <https://www2.ed.gov/policy/speced/guid/idea/monitor/state-contact-list.html> and to ED's Student Privacy Policy Office at <https://studentprivacy.ed.gov>.

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section, *General Requirements for Billing, Claiming, and Accounting for SBS Medical and Administrative Costs*, for more information on the MERs. Prior to the change in the free-care policy, most school-based providers that were reimbursed actual cost utilized an IEP-based MER as one of the allocation statistics in an overall cost identification process to compute Medicaid's portion of allowable cost. This MER includes all students with IEPs as part of their assessed disability. Though rare, students with IEPs could receive only educational (not medical) services. These students would not be included in this IEP MER. As discussed above, IEP-based MERs are usually based on the following formula:

$$\frac{\text{Number of Medicaid enrolled students with an IEP who receive medical services}}{\text{Number of students with an IEP who receive medical services}}$$

Instead of an IEP-based ratio, school-based providers have the option to use a more general MER, such as the allocation ratio that typically is used to identify Medicaid's portion of allowable cost for Medicaid services that are available broadly and generally and not specified in a student's IEP. If an LEA chooses, they could use this general MER for **all** Medicaid direct care and administrative services, for ease of administration. This general MER is the best option for allocations outside of the students with IEP MER, to capture Medicaid services. As discussed above, this allocation ratio is usually based on the following formula:

$$\frac{\text{Number of Medicaid enrolled students in the LEA}}{\text{Total number of students in the LEA}}$$

b) Use of an RMTS to Fully Identify Medicaid's Portion of Allowable Cost

RMTSs are normally structured to identify the portion of time associated with activities that are related to Medicaid-covered services. Once the RMTS statistics are applied to costs for practitioners or employees (including salaries and fringe benefits), the portion of these costs that are applicable to medical activities can then be identified. Once the MER is applied to the portion of the practitioner or employee costs that is applicable to medical activities, the portion of these costs that is applicable to Medicaid can be identified.

Instead of applying a MER to the portion of cost that is applicable to medical activities at the LEA specific level, school-based providers could restructure the RMTS coding to identify

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moments that are both applicable to a Medicaid-covered service and furnished to a Medicaid-enrolled student. This option, like any time study option, would be subject to the State or LEA demonstrating that the time study is statistically valid. This one step process would apply the RMTS statistics to the entire State in one-step to allocate costs to Medicaid, and potentially decrease administrative burden. The disadvantage would be each LEA would receive the RMTS statistics that would be a statewide average. Either the one-step or two-step processes would be used in each State, and no blending of processes should be used, as this would not allow for mutually exclusive allocations.

G. Special Considerations for Transportation and Vaccines as SBS

1. Specialized Transportation

When conducting an activity pursuant to 42 C.F.R. § 431.53, necessary transportation is an administrative activity under the plan and is matched at the standard 50 percent federal matching rate provided under section 1903(a)(7) of the Act for administrative expenditures. However, necessary transportation can also be implemented as an optional medical service under 42 C.F.R. § 440.170(a), based on section 1905(a)(31) of the Act, which provides the Secretary the authority to include in the definition of medical assistance “any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary.” Thus, States may meet the assurance of transportation requirement by providing necessary transportation as an administrative activity or as an optional medical service; when provided as an optional medical service, transportation expenditures are matched at the applicable FMAP.

As a general rule, Medicaid payment is not available for the transportation of Medicaid-enrolled students to school, even when a Medicaid-covered school-based health service is provided in the school. Education is the primary purpose of attending school, while any medical services provided in a school-based setting are a secondary purpose of the student’s presence at the school. State Medicaid agencies are required to ensure that necessary transportation is available for beneficiaries to access covered services,¹²⁵ but when the student is already present at school (perhaps through the use of LEA-provided non-specialized school transportation), it is not necessary for Medicaid to cover additional transportation to ensure access to covered services furnished as SBS. However, Medicaid payment is available for transportation to onsite SBS for students receiving services under IDEA. Specifically, section 1903(c) of the Act provides that States may not be “prohibited or restricted from receiving payment...for medical assistance for covered services...because such services are included in the student’s IEP or IFSP.”¹²⁶

¹²⁵ Section 1902(a)(4) of the Act and 42 C.F.R. § 431.53.

¹²⁶ Section 1903(c) of the Social Security Act:

(c) Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's IEP established pursuant to part B of IDEA or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part C of such Act.

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CMS policy related to reimbursement of specialized transportation expressed in prior guidance¹²⁷ remains unchanged. States must have specialized transportation specified in a student's IEP for it to be coverable by Medicaid. However, transportation not specified in an IEP is not covered because the primary benefit from ordinary school transportation is for school attendance. Ordinary school transportation is not targeted to address the student's medical needs and is not covered by Medicaid. Once at school, there is no further need for transportation. The fact that a provider was at the school and provided care to a Medicaid-covered student does not create the need for Medicaid non-emergency medical transportation. However, specialized transportation may be identified in an IEP and furnished primarily to ensure that the student's medical needs are met, including under the EPSDT benefit.

FFP may be claimed for necessary transportation when the Medicaid-enrolled student must leave the school and go into the community to receive Medicaid-covered services. FFP is available for the cost of transporting the student from school to the community provider and back to school or home, and for transporting the student from the home to the provider and then to school. The cost of transporting an aide when an aide is necessary to accompany the student can be claimed separately as personal care assistance.

SBS Specialized Transportation Policy

School-based specialized transportation is defined as transportation to a medically necessary service (as outlined in the IEP of an enrolled Medicaid beneficiary) provided in a specially adapted vehicle that has been physically adjusted or designed to meet the needs of the individual student under IDEA (e.g., special harnesses, wheelchair lifts, ramps, specialized environmental controls, etc.) to accommodate students with disabilities in the school-based setting. Note: the presence of only an aide (on a non-adapted bus/vehicle) or simple seat belts do not make a vehicle specially adapted. Specialized transportation may consist of a specially modified, physically adapted school bus or other vehicle in the specialized transportation cost pool.

The most common physical adaptations to a bus or other vehicle include: special harnesses, wheelchair lifts, and ramps, but special physical adaptations could also include air conditioning and/or specialized suspension systems, for instance. In all cases, the medical need for physical or environmental adaptations during transport from home to school and back home (or to an alternative site to receive the IEP service) must be identified in the IEP. FFP is not available for the cost of transporting a student who rides a physically adapted bus or other vehicle, but does not have a medical reason documented in an IEP to make use of the particular bus/vehicle adaptation.

For example, if a Medicaid-enrolled student requires specialized transportation in a vehicle adapted to serve the needs of the disabled, including a specially adapted school bus/vehicle, that specialized transportation may be billed to Medicaid if the need for that specialized transportation is identified in the IEP and the student receives a medically necessary Medicaid-covered IEP service in school on the day that specialized transportation is claimed (per above criteria). In addition, if a student resides in an area that does not have regular school transportation (such as those areas in close proximity to a school), but has a medical need for

¹²⁷ See Transportation, page 2. a

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specialized transportation that is noted in the IEP, that specialized transportation may also be billed to Medicaid if the criteria identified above are met. Specialized transportation from the school to a provider in the community also may be billed to Medicaid. These policies apply whether the State claims FFP for transportation under Medicaid as medical assistance or as an administrative expenditure.

An IEP should include only specialized services that a student would not otherwise receive in the course of attending school. Therefore, a student with special education needs under IDEA who does not have transportation needs included on their IEP should not have their transportation billed to Medicaid. No other students without an IEP can be included in specialized transportation for SBS.

Medicaid-enrolled students without an IEP (even those with other plans including a 504 Plan) who need to get to a Medicaid-covered service in the community should access the necessary transportation process as required and defined by the State, either as an administrative activity pursuant to 42 C.F.R. § 431.53, or as an optional medical service under 42 C.F.R. § 440.170(a), as described above.

Payment for SBS Specialized Transportation

Normally, FFP is not available for the cost of transporting students to and from school as the responsibility for this activity lies with the education program. However, FFP is available for transporting students receiving services pursuant to IDEA to and from school using the following criteria:

1. The student has a written IEP;
2. Specialized transportation (and the specific adaptation) is noted in the IEP as a medically necessary service;
3. The student is enrolled in Medicaid;
4. The student receives a Medicaid-covered IEP service on the day that transportation is claimed; and
5. The service billed only represents the costs associated with the trip on the specially adapted transportation for direct medical services (or administrative claiming) as listed in the IEP (e.g., the one-way trip).

If these criteria are met, a State Medicaid agency may pay a fee schedule rate or a cost per trip rate for SBS specialized transportation that is comprehensively described in the Medicaid State plan, as a direct service, using IGTs or appropriations to support the non-federal share. If the payments are more than the usual and customary charge in the State, CMS may ask for documentation that the rates are economic and efficient, as with other SBS. A State Medicaid agency may also opt to pay for specialized transportation under administrative claiming, and follow the process as outlined above in E. Administrative Claiming for SBS.

A State Medicaid agency may also choose to pay for SBS specialized transportation with CPEs using actual costs by creating a discrete cost pool of allowable costs related to SBS specialized transportation (e.g., bus/vehicles drivers, mechanics, fuel, maintenance, leases, insurance costs,

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depreciation, contracted costs, etc.). The State would step down these costs to Medicaid using a one-way trip ratio of: Medicaid-eligible IEP one-way trips / all one-way trips on the specially adapted vehicles in the cost pool (including any IEP and non-IEP trips taken in the vehicles). The Medicaid-covered trips are the one-way trips provided to the Medicaid-enrolled IEP students meeting the five criteria described above. If a discrete SBS specialized transportation cost pool cannot be isolated, LEAs and States should assist schools in isolating these costs. If these efforts are not possible, CMS would consider a temporary methodology that starts with all transportation costs (or some discretely defined subset of transportation costs) and reasonably allocates costs to Medicaid. This temporary methodology would need to be reviewed by CMS periodically and LEAs would be expected to continue efforts to isolate SBS specialized transportation costs to a discrete cost pool.

One example for allocating costs for specialized transportation is in the table below. Starting with all transportation costs, LEAs would allocate to SBS specialized transportation costs using the ratio of all IEP students that have specialized transportation in their IEP / all students in LEA (or the following ratio: all one-way trips of all IEP students that have specialized transportation needed in their IEP / all students' one-way trips for all transportation in LEA (See note on estimating this using the formula below.)). If an LEA wants to limit the cost pool to a discrete number of specialized transportation vehicles, instead of the entire fleet, they may do so. This would require a careful count of the one-way trips on just the vehicles included in the cost pool. This would further be allocated to Medicaid using the ratio the total number of eligible one-way trips for Medicaid-enrolled IEP students with an IEP that includes transportation in their IEP / all transportation one-way trips in the LEA (including all possible one-way trips in the LEA consistent with the vehicles included in the cost pool). This methodology allows an estimation of the all possible one-way trips in the LEA to be calculated using the formula (all students in the LEA x number of school days x two trips per day). This is a conservative estimate, but also allows for a less administratively burdensome estimation of the total number of one-way trips. If the data are available, an LEA may use all one-way trips for IEP students in the LEA as the denominator. This requires a careful count of all eligible IEP student one-way trips in the LEA, but could provide a better estimation of the costs to Medicaid.

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Example of Allocating costs to Medicaid

In Specialized Transportation (current policy for allocating to Medicaid)

1. Create a discrete cost pool for specialized transportation of any costs related to specialized transportation (e.g., bus drivers, mechanics, fuel, maintenance, leases, insurance costs, depreciation, contracted costs, etc.,).
2. Step down to Medicaid using the ratio Medicaid- eligible IEP 1-way trips / ALL 1-way trips on the specially adapted vehicles in the cost pool (including any IEP and non-IEP trips taken in the vehicles). (The numerator is the 1-way trip provided to the Medicaid enrolled IEP students meeting the 5 circumstances described above)

Specialized Transportation (when no separate cost pool from the general transportation cost pool can be established- generally only a temporary methodology used for a limited time in order to convert to the above methodology. This could also be limited to the number of specially adapted vehicles used to provide specialized transportation that also provide transportation to general education students, provided other costs can be isolated to these vehicles.)

1. Create a cost pool of ALL transportation allowable costs (e.g., bus drivers, mechanics, fuel, maintenance, leases, insurance costs, depreciation, contracted costs, etc.,).
2. Step down to specialized transportation using the ratio of all IEP students that have specialized transportation needed in their IEP / ALL students in LEA (or the ratio all 1-way trips of all IEP students that have specialized transportation needed in their IEP / ALL students' 1-way trips for ALL transportation in LEA.
3. Further step down to Medicaid using the results of step 2 by the ratio- the total number of eligible 1-way trips for Medicaid-enrolled IEP students with an IEP that includes transportation in their IEP / ALL transportation 1-way trips in the LEA (limited to ALL possible 1-way trips in the LEA, consistent with the vehicles included in the cost pool). This methodology allows an estimation of the ALL possible 1-way trips in the LEA to be calculated using the formula (all students in the LEA x number of school days x 2 trips per day). If data are available an LEA may use all 1-way trips for IEP students in the LEA as the denominator.

Example for accounting for eligible one-way trips for allocating specialized transportation to Medicaid:

A specially adapted bus/vehicle carries 12 students on the bus/vehicle in the morning going to school. 10 students have IEPs. Of these 10, 6 are enrolled in Medicaid. All of the Medicaid-enrolled students have IEPs, but only 4 of these have specially adapted transportation written as a required service in their IEPs. Of these, only three received a required IEP medical service at school on the day of the transportation.

In the above example, there would be a total of 12 one-way trips and 3 of these one-way trips would be eligible for Medicaid payment. Therefore, the one-way trip ratio would be:

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Numerator- 3 Medicaid-covered one-way trips / Denominator- 12 total one-way trips = 25 percent, for this example as an allocation to Medicaid. So, 25 percent of the costs associated with the morning trip to school for this specially adapted bus/vehicle would be 25 percent of the total costs.

These examples of allocations to specialized transportation and to Medicaid are examples of allocation methodologies currently in use and do not represent the entire universe of possible approvable allocation methodologies. Generally, CMS works closely with State Medicaid agencies on allocation methodologies to arrive at a reasonable methodology that accurately reflects the actual costs of providing the Medicaid-covered services.

2. “Vaccines for Children” Program and Impact on Claiming

Vaccine doses distributed to providers under the Vaccines for Children (VFC) program are federally purchased. Therefore, there is no need to provide separate Medicaid coverage of these vaccine doses, and VFC providers may not impose a charge for the cost of the vaccine dose when vaccinating a VFC-eligible child. However, section 1928(c)(2)(C)(ii) of the Act allows VFC providers to impose a fee for the administration of a VFC vaccine as long as the fee, in the case of a VFC-eligible child, does not exceed the cost of such administration (as determined by the Secretary based on actual regional costs for such administration). Generally, Medicaid-enrolled VFC providers, including schools, would charge the State Medicaid program this administration fee when the administration of a VFC vaccine is covered under Medicaid. In a school setting, this can have specific implications for claiming and for Medicaid payment.

Impact of the VFC on SBS Reimbursement Practices

- The cost of VFC-covered, federally purchased vaccine doses cannot be included in the pool of allowed cost certified by a LEA as either a direct or indirect cost.
- This limitation must be reflected in any time study used to allocate cost for the purpose of identifying cost eligible for certification.

H. Third Party Liability

THINGS TO CONSIDER:

- *States may suspend or terminate efforts to seek reimbursement from a liable third party if they determine that the recovery would not be cost-effective pursuant to 42 C.F.R. § 433.139(f), including for IDEA or 504plan services. This could ease administrative burden at schools.*
- *States may exempt certain items or services from TPL requirements when submission of claims for those items or services would always result in denial.*
- *States may elect not to identify or follow up on specific diagnoses and trauma codes, based on experience that the codes have proven not to identify liable third parties nor generate collections.*

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- *State Educational Agencies can elect to pay a third party's liability using its own funds.*
 - *States may use billing agents or other contractors to assist with billing.*
-

A third party is any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance for Medicaid-covered services furnished under the Medicaid State plan.¹²⁸ Under Medicaid law and regulations, Medicaid is generally the payer of last resort (exceptions to this general rule are discussed further below). Congress intended that Medicaid, as a public assistance program, pay for health care only after a beneficiary's other health care resources have been exhausted.

State Medicaid agencies are required to take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the Medicaid State plan.¹²⁹ Such measures include specific requirements to identify and recover payments from liable third parties. These third parties, as defined in law, include health insurers, MCPs, group health plans, and any other party that is legally responsible to pay for care and services. State Medicaid agencies are required to integrate pursuit of TPL payments with mechanized claims processing and information retrieval systems used to administer Medicaid programs. Furthermore, State Medicaid agencies must require Medicaid applicants to assign to the State their rights to medical support and third-party payments as a condition of Medicaid eligibility. Applicants for Medicaid must cooperate in identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.¹³⁰

The below sections discuss the general rule around payment of claims where TPL exists, as well as significant exceptions for preventive pediatric services, medical student support services, and Medicaid-covered services listed on a Medicaid eligible student's IEP.

1. Payment of Claims and Cost Avoidance Requirements

There are specific requirements in statute and regulations regarding the payment of claims by the State Medicaid agency if it is determined that TPL exists.

If the State Medicaid agency finds that TPL exists, the State Medicaid agency generally must reject (but not deny) the claim. When a State Medicaid agency rejects a claim because of known or suspected TPL, it typically sends the claim back to the provider noting the third party that Medicaid believes to be legally responsible for paying the claim. The provider should then bill the legally liable third party. If a balance remains after the third party has paid the provider or denied payment for a substantive (i.e., non-procedural) reason, the provider can submit a claim to the State Medicaid agency for payment of the balance, up to the maximum Medicaid payment amount established for the service in the Medicaid State plan.

¹²⁸ See 42 C.F.R. § 433.136.

¹²⁹ See Section 1902(a)(25) of the Act and implementing regulations at 42 C.F.R. § 433.138.

¹³⁰ See Section 1902(a)(45), 1912 of the Act and implementing regulations at 42 C.F.R. § 433.148.

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If TPL exists but does not cover the specific Medicaid services provided, the provider would have to furnish documentation to the State Medicaid agency that, although TPL generally exists for the beneficiary, there is no coverage for the services provided. After the documentation is given, the provider does not have to continually pursue TPL for the services provided which are not covered by the third party. At this point, the claim could be submitted to, and paid by, the State Medicaid agency. The provider would need to establish annually thereafter that coverage for those non-covered services has not changed. Many services covered by State Medicaid agencies under their Medicaid programs are not covered by otherwise liable third parties of Medicaid beneficiaries. As such, the provider would not need to pursue TPL every time the service was furnished as long as it was demonstrated such coverage is not available by otherwise liable third parties.

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

Generally, State Medicaid agencies are required to use the cost avoidance method (described below) if probable TPL is established at the time the claim is submitted to the State Medicaid agency. However, the State Medicaid agency must use the pay and chase method (also described below) when certain exceptions apply, the two most important of which are medical child support and preventive pediatric services.

2. Cost Avoidance

Federal regulations at 42 C.F.R. § 433.139(b)(1) concerning the cost avoidance requirements state:

“If the agency has established the probable existence of third-party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability. The establishment of third-party liability takes place when the agency receives confirmation from the provider or a third-party resource indicating the extent of third-party liability. When the amount of liability is determined, the agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.”

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

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Federal regulations at 42 C.F.R. § 433.139(e) permit State Medicaid agencies to obtain a waiver of cost avoidance method of payment of claims and instead use the pay and chase method. To do so, the State Medicaid agency has to demonstrate that the cost avoidance method of payment of claims is not cost-effective. An activity would not be cost-effective if the cost of the required activity exceeds the TPL recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the State Medicaid agency. Therefore, the State Medicaid agency must demonstrate that the total cost of using the cost avoidance method of payment of claims exceeds the total TPL recoupment, and that the cost avoidance method of payment of claims accomplishes, at the same or higher cost, the same objectives as using the pay and chase method of payment of claims. Waivers of the cost avoidance method of payment of claims are rare.

3. Pay and Chase - Preventive Pediatric Services and Medical Child Support Services

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

State Medicaid agencies must use pay and chase, rather than use cost avoidance, when the claim is for medical child support services or preventive pediatric services that are covered in the Medicaid State plan. The intent of this requirement is to alleviate the administrative burden associated with TPL efforts so as not to discourage participation in the Medicaid program by physicians and other providers of these types of services, since beneficiaries in need of such services may have difficulty finding providers in many communities. State Medicaid agencies are given discretion to define the list broadly.

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

4. Exception to Medicaid as the Payer of Last Resort – Medicaid-covered Services on a Medicaid Eligible Student’s IEP

There are a few exceptions to the general rule that Medicaid is the payer of last resort, and these exceptions generally relate to federal-administered health programs. For a federal-administered program to be an exception to the Medicaid payer of last resort rule, the statute creating the program must expressly state that the other program pays only for claims not covered by Medicaid; or, is allowed, but not required, to pay for health care items or services.

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Section 1903(c) of the Act permits an exception to the TPL requirements for Medicaid-covered services included in a Medicaid eligible student's IEP. This means that Medicaid will pay primary, or prior to federal IDEA funds for Medicaid-covered services listed in a student's IEP.

Although the Medicaid program pays first for covered IDEA services, these services are still subject to the TPL requirements applicable to any other services furnished under the State Medicaid program. The State Medicaid agency must still pursue payment for TPL as Medicaid is secondary to all other sources of payment.

5. Impact of the TPL Requirements on School-Based Providers

While IDEA ensures eligible students with disabilities receive a FAPE, it does not create exceptions to Medicaid requirements and procedures or expand the scope of Medicaid responsibility or coverage. Therefore, schools or their health practitioners who seek to bill the Medicaid program for reimbursement for health services must meet federal and State Medicaid provider qualifications, including requirements to bill third parties.

In addition, schools must abide by the payment of claims provisions at 42 C.F.R. § 433.139 where liable third parties are involved. This means that, as a Medicaid provider, schools may be required to bill the beneficiary's health insurance first before billing Medicaid to determine the extent of the insurer's payment liability for services. If, under Medicaid, the services meet one of the regulatory exceptions, the State Medicaid agency may pay up to the maximum Medicaid payment amount established for the service in the Medicaid State plan and seek recovery of reimbursement from the liable insurer. For medical child support and preventive pediatric care services, the school provider may bill the State Medicaid agency, which will pay the claim, and the State Medicaid agency will seek reimbursement from a liable third party.

Medicaid does not have an interest under its TPL requirements concerning which person, organization or agency pays the third party's liability. Thus, if the SEA elects to pay the third party's liability through its own funds, that is permissible under the Medicaid statute. For example, if a particular service, such as PT, is billed at \$50 and any private insurance coverage is available to meet \$40 of that payment, then Medicaid's payment is the difference between the Medicaid payment rate and third-party payment, assuming the Medicaid rate is higher. The SEA may elect to satisfy the \$40 liability. However, if Medicaid erroneously paid the \$50 in the first instance and later discovered the beneficiary had private insurance coverage, the Medicaid agency must pursue recovery from the third party. If the State Medicaid agency or LEA assumes the liability of the third party, Medicaid payment could be made minus the amount assumed on behalf of the third-party payer.

VII. Random Moment Time Study

THINGS TO CONSIDER:

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- *Most schools use a RMTS to determine how much time school staff spend performing Medicaid reimbursable work activities.*
 - *A RMTS must reflect all of the time and activities (whether allowable or unallowable under Medicaid) performed by school employees.*
 - *School-based providers should carefully consider time study elements such as: sample design, identification of a sample universe, RMTS error rate, sample size, RMTS intervals (including treatment of summer period), and activity codes.*
 - *School-based providers should also implement RMTS by developing a sampling plan, developing training to staff, and ensuring adherence to guidelines, including: appropriate notification and response periods, response rates, validation, oversight and monitoring, compilation and analysis of sample results, and documentation.*
 - *New Flexibility: RMTS methodologies may use a 5 percent error rate with a 95 percent confidence level for SBS direct service RMTS sampling to align with SBS administrative claiming RMTS policy. This will decrease minimum sample moments from 2401 to 385 for each time study interval.*
 - *Clarification of Flexibility: CMS encourages immediate notice to time study participants but up to 48 hours advance notice may be appropriate in circumstances where immediate notice is not possible.*
 - *Policy clarifications: Staff substitutions may be permitted with certain caveats if vacant positions are filled or existing positions are updated with replacement staff during the time study period. For any new positions that are created after the participant selection is completed for a particular study period, the position/individual would be included in the universe for the next interval's time study.*
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A. Overview

A RMTS is a statistically valid sampling methodology that can be used by States and LEAs to determine how much time eligible staff spend performing Medicaid reimbursable work activities. The RMTS is used to determine a statistic that is applied to salary and fringe benefits for qualified providers, reported on a cost report for direct medical services. In contrast, administrative activity claiming is determined by application of the RMTS statistic to applicable administrative cost pools, but as discussed above, no cost reports are submitted to CMS and there is no final cost reconciliation for administrative expenditures. RMTS is permitted under 45 C.F.R. § 75.430(i)(5),¹³¹ and with the exception of hospitals and institutional providers, the RMTS must be approved by the federal cognizant agency and CMS.¹³² A RMTS must reflect all

¹³² Note that States should submit changes to design for CMS approval prior to implementation. For example, during the COVID-19 PHE, some States submitted amendments to their RMTS design to allow exceptions to account for changes in school conditions. See 45 C.F.R. § 95.517.

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of the time and activities (whether allowable or unallowable under Medicaid) performed by school employees, who often perform both direct services (e.g., medical, vocational, or social services; teaching) and administrative activities (e.g., outreach or care coordination). Consistent with 45 C.F.R. § 75.430(i)(5), these staff are randomly selected and carefully document all the work they do – only some of which may be Medicaid reimbursable – during a specific, randomly selected time interval. Each activity is then assigned an activity code that clearly distinguishes direct services from administrative activities. The results of the study are then used to estimate total effort for school employees in the same position designations, and who participate in Medicaid activities as a function of their job duties. Ultimately, the methodology results in a percentage of time that is applied to direct service costs and administrative activity costs as a first step in determining an appropriate claiming allocation to Medicaid.

When developing a RMTS, States or LEAs should carefully consider time study elements such as: sample design, identification of a sample universe, RMTS error rate, sample size, RMTS intervals (including treatment of the summer period), and activity codes (including using a parallel coding structure to distinguish Medicaid activities from similar activities that are not-Medicaid reimbursable, ensuring avoidance of duplicate claiming or cost-counting, and providing examples). States or LEAs should also provide training to staff to ensure adherence to guidelines, including appropriate notification and response periods, response rates, validation, oversight and monitoring, compilation and analysis of sample results, and documentation.

While a RMTS is typically used to identify and allocate personnel costs, entities should be aware of other allowable methods to claim personnel costs, including the use of employee worker logs and contractual agreements where contract staff are used in the delivery of Medicaid-covered services or performance of Medicaid allowable administrative activities. Additionally, while sampling typically comprises samples from the same time period for which claims are being made, in limited circumstances, results from one period can be used to support claims from prior periods through a process called “backcasting.”

Below, we further detail RMTS concepts and considerations that school-based providers, SEAs, LEAs, and State Medicaid Agencies should review when designing and implementing a RMTS for Medicaid school-based claiming.

B. Designing a RMTS

When designing a RMTS, States and LEAs should carefully analyze their operations to identify the universe (i.e., all employees whose costs are to be allocated), programs/services within the universe, sample objectives, factors that could cause bias in a sample (e.g., the use of flex schedules), and considerations for addressing potential bias. New flexibilities aligning the RMTS error rates (discussed below) strengthen the rationale to conduct unified time studies (i.e., including direct medical and administrative activities in the same time study) thereby safeguarding against duplication of claiming. States may conduct separate time studies for different cost pools.

To ensure that a RMTS reflects all of the activities performed by the time study participants, the State and school districts should work together to establish a master list of activities that are

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performed by time study participants and by the programs in which time study participants engage during the work day (that is, the programs in service of which the time study participants perform the activities that make up their work day). The State should then determine which of the activities are allowable as Medicaid-covered services and administrative activities.

The SBS Claiming Time Study Implementation Plan should include sufficient information for a thorough review of the RMTS design. See *SBS Claiming Time Study Implementation Plans* section V.E.8. for additional details about the SBS Claiming Time Study Implementation Plans.

1. Identification of the Sample Universe or “Participant List”

The RMTS sample universe (or Participant List) should include all staff who potentially perform Medicaid direct service or administrative activities, subject to the limitations below. A list of all employees, their activities, and their job titles should be kept on file and updated prior to the start of each time study period (e.g., quarterly or monthly). In determining the universe of participants for the time study, entities should consider which employees should be included in the sample universe, which costs of such employees should be included in the cost pool(s), and whether costs are funded by sources other than the Medicaid program.

Allocation of certain costs, funded by sources other than the Medicaid program, may need to be offset from costs allocated 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 for allocation to Medicaid are offset by the funds from the educational grant program (both the federal educational grant funds and any non-federal share required to be contributed under the terms of that grant).

If a time study participant’s salary is wholly funded by third party dollars (such as other Federal grants or private foundations), the staff person cannot 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 amounts from third party sources need to be applied in offsetting the costs allocated to 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 whether the costs are funded by other non-Medicaid sources, (and whether such funding requires an offset or exclusion of costs from the cost pool) must all be considered in determining the universe of participants for the time study.

In some instances, school employees who provide direct medical services may also perform Medicaid administrative activities. Examples of such employees can include nurses, physical therapists, and other specialized instructional support personnel and teacher aides. However, if the costs of such staff are completely offset (see *Offsetting 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 staff, then there would be no reason to include such staff in the

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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 staff from the sample universe. For example, medical staff hired by schools as contractors¹³³ and paid on a fixed fee basis (e.g., audiologists paid a set amount for each hearing test performed) who do not perform any other administrative activities should not be included in the time study. Such staff should not be included in the sample universe and therefore, their costs would be excluded from the base cost pool to be allocated.

Under certain conditions, a State may include vacant positions in the participant roster. If there are vacant positions on the finalized list that may be filled during the study period, as well as existing positions that may be updated with replacement staff, the State may include substitutions, with caveats. If such positions are filled during the study period, that individual may participate in the time study if they have been trained on the time study process. In such cases, the newly hired time study participant would complete the time study moment(s) (if sampled), and actual costs incurred for the position(s) during the time study would be eligible to be reported. In such cases, the State agency's sampling process must retain accountability over substitutions for vacancies and an audit trail should be maintained. For any new positions that are created after the participant selection is completed for a particular study period, the individual would be included in the universe for the next interval's time study. For departing staff, if a vacated position is not filled before the end of the study period, then only those proportional costs incurred during the portion of the study period they were employed would be allowable in the cost pool. The cost data and time study should be updated before each study period to add new hires and remove transfers and terminations.

The random moment sampled should be structured such that every moment in the workday sample universe has an equal probability of being selected. In addition, the sample design should cover the entire time period used to claim FFP in the reporting period and capture 100 percent of the staff activities. The total number of moments sampled is based on the selected error rate and confidence levels.

The scope of the sample universe of moments includes all working days in the reporting period but does not include periods when school is closed and staff are not working, such as holidays. Any day that an employee is paid must be counted as a work day for the purpose of determining the sample universe. If an entity wishes to exclude certain days, weeks, or other periods from the universe, then the associated costs must also be excluded from cost reporting and are not eligible for FFP.

The entity should use each employee's individual schedule rather than a standardized work day (which may not reflect all individual employees' actual work activities) in the sample, considering actual hours worked and accounting for any "flex time" or similar arrangements that may vary an employee's start and stop times. Consistent with 45 C.F.R. § 75.430(i)(5), the time study should capture 100 percent of the time of each participant's daily work activities. As a

¹³³ See [Contractual Arrangements](#) section for additional information regarding contractors.

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result, the selection of random moments should be inclusive of all paid time spent during the work day, including lunch, but excluding an unpaid lunch break. In addition, in a residential school setting, the entity should use the individual's schedule, even if the individual works non-standard hours over an extended period of the day.

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.

2. RMTS Error Rate

For statistical validity, pursuant to 45 C.F.R. § 75.430(i)(5)(i), CMS has historically required a 95 percent confidence level with an overall error rate (or precision level) of +/- 2 percent in determining the sample size for the number of random moments to be selected for direct medical services RMTS. With regard to time studies that are only applicable to State program administrative activities, CMS has allowed a 95 percent confidence level with an overall error rate of +/- 5 percent.

In order to allow States the ability to conduct a unified RMTS for administrative activities and direct medical services, CMS prospectively will approve Medicaid SBS Claiming Time Study Implementation Plans that use a 95 percent confidence level with a +/- 5 percent overall error rate for all time studies. While still adhering to 45 C.F.R. § 75.430(i)(5)(i), this policy reduces the sample size required for the RMTS and is intended to reduce administrative burden for States implementing Medicaid cost allocation systems. If a State changes methodology to align with this new flexibility of +/- 5 percent overall error rate, then the State should submit a revised Medicaid SBS Claiming Time Study Implementation Plan to CMS for review and approval. Currently, this flexibility is only available for use in Medicaid SBS because the BSCA has directed CMS to reduce administrative burden and support Federal compliance with billing and payment for States. CMS would expect to release additional guidance before extending the flexibility to other Medicaid contexts besides SBS.

3. Sample Size

The sample size used to allocate administrative costs should be sufficient to ensure the time study results meet a 95 percent confidence level with an overall error rate of +/- 5 percent pursuant to 45 C.F.R. § 75.430(i)(5)(i) (as described above). In addition, 0.5 should be the maximum anticipated rate of occurrence of the activities being observed.

Thus, the formula to calculate the required sample size to meet CMS requirements is:

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RMTS Sample Size Calculation

$$n = p(1-p) / (d/z)^2$$

Where

n = sample size

p = maximum anticipated rate of occurrence of the activities being observed

d = desired error rate

z = 95 percent confidence level factor (equal to 1.96)

Prior to generating extra sample moments to compensate for factors such as flex time, the above formula using the given specified parameters (p=0.5, d=.05, z=1.96) produces a recommended minimum sample size of 385.

4. Oversample

All completed responses should be used in a RMTS. CMS allows for the use of an alternate methodology in cases where the Time Study Implementation Plan specifies an oversample to ensure an adequate number of valid responses for the treatment of time study non-responses are achieved. The alternate methodology CMS historically has approved uses an 85 percent valid response rate. If the response rate is above 85 percent, nonresponses may be discarded and not included in the time study results. However, if the valid response rate is below 85 percent, CMS has required **all** non-responses to be included and coded as non-Medicaid (not simply enough responses to reach the 85 percent response rate, but 100 percent of nonresponses). The reason for this policy is to encourage compliance with the time study process. If the 85 percent response rate is not achieved and the non-responses are all included and coded as non-Medicaid, thus bringing down the claimable percentage, it should serve as an incentive to the State to mitigate and avoid excessive non-responses becoming a recurring issue.

CMS recommends an oversample of 15 percent to ensure an adequate number of valid responses are received and to meet the required precision level. Note that the oversample only may be used to compensate, but not substitute, for the potential number of nonresponses. As noted above, completed time study responses should not be discarded or ignored, and all non-responses should be included in the time study results, except in cases as permitted in the State's approved SBS Time Study Implementation Plan.

If using the recommended minimum sample size of 385, incorporating a 15 percent oversample would increase the sample size to 443 (385 + .15*(385)). The standard number of moments, plus the oversample, is the total number of moments to be sampled.

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Workers who do not respond to their sampled time moment may still be included in the study as discussed below in the “VII.C.4. “Response Rate.” Additionally, activity codes should be established to fully account for vacations, sick time, lunch hours, and other paid time not at work. If those chosen for the time study are absent during the reporting period, the absence should be reported on the time study and the related costs included in the cost pool.

CMS requires a description of the treatment for nonresponse in the SBS Time Study Implementation Plan. As a general principle, any alternate methodology for the treatment of nonresponses must be statistically valid. Alternate methodologies need to be submitted to CMS for review and approved prior to implementation.

5. RMTS Intervals

a) Time Study Intervals

A time study interval is the period of time during which a random moment can be selected to survey. The time study interval can be a calendar quarter or other period of time as needed. If there are multiple intervals during the cost year, and ultimately an average of time studies is used for claiming, then the time study intervals that are averaged should be the same length. The same number of moments are sampled during each interval.

Pursuant to 45 C.F.R. § 75.430(i)(5), a State must assure that the sample universe from which the moments are selected cover the entire school year (the time study moments cannot be selected from an arbitrary time period, e.g., November to February, and applied across the entire school year). States must conduct a time study in at least three out of four quarters (typically August through June or the school year).¹³⁴ In certain situations (e.g., the summer period), States can average results of time studies conducted during the cost year (meaning average the three prior same school year quarters to derive the summer period) as discussed below.

b) Treatment of Summer Period

For the purposes of RMTS, the summer break, known as the “summer period,” is distinguished from the regular school year. The summer period refers to the period between the end of one regular school year and the beginning of the next regular school year.

Due to the structure of school years, CMS policy allows quarterly time studies to be conducted three times per school calendar/cost reporting year, and allows schools to use an average of the three prior quarter’s results for the summer months (“summer period average”). Since schools typically spread salaries over 12 months for many employees, the average of the prior months’ RMTS statistics can be applied to the costs that accrue during the summer period. However, if there are any Medicaid-covered services or allowable activities that occur during the summer months, a time study for the summer months must be conducted. For example, many schools have End of School Year (ESY) programs that allow students with IEPs to continue to receive SBS throughout the year.

¹³⁴ See 2 C.F.R. § 430(i)(5)(i)(B) and (C).

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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 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.

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

Scenario 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.

Scenario 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.

Scenario 3. If the regular school year begins in the middle of a calendar quarter (e.g., 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 the potential days to be chosen for the time study must begin with August 31st.

Scenario 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.

States must address the treatment of the summer period in their Time Study Implementation Plan, including the practices of the applicable claiming unit related to the summer period.

In a typical cost report, States average Medicaid school-based RMTS interval results to create one percentage to claim direct service costs. That may be an average of three periods, or, if there is a summer period time survey, it may be an average of four.

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6. Activity Codes

Activity codes are used to capture 100 percent of activities performed by school employees. These codes allow for clearly distinguishing allowable Medicaid functions from non-allowable functions, and direct services from administrative activities. The latter is important because employees often perform both direct service and administrative activities.

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 claiming entity provides a medical service, the practitioner should not bill separately for the cost of a referral to a specialist provider as an administrative expense. These activities are included and paid for as part of the medical service, with FFP available at the appropriate FMAP when all applicable requirements are met.

To ensure that all time study participants are appropriately reflected in the time study, staff classifications and associated supporting documentation (such as position descriptions) for participants should also be reviewed and considered in developing time study activity codes. This will also help ensure that the unique responsibilities and functions performed by participants, as well as programs applicable to participating schools or school districts, are accounted for and included as appropriate in time study activity codes.

a) Parallel coding structure

The use of a coding structure that includes parallel Medicaid and non-Medicaid activity codes ensures that the time study captures 100 percent of time and appropriately allocates activities that benefit both Medicaid and non-Medicaid programs. These specific parallel time study activity codes not only ensure all activities performed by the time study participants are captured, but that Medicaid activities are distinguished from similar activities that are not payable by Medicaid. An example of activity that is not payable by Medicaid would be making referrals to social and educational services such as child care, employment, job training, and housing; one code might be used for that activity regardless of whether it is performed for a Medicaid beneficiary or not. However, a parallel coding structure would use separate codes for making referrals to Medicaid-coverable medical services, since that activity can be covered by Medicaid; in this example, one code would be used for making referrals to medical services for a Medicaid beneficiary and a different, parallel code for performing the same activity for a non-Medicaid beneficiary.

b) 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

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CMS's position on what is a duplicate payment in the event of a disallowance by requesting CMS reconsideration and/or through appeal to the HHS Departmental Appeals Board (DAB).¹³⁵

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

- 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 is already reflected in the payment rate for medical assistance services and may not be claimed separately as an administrative cost.
- Activities that have been, or will be, paid for as a medical assistance service (or as a service of another (non-Medicaid) program) (See *Section Cost Principles for SBS Direct Medical Service Claiming and Administrative Claiming Used in CPEs* on performing direct services vs. administrative activities).
- Activities that already have been claimed as a Medicaid administrative cost.
- Activities that are included as a part of managed care capitation rates and are paid for by an MCP.

c) Activity code examples

The universe of activity codes used in the time study must capture the following categories of activities:

1. **Unallowable** - the activity is unallowable as an administrative activity or direct service under the Medicaid program. This is regardless of whether or not the population served includes Medicaid eligible individuals. For example, an activity the sole purpose of which is to provide a general education to a student.
2. **Allowable: Total Medicaid (100 percent attributable to Medicaid; sometimes referred to as “not discounted”)** - the activity is solely attributable to the Medicaid program and as such is not subject to the application of the MER;
3. **Allowable: Proportional Medicaid Share (activities or services to which the MER or similar allocation statistic must be applied)** - the activity is allowable as an administrative activity or direct service under the Medicaid program, but the allocable share of costs must be determined, e.g., by applying the percentage of the Medicaid-enrolled population included in the time study; and/or
4. **Allowable: Reallocated Activities** – those activities which are reallocated across other codes based on the percentage of time spent on allowable/unallowable administrative

¹³⁵ See 42 C.F.R. § 430.42.

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activities.¹³⁶ The time study code that is reallocated in the school-based environment is typically referred to as General Administration and it includes only administrative activities that cannot be otherwise classified, such as lunch breaks and performing administrative or clerical activities related to general building or district functions or operations. See Appendix for additional examples. 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.

These categories are reflected in the following codes:

- U = Unallowable
- TM = Total Medicaid
- PM = Proportional Medicaid
- R = Reallocated Activities

The following is an example of a coding scheme for a school-based setting and may not reflect the full scope of activities undertaken by the claiming entity, or the applicable FFP rates. See Appendix for more discussion on these Administrative Codes.

Staff should document time spent on each of the following activities. Coders may only select one code for a given moment.

Code	Code Text	Activity	Direct Service Indicator	MAC Indicator
	Prov Services	PROVISION OF SERVICES		
1A	Outreach	Non-Medicaid Outreach	U	U
1B	Outreach	Medicaid Outreach	U	TM/50 percent
2A	Enrollment	Facilitating Non-Medicaid Eligibility Determination	U	U
2B	Enrollment	Facilitating Medicaid Eligibility Determination	U	TM/50 percent
3	Educational Services	School Related and Educational Services	U	U

¹³⁶ If 20 moments are “reallocated activities,” then the school can divide those up and allocate proportionally to the percentages of moments found in the other codes. For example, if code 1 has 30 percent, code 2 has 30 percent, code 3 has 30 percent and code 4 has 10 percent of the moments, then the reallocation of the 20 moments should be 30 percent to code 1, 2, and 3 and 10 percent to code 4.

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4A	DirNonIEP	Direct Medical Services- Not Covered as IDEA/IEP Services, Not Covered on a Medical Plan of Care and Not Meeting State Coverage Criteria (e.g., Not Medically Necessary)	U	U
4B	DirMedIEP	Direct Medical Services- Covered as IDEA/ IEP Services, Not Covered on a Medical Plan of Care	PM (IEP Ratio)	U
4C	DirMedFreeCare	Direct Medical Services – Covered on a Medical Plan of Care, Not Covered as IDEA/ IEP service	PM (MER)	U
5A	Transportation	Transportation Non- Medicaid	U	U
5B	Transportation	Medicaid Transportation	U	PM/50 percent
6A	Translation	Non-Medicaid Translation Services	U	U
6B	Translation	Medicaid Translation	U	PM/50 percent
7A	Planning	Non-Medical Program Planning, Policy Development, and Interagency Coordination	U	U
7B	Planning	Medical Program Planning, Policy Development, and Interagency Coordination	U	PM/50 percent
8A	Training	Non-Medical/Medicaid Related Training	U	U
8B	Training	Medical/Medicaid Related Training	U	PM/50 percent
9A	Referral	Referral, Coordination, and Monitoring of Non- Medicaid Services	U	U
9B	Referral	Referral, Coordination, and Monitoring of Medicaid Services	U	PM/50 percent

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10	GA	General Administration	R	R
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Activity codes should represent the actual duties and responsibilities of participating school or school district employees, consistent with the operational principles discussed above. The *Appendix: Activity Codes* provides examples of appropriate activity codes. These activity codes represent a model set of activity categories, including administrative activities and direct services, that may be used and adapted to reflect the State’s specific program environment, etc. While recommended for use by States, States and schools have flexibility in applying these activity codes. Similarly, certain activity codes and/or the examples included under particular activity codes may not be applicable to some school-based administrative claiming processes. These activity codes may be modified by States working with their LEAs 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 guidance.

C. Implementing RMTS

1. Sampling Plan

A sampling plan is a document that is used to execute the sample design and operationalize the RMTS. An element of a Medicaid Time Study Implementation Plan (as discussed in *SBS Claiming Time Study Implementation Plans* section), the sampling plan contains a detailed outline of which measurements will be taken at what times, on which material, in what manner, and by whom. A statistical sampling plan follows the laws of probability, allowing one to make valid inferences about a population from the statistics of the samples taken from it. It also allows the claiming entity to determine in advance the magnitude of the sampling errors.

The sampling plan should contain all the elements for a RMTS for the period. It can be used akin to a checklist to re-create the study if it is audited after the study conducted. It contains items such as:

- Sample design
- Sample universe
- Error Rate
- Sample size, including its derivation
- RMTS intervals
- Activity codes

The RMTS process is described as four steps:

1. Identify total pool of time study participants
2. Identify total pool of time study moments
3. Randomly select moments and randomly match each moment to a participant
4. Notify participants about their selected moments

The following elements of the sampling methodology must meet CMS requirements for statistical validity, consistent with 45 C.F.R. § 75.430(i)(5):

- An explanation of how the sample is drawn;

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- The description of the sample universe, cost pool, and valid moments;
- A narrative that defines the period of the time study, including the start date and any dates excluded from consideration; and
- The notification process for participants.

2. Training for Staffing Time Study

Appropriate training should be provided to all employees participating in the RMTS before sampling begins. Employees should be aware of relevant internal controls, time study procedures and protocols, documentation requirements, oversight and monitoring procedures, and claiming requirements, including the level of detail needed in documentation of activities. Appropriate training will help to ensure that the data collected are consistent and accurate and will enhance the reliability of the study results.

Staff may be trained before or after they are selected for inclusion in the time study, but prior to their first sampled moment. There should be a mechanism in place to assess how often training is required and to revise the training schedule as needed. The frequency of training should also consider staff turnover. To ensure consistent application, all training documentation, including the schedule of training on sampling and documentation expectations, as well as the activity code guide should be maintained and available for audit purposes.

3. Time Study Notification and Response

In an August 18, 2022, CMS Informational Bulletin,¹³⁷ CMS stated that:

CMS ... recommends no prior notification to staff participating in an RMTS but has approved RMTS methodologies that allow staff participating in the RMTS up to 2 business days to respond with information about their activity at their assigned random moment to accommodate circumstances in which a participating staff member may not be able to respond immediately to the RMTS request. This policy is intended to help ensure the reliability of the RMTS results.

These policies are intended to help ensure the reliability of the time study results as well as to minimize bias. In order to help ensure the accuracy and statistical validity of the time study results and not introduce any bias, the participant should ideally not be notified until the exact time and date of their moment, and they should complete the random moment response at that time. In addition, the farther a participant's reported response is from the sampled moment, the more likely the participant's recall of the assigned moment may be compromised.

While the recommendations above are intended to eliminate errors and bias with regard to time studies to the greatest extent possible, CMS is aware of the many challenges school-based providers face, in areas such as geography to technology, when operationalizing a time study. As

¹³⁷ See <https://www.medicaid.gov/federal-policy-guidance/downloads/sbscib081820222.pdf>

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such, CMS will work with States and school-based providers to reduce their upfront notification period and their response period as much as possible.

While we would encourage States to use a zero-notice approach when possible, we would like to clarify that CMS may recognize up to two days prior notice, as appropriate to the circumstances. We also recognize that in certain circumstances no prior notification will result in a significant non-response rate. For example, in some rural areas where internet access is weak, under a zero-notice policy, participants may not learn of their moment until after the moment has occurred. In addition, States or LEAs cannot direct or encourage staff to change their schedules to focus on Medicaid activities during their assigned moment.

If a State believes that up to two days prior notice (and two days response) is still not sufficient, the State should propose an alternative to CMS and provide its rationale. We will consider additional time for prior notification (or response) upon request from a State in such circumstances.

4. Response Rate

To ensure an adequate number of responses are received and the required error rate is achieved, CMS strongly recommends oversampling to maintain statistical validity. An oversample may be used to compensate (not substitute) for the potential number of nonresponses. The State may make other adjustments as necessary, e.g., to account for employee flex schedules. Whether adjustments are made or not, the minimum number of valid responses must equal 385 moments.

Codes should be established to fully account for any moment selected, including paid time not at work (e.g., Code 10 above). This is distinguishable from a **nonresponse** which is considered to be any moment in which the participant did not respond within 48 hours of the moment. For instance, if the participant did not respond, and no documentation was provided to indicate the employee was on paid leave, this would be considered a **nonresponse**. If the participant was on paid leave and the RMTS coordinator could code such activity properly by viewing the paid leave documentation, such coding would be considered a valid response.

Responses for moments that occurred when an employee is on unpaid time off or if they have left their position and have not been replaced, are considered **invalid responses**. These employees should be removed from the sample, because time study results are applied to personnel costs, and sample moments for unpaid time can distort those results. Please note that because such responses are considered invalid, they do not count toward the 85 percent valid response rate. In contrast, paid time off is a valid response that should be coded as General Administration and reallocated based upon the other activity code results.

Workers who do not respond to their sampled time moment would typically be included in the time study results. However, CMS allows for the use of an alternate methodology for the treatment of time study non-responses. The alternate methodology CMS has approved states that if the response rate is above 85 percent, non-responses may be discarded and not included in the time study results. If the 85 percent valid response rate is not achieved, CMS policy requires **all** non-responses to be included and coded as non-Medicaid (not simply enough responses to reach

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the 85 percent response rate, but 100 percent of non-responses). The reason for this policy is to encourage compliance with the time study process. If the 85 percent response rate is not achieved and the non-responses are all included and coded as non-Medicaid, thus bringing down the claimable percentage, it should serve as an incentive to time study coordinators and participants to avoid excessive non-responses becoming a recurring issue. That, along with adequate training, should help ensure the validity of the time study results. In addition, States should implement internal controls to ensure compliance.

A description of the treatment for nonresponse should be included in the SBS Time Study Implementation Plan. As a general principle, any alternate methodology for the treatment of nonresponses must be statistically valid. Alternate methodologies need to be submitted to CMS for review and approved prior to implementation.

5. Validation

States should validate, or ensure the accuracy and quality of, the time study data. 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, to ensure that an individual is not reported to be furnishing a direct service and performing an administrative activity at the same time. However, regardless of the validation mechanism that States employ, appropriate documentation supporting their claims must be maintained and available for audit purposes (see *Documentation Expectations and Requirements for Covered Medicaid Services* discussion above). The State should work with CMS to develop an acceptable validation mechanism. Another acceptable validation protocol could be to sample 5-10 percent of the moments each quarter and trace the responses to supporting documentation, such as leave approvals, worker schedules, activity logs, etc.

6. Oversight and Monitoring Process

Oversight and monitoring of the RMTS system are the responsibility of both the State and the individual claiming entity to ensure compliance with all applicable requirements. Sufficient resources should be allocated to ensure that only those administrative costs that are necessary for the proper and efficient operation of the Medicaid program are claimed for Medicaid reimbursement. The State and/or claiming entity are expected to have a system of quality controls in place to ensure the effectiveness and efficiency of operations, reliability of financial information and compliance with applicable laws and regulations. The quality control system should address documentation requirements, measures to ensure employees receive proper training, and oversight of any outside entities contracted to operate the program, among other aspects. Inadequate oversight creates vulnerabilities in State agencies' use of RMTS as a basis to allocate and claim federal financial participation in Medicaid expenditures.¹³⁸ States must include an oversight and monitoring protocol in the Medicaid Time Study Implementation Plan that is submitted for CMS review and approval.

¹³⁸ See Vulnerabilities Exist in State Agencies' Use of Random Moment Sampling to Allocate Costs for Medicaid School-Based Administrative and Health Services Expenditures (A-07-18-04107) at <https://oig.hhs.gov/oas/reports/region7/71804107.asp>.

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In order to ensure that the time study is statistically valid, the State Medicaid agency and/or claiming entity must monitor the compliance with the sampling methodology. Continual oversight of the RMTS system should consist of ongoing validation of the moments selected and quarterly analytic procedures. An example of an analytic procedure would be to compare quarterly activity levels to ensure there are no aberrant patterns. Appendix B contains a sample oversight and monitoring plan.

7. Compilation and Analysis of Sample Results

The RMTS results in an allocation statistic to be applied to SBS and administrative costs. The resulting formula for determining the percentage of allowable costs for a program would be:

$\frac{\text{\# of sampled moments performing allocable activity recorded by time study}}{\text{Total \# of moments in time study}}$
--

To determine the claim amount, costs are allocated to each activity based on the results of the RMTS. When claiming, the RMTS results apply to the cost pools for all the staff in the sample universe, and should be for the same period as the time study. If the time study results in multiple allocation percentages, each percentage is only applied to the applicable cost pool(s) used to derive the percentage. Codes that include nonproductive time or general activities (e. g. paid time off, administrative meetings, etc.) should be reallocated to other activities on a pro rata basis as appropriate as discussed in Section VII.I.6. “Activity Codes.”

Note that the cost pool(s) should be the net of applicable credits, and should include the entire period costs (except for the time and associated costs that were adjusted out). For Medicaid-allowable activities that can be provided to both Medicaid and non-Medicaid beneficiaries, the entity must apply a MER to the activity to determine Medicaid’s proportionate costs. The only administrative activities not subject to application of the MER are Medicaid outreach and facilitating Medicaid eligibility determinations, as discussed above.

8. Documentation of the RMTS

Documentation of the RMTS is critical. To verify the propriety of claims, documentation, at a minimum, should consist of the sample design, including computation of the universe, sampling techniques used, the data and analysis used to compute the sample size, sample selection procedures (including the random seed - defined below), the frequency of the time study (i.e., intervals), special treatment for summer periods, definitions, and any other materials needed to verify steps within the process. Samples that cannot be replicated will not be considered valid for purposes of using them as a basis for claiming FFP.

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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 Medicaid State plan. For more information, see *Documentation to Support RMTS* section.

The State is ultimately responsible for validation of time study results. States should consider the above approach for documentation, or some comparable procedure that adequately documents Medicaid sampled activities.¹³⁹

Seed Numbers used to Randomly Select Moments to be Sampled:

A seed number is a starting point for generating random numbers. Sampled moments in a RMTS are determined by randomly generating numbers that correspond to each individual moment in a survey sample. Knowledge of the seed number allows replication of the sample and results. There have been numerous OIG audits that have resulted in audit recommendations that portions of FFP be returned to the federal government as the OIG was unable to obtain the seed numbers from the State or the LEA to verify the statistical validity of the time study.¹⁴⁰ Please note that any and all underlying data that would be needed to replicate any aspect of sampling or verify the overall statistical validity of the time study should be preserved.

Training of Time Study Participants and Time Study Administrators:

Training should be provided to anyone involved in the time study administration or review of the procedures to ensure that all requirements are being followed by time study participants. Additionally, these administrators should be aware of how to properly verify, record and document all information to support the documentation of moments. For example, if a random moment that was used to calculate a Medicaid claim is selected for audit, an auditor would need to compare the time study records against supporting source documentation that may include a review of employee rosters, employee position descriptions, employee leave approvals, or employee flex schedules. Each potential source document must be able to support the information that was included for purposes of making the Medicaid claim. If any of the source documents are inaccurate or incomplete, the auditor may note the claim as invalid and the State may be required to return associated FFP back to the federal government.

¹³⁹ The HHS OIG has done numerous audits that have involved reviews of random moment sampling plans. In the majority of such audits, the OIG has found deficiencies in documentation that have led to questioning the FFP related to the findings. While there is no definitive rule for what amount of documentation is acceptable, CMS recommends that States ensure that every State and federal requirement are specifically documented in a clear manner and that such criteria is followed exactly as it is written. See HHS Office of Inspector General Audit (A-02-17-01006) <https://oig.hhs.gov/oas/reports/region2/21701006.asp> & (A-07-18-04107) <https://oig.hhs.gov/oas/reports/region7/71804107.asp>

¹⁴⁰ See <https://oig.hhs.gov/oas/reports/region4/41500101.pdf>; <https://oig.hhs.gov/oas/reports/region6/61400002.pdf>; <https://oig.hhs.gov/oas/reports/region4/41300094.pdf>; <https://oig.hhs.gov/oas/reports/region1/11400003.pdf>; <https://oig.hhs.gov/oas/reports/region4/41500103.pdf>

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D. Other Methods to Claim Personnel Costs

While a RMTS is typically used to identify and allocate costs, it is not the only option. Regulations on personnel expenses in 45 C.F.R. § 75.430(i) require that charges to federal awards must be based on records that reflect the actual work performed. The records must:

- be supported by a system of internal controls that provides reasonable assurance charges are accurate, allowable, and properly allocated,
- reflect the total activity for which the employee is compensated,
- encompass both federally assisted and all other activities for which the employee is compensated, and
- support the distribution of the employee's salary or wages among specific activities or cost objectives.

1. Employee Worker Log

An employee worker log or activity sheet is reflective of the actual work performed during a period of time. In some instances, States utilize a worker log for personnel timekeeping in place of another quantifiable measure of employee effort. Although there is no standard increment of time that must be utilized in a worker log, the timesheet needs to be descriptive enough to allow a third party to accurately determine the amount of time spent on each activity. Generally, CMS recommends the use of a 15- or 30-minute increment to document activities. If an employee spends an entire 8-hour day performing one activity, the timesheet would only need to show one activity code for 8 hours. If the employee performed multiple activities in the 15- or 30-minute increments, then they should report each of those activities. The timesheets should clearly note what Medicaid activity is being performed, or it must be readily deduced from the documentation provided. The timesheets should also be certified by the employee and the supervisor on a bi-weekly or monthly basis.

In lieu of a worker log being completed 100 percent of the time, States may conduct a worker day log for a portion (or sample) of the time study period that adheres to the statistical validity criteria and is described in the SBS Claiming Time Study Implementation Plan. Pursuant to 45 C.F.R. § 75.430(i)(5), the length of the specified period is based on the number of workers who participate, and is determined in accordance with the statistical sampling standards. As an example, to meet the 95 percent confidence level and +/-5 percent error rate, the sample size must be roughly 400 worker-weeks. This means that for each time study period, 400 workers can do a one-week time study or 200 workers need to complete a two-week study or 40 workers do 10-week study. The required number of workers would record all of their daily work activities for the specified length of time. The specified period and length of time should be representative of the entire service period.

2. Contractual Arrangements

CMS has allowed States and Medicaid providers that use contractual agreements with practitioners to perform allowable activities (instead of school employees) to use the relevant contract provisions as a means to allocate cost. The cost of the contract can be directly billed to

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Medicaid without doing any type of further cost allocation, provided the services are allowable and meet other cost principle requirements set forth in 2 C.F.R. Part 200 and 45 C.F.R. Part 75. States should be careful though not to bill Medicaid indirect costs if they are already included in the contract with the contractor or if they are already considered within the contractual rate. In other cases, even with a contractual arrangement, allocation may be necessary. See the table below for different scenario/examples:

If	Then	Example
The contract is applicable to direct medical Medicaid services and no additional cost outside of the contract is incurred by the claiming entity.	No additional allocation is needed	School contracts with a therapist to provide only direct services to Medicaid-enrolled students.
The contract is applicable to direct medical Medicaid services and additional cost outside of the contract is incurred by the claiming entity.	Additional allocation may be needed	School contracts with a therapist to provide only direct services to Medicaid-enrolled students and school provides the equipment for the services.
The contract is applicable to both direct medical Medicaid services, as well as State program administrative activities.	Additional allocation will most likely be needed	School contracts with a therapist to provide direct services to Medicaid-enrolled students and therapist also conducts referrals to other providers and coordinates care (as admin. activity, not medical service)...
The contract is applicable to non-Medicaid services , direct medical Medicaid services and/or State programs administrative activities.	Additional allocation will most likely be needed	School contracts with a therapist to provide direct services to all students, regardless of whether the therapist also conducts referrals and coordination on behalf of all students.

Please note that other proposals to document personnel costs will be considered by CMS on a case-by-case basis in accordance with all applicable requirements, including those in 45 C.F.R. § 75.430.

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E. Backcasting

In general, sampling typically includes samples from the same time period for which claims are being made. However, HHS has recognized “backcasting” as a process under which sample results from one time period can be used in supporting claims from previous time period(s), under certain circumstances. Backcasting involves the use of sample results from one period to support claims from prior periods that are contiguous when no better documentation is available, provided that it can be shown that there are no significant differences between the periods. The HHS Departmental Appeals Board has discussed the circumstances in which backcasting may be acceptable in several decisions.¹⁴¹

Below are the general principles relevant to the use of backcasting:

- Each case must be judged by its particular circumstances.
- The sample period must be contiguous to the claiming period to which the sample period results will be applied retroactively.
- The State must demonstrate no “significant differences” between the periods in question as there must be a degree of similarity in circumstance between the two periods to support the retroactive application of sampling results.
 - Mere performance of the same functions in the current period and in the past period is not sufficient to establish that the circumstances are not substantially different.
 -

¹⁴¹ See, e.g., Missouri Department of Social Services, DAB No. 1021, at 14 (1989), available at <https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/1989/dab1021.pdf> (“The Board’s analysis therefore permits sample results from one period to be used to support claims from contiguous periods when no better documentation is available, provided that it can be shown that there are no significant differences between the periods. The Board has recognized this approach as an expedient tool, particularly when the parties are in agreement on the need to establish a claim amount. The party asserting the use of data for unsampled periods has the burden of showing that circumstances relating to the sampled and unsampled periods are such that the data can be used for the unsampled period. . . . The uncontested soundness of the data provided during the sample period is not sufficient in itself to support the application of the data as support for expenditures made in earlier periods; the conditions surrounding the expenditures must closely approach those in the sampled period.”); California Department of Health Services, DAB No. 666 (1985) available at: <https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/1985/dab666.html> (If there are significant differences, use of the later period is inappropriate); Ohio Department of Human Services, DAB No. 900 (1987) available at <https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/1987/dab900.html> (The program for which costs are being claimed has remained so constant that there is no significant differences between the data for the audit period and the data for the subsequent period); California Department of Health Services, DAB No. 1606, at 10-12 (1996), available at <https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/1996/DAB1606.pdf> (finding that backcasting was inappropriate because the sample period was not contiguous to the claim period and the State failed to establish that the circumstances in the sample period were not substantially different from those in the retroactive claim period).

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VIII. Conclusion

As discussed previously, the BSCA directed CMS to provide additional guidance to States related to Medicaid and CHIP-covered SBS. CMS, in consultation with ED, has updated its past manuals with this guide. Both previous guidance documents issued by CMS, including the 1997 School-based Services Technical Review Guide and the 2003 School-based Administrative Claiming Guide, are superseded by this guide. Additionally, CMS goes beyond those previous guidance documents and explains other policies and practices that States may employ in implementing SBS.

CMS strived to include every SBS policy and mechanism to allow States and LEAs the greatest flexibilities as far as implementing and expanding SBS. We encourage States to take advantage of these flexibilities, and in particular, to expand services as allowed under the “free care” policy discussed above as well as mental health and SUD services. CMS realizes that not every State flexibility or contingency can be considered, but we encourage States and providers to work with CMS and ED as they consider changes to their SBS program based on the information presented in this guide.

CMS is available to provide TA to States and providers to best implement their programs. If you are interested in receiving TA, please email CMS at: SchoolBasedServices@cms.hhs.gov.

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IX. Appendix

1. Additional Resources for School-Based Services

The ED published “A Parent Guide to the Family Educational Rights and Privacy Act (FERPA)” to help parents understand their rights. The Family Educational Rights and Privacy Act, or FERPA (20 U.S.C. § 1232g; 34 C.F.R. Part 99), provides certain rights for parents regarding their students’ education records. FERPA gives these rights to parents. For more information visit: <https://studentprivacy.ed.gov/resources/parent-guide-family-educational-rights-and-privacy-act-ferpa>

The Substance Abuse and Mental Health Services Administration- SAMHSA 988: State Medicaid Agencies and any school can partner to expand the use of the 988 Suicide and Crisis Lifeline that is available to anyone that is experiencing suicidal, substance use, and/or mental health crisis, or any other kind of emotional distress. To learn more about how to partner with SAMHSA or for more information, visit: <https://www.samhsa.gov/find-help/988/faqs#roles-and-funding>

CMS has additional information about how States can maximize their Medicaid Eligibility data for various populations. To learn more, review the Opportunities for States with Integrated Eligibility Systems and/or Workforces from September 2022 resource that can be accessed at: <https://www.medicaid.gov/resources-for-states/downloads/opp-unwind-eff-st-integ-elig-sys-workforce.pdf>

Note on CMS data-related sources for SBS. There are no federal requirements for procedure or diagnosis codes (e.g., HCPCS, CPT, CDT, ICD-10, etc.); however, States may have their own requirements for SBS. CMS has multiple data-related resources. One resource that is available is [Using Z Codes: The Social Determinants of Health \(SDOH\) Data Journey to Better Outcomes](#) resource. This information is optional for States that have the data capacity. To learn more, reach out to CMS for technical assistance and see more at this link: <https://www.cms.gov/files/document/zcodes-infographic.pdf>

2. Notes on Administrative Activities

Administrative activities performed in support of medical services that are not coverable or reimbursable under the Medicaid or CHIP programs would not be allowable as Medicaid or CHIP administrative activities. In order for a medical service to be reimbursable, the provider furnishing such services must be participating in the Medicaid or CHIP programs, and bill Medicaid or CHIP for the service. If the provider is not participating or chooses not to bill Medicaid or CHIP for the service, then the service cannot be paid by Medicaid or CHIP and the administrative expenditures related to the service are also not allowable.

In order for the medical services to be payable under the Medicaid or CHIP State plan, the following requirements must be met:

- The medical services must be furnished to a Medicaid or CHIP-enrolled individual.

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- The medical services must be coverable and must meet any specific coverage requirements applicable to the service. States are reminded that, even if a particular service is not generally covered under the Medicaid State plan, coverage may be required under the EPSDT benefit for an EPSDT-eligible beneficiary if the service could be covered under the Medicaid State plan.
- The furnishing provider must be a participating provider in the Medicaid or CHIP programs, with a provider agreement and a Medicaid/CHIP provider identification number.

3. Activity Codes

The following activity code sets describe in more detail what activities could comprise the example activity codes described in the Activity Codes section. **These activity codes may be modified by States working with their LEAs 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 guidance.**

CODE 1.a. NON-MEDICAID OUTREACH

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 students with special education 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.

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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 eligible beneficiaries 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 students 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

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Children (WIC), child care, Head Start, home visiting, 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 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.

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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 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 IFSP, for children under 3 years old.)
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 academic 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.

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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 4A. DIRECT MEDICAL SERVICES - NOT COVERED AS IDEA/ IEP SERVICES,
Not Covered by Medicaid**

Use this code when the participant is providing direct client care services for which medical necessity has not been determined or for a service that is being provided by someone for which the service is not in their scope of practice. This code includes pre and post activities associated with the actual delivery of the direct client care services, e.g., paperwork or staff travel required to perform these services.

1. Administering first aid;
2. Screening services conducted by non-qualified providers;
3. Mental health services conducted by non-qualified providers; and
4. Nursing services conducted by non-qualified providers.
5. Providing a medically necessary service to someone who is not a student (e.g. staff member)

CODE 4B. DIRECT MEDICAL SERVICES – COVERED AS IDEA/ IEP SERVICES

IDEA/IEP SERVICES

Use this code when district staff (employees or contracted staff) provide direct client services as medically necessary covered services delivered by districts under the SBS Program. These direct client services may be delivered to an individual and/or group in order to ameliorate a specific condition and are performed in the presence of the student(s). This code includes the provision of all IDEA/IEP medical (i.e. health-related) services and may be delivered in person or via telehealth, when requirements are met.

All IDEA and/or IEP direct client care services when the student is present:

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- Providing health/mental health services as covered in the student's IEP.
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports as covered in the student's IEP.
- Audiologist services including evaluation and therapy services (only if included in the student's IEP);
- PT services and evaluations (only if included in the student's IEP);
- OT services and evaluations (only if included in the student's IEP);
- Speech Language Therapy and evaluations (only if included in the student's IEP);
- Psychological services, including evaluations (only if included in the student's IEP).
- Counseling services, including therapy services (only if included in the student's IEP);
- Providing personal aide services (only if included in the student's IEP);
- Nursing services and evaluations (only if included in the student's IEP), including skilled nursing services on the IEP and time spent administering/ monitoring medication only if it is included as part of an IEP and documented in the IEP;
- Physician services and evaluation, including therapy services (only if included in the student's IEP);
- Social Work services and evaluation, including therapy services (only if included in the student's IEP);
- Any other services defined as covered by the states SBS program and included on the student's IEP.

This code also includes pre and post time directly related to providing direct client care services when the student is not present. Examples of pre and post time activities when the student is not present include: time to complete all paperwork related to the specific direct client care service, such as preparation of progress notes, translation of session notes, review of evaluation testing/observation, planning activities for the therapy session, travel to/from the therapy session, or completion of billing activities.

- Pre and post activities associated with physical therapy services, for example, time to build a customized standing frame for a student or time to modify a student's wheelchair desk for improved freedom of movement for that client;
- Pre and post activities associated with speech language pathology services, for example, preparing lessons for a student to use with an augmentative communicative device or preparing worksheets for use in group therapy sessions;
- Updating the medical/health-related service goals and objectives of the IEP;
- Travel to the direct service/therapy;
- Paperwork associated with the delivery of the direct care service, as long as the student/client is not present. Such paperwork could include the preparation of progress notes, translation of session notes, or completion of billing activities; and
- Interpretation of the evaluation results and/or preparation of written evaluations, when student/client is not present. (Assessment services are billed for testing time when the student is present, for interpretation time when the student is not present, and for report writing when the student is not present.)

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CODE 4C. - Direct Medical Services – Covered on a Medical Plan of Care, Not Covered as IDEA/ IEP service

Use this code when district staff (employees or contracted staff) provide covered direct medical services under the SHS Program when documented on a medical plan other than an IEP/IFSP or where medical necessity has been otherwise established. These direct services may be delivered to an individual and/or group in order to ameliorate a specific condition and are performed in the presence of the student(s).

All medical services with the student present including:

- Providing health/mental health services as covered in the student’s medical plan other than an IEP/IFSP;
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports as covered in the student’s medical plan other than an IEP/IFSP or as part of the development of an IEP/IFSP; and
- Covered services for which medical necessity has been determined.

The list of services corresponds to all of the services outlined in the Medicaid State Plan. This includes:

- Audiologist services including evaluation and therapy services (only if included in the student’s medical plan);
- PT services and evaluations (only if included in the student’s medical plan);
- OT services and evaluations (only if included in the student’s medical plan);
- Speech Language Therapy services and evaluations (only if included in the student’s medical plan);
- Counseling services, including therapy services (only if included in the student’s medical plan or when medical necessity has been determined);
- Nursing services, evaluations, and administering / monitoring medication (only if medical necessity has been determined including skilled nursing services on the medical plan and time spent administering/monitoring medication.);
- Physician services and evaluation, including therapy services (only if included in the student’s medical plan); Social Work services and evaluation, including therapy services (only if included in the student’s medical plan); and Examples of pre and post time activities when the student/client is not present include: time to complete all paperwork related to the specific direct service, such as preparation of progress notes, translation of session notes, review of evaluation testing/observation, planning activities for the therapy session, travel to/from the therapy session, or completion of billing activities.
Any other services defined as covered by the states SBS program and included on the student’s medical plan.

General examples that are considered pre and post time:

- Updating the medical/health-related service goals and objectives of the medical plan of care;

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- Travel to the direct service/therapy;
- Paperwork associated with the delivery of the direct care service, as long as the student/client is not present. Such paperwork could include the preparation of progress notes, translation of session notes, or completion of billing activities; and
- Interpretation of the evaluation results and/or preparation of written evaluations, when student/client is not present. (Assessment services are billed for testing time when the student is present, for interpretation time when the student is not present, and for report writing when the student is not present.)

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 that meets the Medicaid definition of "specialized transportation" to and/or from school for students with specialized medical needs."
2. 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.

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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/75 percent FFP or the CHIP rate subject to the administrative claiming 10 percent cap

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 students. Non-medical services may include social services, educational services, vocational services, and State or State education mandated student 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

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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 students 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 students, 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

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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 students 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 eligible beneficiaries, 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 MCPs, 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 MCPs, who will provide services to targeted population groups, e.g., EPSDT students.

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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.

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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 SEA mandated student 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)**

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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, including mental health or substance use disorder 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 student 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 student with special/severe health care needs.
10. Coordinating the completion of the prescribed services, termination of services, and the referral of the student to other Medicaid service providers as may be required to provide continuity of care.
11. Providing information to other staff on the student'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 MCPs as appropriate.

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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 that are not related to the delivery of health care services.
4. Attending or facilitating school or unit staff meetings or training that is not related to the delivery of health care services, 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.

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4. SBS Claiming Time Study Implementation Plan Example

COLORADO SCHOOL HEALTH SERVICES PROGRAM TIME STUDY IMPLEMENTATION GUIDE FOR DIRECT SERVICES AND MEDICAID ADMINISTRATIVE CLAIMING EFFECTIVE: October 1, 2020

Vision

The State of Colorado, Department of Health Care Policy and Financing (The Department) is committed to providing an efficient and effective School Health Services (SHS) program. The program is comprised of Direct Services and Medicaid Administrative Claiming (MAC) components designed to ensure the optimum delivery of services to our clients. In keeping with this vision, The Department implemented a statewide Random Moment Time Study (RMTS) methodology to support proper Medicaid reimbursement for delivered services.

Introduction

In 1997, Colorado established the SHS Program to be administered by The Department. Colorado State law allows reimbursement for the provision of Medicaid-covered health services for Medicaid-enrolled students in public schools. Any public-school district, Board of Cooperative Education Services (BOCES), or a K-12 educational institutions (herein after referred to as "district") may participate in the SHS program.

The Department partnered with districts to implement a new reimbursement program for Direct Service and MAC in Colorado, according to the specifications and approval of the federal Centers for Medicare and Medicaid Services (CMS). The SHS Program is jointly run by The Department and the Colorado Department of Education (CDE). In 2019, The Department amended the SPA 19-0021 to expand the coverage of SBS from Medicaid enrolled students with an Individual Education Program (IEP) or Individual Family Services Plan (IFSP) to include all Medicaid-enrolled students where medical necessity has been otherwise established. This change was made in accordance with the Directors Letter from the CMS dated December 15, 2014 which removed the Free Care provision from CMS policy. The purpose of these agreements is to assist The Department in providing effective and timely access to care for Medicaid recipients; to assure more appropriate utilization of Medicaid-covered services; and to promote activities that reduce the risk of poor health outcomes for the State's most vulnerable populations. The Department requires that participating districts participate in the statewide RMTS.

SHS Enrollment Criteria

Effective upon approval of SPA 05-006 and the approved time study methodology, districts began operating under the federal guidelines as outlined in the State's approved Time Study Implementation Guide for Direct Services, Targeted Case Management, and MAC. The proposed Time Study Implementation Guide was revised in SPA 19-0021 to include Free Care. Once CMS approved the State's Time Study Implementation Guide for Direct Services and MAC, The Department implemented regulation changes that outline new time study guidelines for

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participating districts.

The Department must be assured that each participating district is capable of administering the project and requires that each district assign an SHS Program coordinator to act as a liaison between The Department and the district's providers.

Required Personnel

Each district must designate an employee as the SHS Program coordinator. This single individual is designated within a local agency to provide oversight for the implementation of the time study and to ensure that policy decisions are implemented appropriately. The district must also designate an SHS assistant coordinator to provide back-up support and oversee time study responsibilities when the coordinator is absent or on leave.

The coordinator responsibilities include but are not limited to:

- Identifying qualified staff for participation in the time study,
- Identifying calendar work days and holidays,
- Identifying work schedules (shifts) for participants in the time study
- Maintaining the district RMTS staff pool list,
- Providing participant information for the RMTS staff pool list to the State's vendor,
- Monitoring staff participation in the time study,
- Report and/or coordinate reporting financial information,
- Understanding the SHS Program rules and distribution of information, and
- Acting as a liaison between the State and participant.

Central coding is not a function of the district but of the State's vendor. Thus, district staff are not trained on Medicaid allowable activities vs. non-Medicaid activities. The training for the coordinator has been designed to assist them in appropriately identifying staff that are eligible to participate in the program. In order for the coordinators to be able to support the identification of staff, the training materials outline examples of activities that are reimbursable under the program. These examples allow the coordinator to make a match between eligible staff and reimbursable activities.

The Department requires coordinators attend an initial RMTS training and any additional mandatory RMTS trainings as requested. The assistant coordinator may also attend the initial RMTS training or be trained by the coordinator. Other district staff may also attend trainings, at the request of the district and at The Department's discretion. Training is further described on page 10.

Random Moment Time Study

In most districts, it is uncommon to find staff whose activities are limited to just one or two specific functions. Staff normally perform a number of activities, some of which are related to direct covered services and some of which are not. Determining the percentage of time spent by workers

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on activities related to the provision of direct covered services, as well as to all other functions, requires an allocation methodology that is objective and empirical (i.e., based on documented data). Staff time has been accepted as the basis for allocating staff cost. The federal government has developed an established tradition of using time studies as an acceptable basis for cost allocation.

A time study reflects how workers' time is distributed across a range of activities. A time study is not designed to show how much of a certain activity a worker performs; rather, it reflects how time is allocated among different activities. The State will utilize a CMS-approved RMTS methodology and all districts who participate in any component of SHS Program will be required to participate in the RMTS process.

The RMTS methodology polls participants on an individual basis at random time intervals over a given time period and totals the results to determine work effort for the entire population of eligible staff over that same time period. The RMTS method provides a statistically valid means of determining what portion of the selected group of participants' workload is spent performing activities that are reimbursable by Medicaid.

Time Study Methodology

Colorado conducts a statewide time study on a quarterly basis for those districts that are participating in any of the SHS Programs (Direct Service and MAC). The purpose of the time studies is to: identify the proportion of administrative and outreach time allowable and reimbursable under the Medicaid Administrative Claiming program; and identify the proportion of direct medical service time allowable and reimbursable under the Direct Service program. This time study will enable the State of Colorado to conduct a cost settlement at the end of the State fiscal year for the Direct Service program and MAC program on a quarterly basis.

The time study is designed to capture 100 percent of time worked. Once the sampled participant responds to the moment, the moment can only be coded to a single activity code. The coding of that moment follows definitions of the activity codes and examples that are outlined in this Time Study Implementation Guide. The reimbursement status of each code is also outlined in the SHS Program Manual.

In order for the sample universe to be determined to support appropriate cost allocation procedures, staff performing similar school-based functions are identified and grouped into two mutually exclusive cost pools. The cost pools are:

Cost Pool 1: Direct Service Cost Pool

Cost Pool 2: Administrative Outreach Personnel Cost Pool

Start and end times of work days are also collected from districts. In addition, calendars identifying the start and end dates for which participants are working are also collected from districts.

Time Study Participants

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All districts that participate in the statewide time study will identify allowable Medicaid direct service and administrative costs within a given district by having staff who spend their time performing those activities participate in a quarterly time study. Staff included in the time study may include part-time, full-time, and/or contracted staff. These districts must certify that any staff providing services or participating in the time study meet the educational, experiential, and regulatory requirements. Participating districts must update their staff pool lists each quarter prior to the generation of the time study sample for that period. Only staff that meet the requirements as outlined in the Colorado Medicaid State Plan can bill Medicaid direct services and be included in the Direct Service Cost Pool. Districts cannot create additional positions to their staff pool list once the time study sample has been generated for that period. Sampled participant updates to name and email address are allowed after a sample is generated however no new positions can be added as previously stated. Positions that are not identified on the quarterly staff pool list are not eligible to have their costs included on that quarter's MAC claim or that quarter of the annual cost report.

Staff pool lists are certified quarterly. As there is no time study for the July – September quarter, there is no staff pool list certified for that quarter. The staff pool list from the previous quarter is used as the basis for the summer quarter. Participants are made active in the RMTS when they are added to the staff pool list and remain active unless the coordinator for the district changes their status to inactive. The district inactivates staff pool list participants when they have either left the district or changed positions to a position that is not eligible to participate in the program.

Individuals such as parents or other volunteers who receive no compensation for their work are not included in the time study process; this would include in-kind “compensation.” For purposes of this Time Study Implementation Guide, individuals receiving compensation from districts for their services are termed “district staff.” Colorado will be using the statewide time study and its two cost pool methodology. All staff will be reported into one of two cost pools: Direct Service Cost Pool or Administrative Outreach Personnel Cost Pool. **The two cost pools are mutually exclusive, i.e., no staff can be included in more than one cost pool.** The Direct Services Staff cost pool is comprised of direct service staff, including those who participate in direct service and administrative claiming activities, as well as direct service only staff, and the respective costs for these staff. These costs include staff time spent on billing activities related to direct services. The Administrative Outreach Personnel Cost pool is comprised of administrative staff and the respective costs for these staff. The following provides an overview of the eligible categories of staff in each cost pool.

Examples of the staff included in each cost pool are included below.

Direct Service Cost Pool

The following positions that are eligible to bill direct medical services in the Colorado Medicaid State Plan include:

- Physician (MD or DO);
- Psychiatrist;
- Nurse Practitioner;
- Registered Nurse;

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- Licensed Practical Nurse;
- Nurse Aide;
- Health Technician;
- Personal Care Aide/Teacher's Aide;
- Bus/vehicle Aide;
- Psychologist;
- School Psychologist;
- Counselor;
- Social Worker;
- Clinical Social Worker;
- Marriage and Family Therapist;
- Applied Behavior Analyst;
- Speech Language Pathologist;
- Speech Language Pathologist Candidate;
- Speech Language Pathology Assistant (SLPA);
- Audiologist;
- Audiology Candidate;
- Speech/Language Impairment Teacher;
- Occupational Therapist;
- Certified Occupational Therapy Assistant (COTA);
- Physical Therapist;
- Physical Therapy Assistant (PTA); and
- Any other job category outlined in the Colorado Medicaid State Plan that is eligible to bill direct medical services.

Administrative Outreach Personnel Cost Pool

The following staff categories are eligible to participate in MAC:

- Administrators;
- Counselors*;
- Interpreters & Interpreter Assistants;
- Pupil Support Services Administrators;
- Psychologist Interns*;
- Special Education Administrators;
- Program Specialist;
- Psychologists*;
- Social Workers*;
- Orientation & Mobility Specialist;
- Resource Specialist/ Family Liaisons;
- School Bilingual Assistants;
- Nurses*;
- Special Education Teachers*; and
- Other groups/individuals that may be identified by the district and approved by The Department.

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* provider types that do need meet the definition of an eligible provider to bill direct medical services as outlined in the Colorado Medicaid State Plan or are not in a position to bill direct medical services but because of their position they function in an administrative capacity

Staff with job titles listed above as eligible for any of the cost pools are not automatically included in the time study. A district must determine whether they meet all requirements above and if they are less than 100% federally funded. Individuals that are known to be 100% federally funded at the time of the staff pool list update will be excluded from the time study. Staff who are partially federally funded may be included in the time study, however, any costs that are included in the cost pool must be net of all federal sources. All criteria must be met in order to be included in the time study.

Part of the RMTS quality assurance process is to ensure that all of the participants that are certified on the staff pool list are included in the sample universe. The district prepares, reviews, and certifies the staff pool lists of eligible participants. All those participants are loaded into the appropriate cost pool. Staff pool lists from all participating districts in a particular cost pool are included in the sample universe. At the end of the quarter, a financial schedule or workbook is available to the districts to report allowable costs for participants included in the sample universe. The list sent to the districts will only include the staff positions reported at the beginning of the process and included in the sample universe. Districts are instructed that they can only report and claim costs for participants that were included on the RMTS staff pool list and thus included in the sample universe.

RMTS Sampling Periods

The sampling period is defined as the three-month period comprising each quarter of the calendar year. The following are the quarters followed for the SHS Program:

- Quarter 1 = October 1 – December 31
- Quarter 2 = January 1 – March 31
- Quarter 3 = April 1 – June 30
- Quarter 4 = July 1 – September 30

The sampling periods are designed to be in accordance with the May 2003 Medicaid School-Based Administrative Claiming Guide, on page 42, Example 4, specifically:

“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.”

Each quarter, districts will identify dates they will be in session and for which their staff are compensated. District staff are paid to work during those dates that districts are in session; as an example, districts may end the school year sometime in June each year. All days including and through the end of the school year would be included in the potential days to be chosen for the time study, including days when staff are required to work but students are not attending school.

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It is important to understand that although districts may end the school year prior to the close of the quarter, staff may receive pay for services provided during the school year through the end of the federal fiscal quarter. The districts typically spread staff compensation over the entire calendar year versus compensating staff only during the months when school is in session.

The majority of district staff work during a traditional school year. Since the time study results captured during a traditional time study are reflective of any other activities that would be performed during the summer quarter, a summer quarter time study will not be conducted. Colorado will use an average of the three (3) previous quarters' time study results to calculate a claim for the July-September period. The three previous quarters utilized for the average for the July – September quarter would be the previous October – December, January – March and April – June quarters. This is in accordance with the May 2003 Medicaid School-Based Administrative Claiming Guide, page 42. Specifically:

“...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.”

State of Emergency Exception

In the event there is a “state of emergency” or other disaster declared in the State of Colorado that results in prolonged district closures that impact the statistical validity of the RMTS as defined in the Sampling Requirements section of this methodology under sampling precision and confidence level, The Department will apply the summer quarter claiming methodology to statistically invalid quarters occurring during the “state of emergency” including the quarter in which the state of emergency is declared and the quarter in which the state of emergency period ends. This means no RMTS will be run during the impacted quarter(s) and claiming will be based on the average of the quarters that were completed. The Department will notify CMS within 15 days of determining that a quarter is statistically invalid, including the reason for the determination, along with details and dates of the declaration of emergency.

Time Study Start and End Dates

District calendars will be updated on a quarterly basis and the sample period start and end dates will be determined and documented for each quarter. The dates that districts will be in session and for which their staff are compensated will be determined by the district. Districts are instructed to include work days when staff are paid to work during those dates that districts are in session: Each quarter, the coordinator has the opportunity to review and update calendar to determine those dates that the district pays for their staff to work, and those dates will be included in the sample.

Sampling Requirements

In order to achieve statistical validity, maintain program efficiencies and reduce unnecessary district administrative burden a consistent sampling methodology for all activity codes and groups

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will be used. The RMTS sampling methodology is constructed to achieve a level of precision of +/- 2% (two percent) with a 95% (ninety-five percent) confidence level for activities. This is in accordance with the policy communicated by the CMS.

Statistical calculations show that a minimum sample of 2,401 completed moments each quarter, per cost pool, is adequate to obtain this precision when the total pool of moments is greater than 3,839,197. Additional moments are selected each quarter to account for any invalid moments or non-responsive moments. Any non-response moments are moments that are not returned.

Invalid moments are moments assigned to staff that are no longer in the position. Invalid moments do not count against the 85% response rate. Non-responses are moments that have not been completed by sampled participants. In the event that an 85% return rate is not met, all non-returned moments will be included and coded as non-allowable codes/non-Medicaid time.

The following formula is used to calculate the number of moments sampled for each time study cost pool:

$$ss = \frac{Z^2 * (p) * (1-p)}{c^2}$$

Where:

- Z = Z value (e.g. 1.96 for 95% confidence level)
- p = percentage picking a choice, expressed as decimal (.5 used for sample size needed)
- c = confidence interval, expressed as decimal (e.g., .02 = ±2)

Correction for finite population:

$$N = \text{population}$$

The following table shows the sample sizes necessary to assure statistical validity at a 95% confidence level and tolerable error level of 2%. Additional moments will be selected to account for unusable moments, as previously defined. An over sample of a minimum of 15% will be used to account for unusable moments.

N=	Sample Size Required	Sample Size plus the Minimum 15% Oversample
100,000	2,345	2,697
200,000	2,373	2,729
300,000	2,382	2,740
400,000	2,387	2,746
500,000	2,390	2,749

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750,000	2,393	2,752
1,000,000	2,395	2,755
3,000,000	2,399	2,759
>3,839,197	2,401	2,762

RMETS Sample Selection Process

The RMETS process is described here as four steps:

5. Identify Total Pool of Time Study Participants
6. Identify Total Pool of Time Study Moments
7. Randomly Select Moments and Randomly Match Each Moment to a Participant
8. Notify Participants About Their Selected Moments

Step 1: Identify Total Pool of Time Study Participants

At the beginning of each quarter, participating districts submit a staff roster providing a comprehensive list of staff eligible to participate in the statewide RMETS time study. This list of names is subsequently grouped into job categories (that describe their job function) and from that list all job categories are assigned into one of the two mutually exclusive cost pools for the statewide time study. The staff pool list is updated on a quarterly basis, and updates are only allowed prior to the start of the quarter.

Step 2: Identify Total Pool of Time Study Moments

The State of Colorado has designed the RMETS to capture 100% of time worked by district staff. At the beginning of each sample period the participating districts submit a calendar that outlines all days that schools are in session. Each participant on the staff pool list is assigned to a shift of time each workday. In accordance with the 2003 Medicaid School-Based Administrative Claiming Guide, the shifts are inclusive of all of the time the participant spends during the workday, including lunch. The participating district also submits a start and end time that covers all the time staff within the district are scheduled to work. Participating districts can submit multiple start and end times (by school site, by job category, etc.) in an effort to address the various staff schedules that occur within the district. All the data submitted by the participating districts is used to develop the sample universe.

The sample universe contains all of the moments for all staff who are working during the quarter. The total pool of “moments” within the time study is represented by calculating the number of working days in the sample period, times the number of work hours of each day, times the number of minutes per hour, and times the number of participants within the time study. The only days and times that are not included in the sample universe are days and times during which no one is working. This time would include times before and after a school is in session as well as days staff are not in session such as weekends and holidays.

Step 3: Randomly Select Moments and Randomly Match Each Moment to a Participant

Using a statistically valid random sampling technique, the desired number of random moments is selected from the total pool of moments. Next, each randomly selected moment is matched up,

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using a statistically valid random sampling technique, with an individual from the total pool of participants.

Each time the selection of a minute and the selection of a staff name occurs, both the minute and the name are returned to the overall sample pool to be available for selection again. In other words, the random selection process is done with replacement so that each minute and each person are available to be selected each time a selection occurs. This step guarantees the randomness of the selection process.

Each selected moment is defined as a specific one-minute unit of a specific day from the total pool of time study moments and is assigned to a specific time study participant. Each moment selected from the pool is included in the time study and coded according to the detail submitted by the sampled participant.

Step 4: Notify Participants about their Selected Moments

Time study participants are notified via email or paper of their requirement to participate in the time study and of their sampled moment. Sampled participants will not be notified of their sampled moment date and time more than twenty-four (24) hours prior to the sampled moment. At the prescribed moment, each sampled participant is asked to record and submit his/her activity for that particular moment. Additionally, if the moment is not completed the participant receives a late notification email twenty-four (24) hours after their selected moment. Throughout this entire process, the coordinators have real-time access in the online system. Coordinators can view their sampled participants, the dates/times of their sampled participant's moments, and whether the moment has been completed but not until on/or after the sampled participant has been notified of their moment date/time. The time study questionnaire or survey is not kept open more than two (2) school days after the end of the time study period to ensure the accuracy of the time study detail. If the statewide return rate of valid moments is less than 85 percentage, non-returned moments will be included and coded as non-allowable codes/non-Medicaid time until the 85-percentage threshold is reached.

The majority of sampled participants receive notifications via email. However, The Department also allows paper-based moments for those participants who do not have email or access to the internet at work. The paper-based moment form mirrors the online time study, asking sampled participants to respond to the same questions in the same order. Paper-based moments are available to the coordinator, who is responsible for ensuring the sampled participant receives the form.

The following steps are taken so that sampled participants who receive paper moments receive their moments and proper notifications:

1. The coordinator will access the sampled participant's blank sample moment form from the RMTS system.
2. The coordinator ensures the participant receives the notification and sample moment form based on the same notification and response time frames listed above.
3. The participant completes the paper sample form and returns it to the coordinator who will email the Department's vendor within two school days after the moment has occurred.
4. The coordinator follows up with the participant within 24 hours after the moment has

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occurred to ensure compliance.

- a. The coordinator will contact the sampled participant if their moment has not been completed to remind them of their sample moment and the importance of completing the moment.
- b. The coordinator can provide the sampled participant the website or the support telephone number that they can utilize to receive additional support they may need to complete the moment.
- c. The coordinator utilizes a variety of communication methods to contact the sampled participant. Those communication methods include, but are not limited to: phone, email, fax, and in-person.

RMTS Responses

All detail from the sampled participant must be sufficient to provide responses to the time study questions needed for accurate coding:

1. Is the service you provided part of the student’s medical plan of care where medical necessity has been otherwise established? (Radio buttons with the options of “Yes – IEP/IFSP”, “Yes - Medical plan of care other than an IEP/IFSP (i.e. 504 plan, student health plan, nursing plan, physician’s order, crisis intervention services)”, “Yes - Medical necessity established in other method”, “No” or “N/A”.
2. Who were you working with during this sample moment? (The sampled participant must create a narrative to answer this question.)
3. Describe in detail the activity you were performing during your sampled moment. Please answer this question even if you answered “No” to the first question. (The sampled participant must create a narrative to answer this question.)
4. Describe in detail why you were doing this activity during your sampled moment. (The sampled participant must create a narrative to answer this question.)

In addition, sampled participant will certify the accuracy of their response prior to submission—sampled participants are assigned a unique username and password or hyperlink that is only sent to them. They must use this unique username and password or hyperlink to login and document their moment. After answering the sample moment questions, they are shown their responses and asked to certify that the information they are submitting is accurate. Their moment is not complete unless they certify the accuracy of the information. Since the sampled participant only has access to their individual information, this conforms to electronic signature policy and allows them to verify that their information is accurate. Each time study participant must certify the accuracy of his/her response prior to submission.

Additional RMTS documentation maintained by the vendor includes:

- Sampling and selection methods used;
- Identification of the moment being sampled; and
- Timeliness of the submitted time study moment detail.

RMTS Coding

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The Department has chosen to utilize a centralized coding methodology to be implemented by the vendor assisting Colorado with the RMTS program. Under that methodology, the sampled participant is not required or expected to code his or her moment. The sampled participant is asked to document their activity by providing specific narrative responses. At the end of the RMTS response, the sampled participant is asked to certify their moment response.

The vendor will code all moments submitted. The vendor will randomly select a 5% sample of the coded responses and submit to the State each quarter for their independent validation. The State's validation will consist of reviewing the sampled participant responses and the corresponding code assigned by the vendor to determine if the code was accurate. If the Department has any disagreements with the code(s) selected there will be a discussion with the vendor to decide how the impacted moment(s) should be coded. After that discussion on coding and if applicable the coding instructions will be modified to document those coding decisions so that they can be consistently applied in future quarters.

At the end of each quarter, once all random moment data has been received and time study results have been calculated, statistical compliance reports will be generated to serve as documentation that the sample results have met the necessary statistical requirements.

RMTS Return Compliance

The districts have the ability to run compliance reports on a daily basis. A statistical validity check of the time study results is completed at the conclusion of each quarter prior to the calculation of the MAC claim. The validity check ensures that the minimum number of responses is received each quarter to meet required statistical validity. The number of completed and returned time study moments is analyzed to confirm that the confidence level requirements have been met. Once the validity of the sample has been confirmed, the time study results are calculated and prepared for the calculation of the quarterly claim.

The Department will require an 85 percent response rate. Moments not returned will not be included in the RMTS database unless the return rate for valid moments is less than 85%. Invalid moments are moments assigned to staff that are no longer in the position, a participant is not scheduled to work, or on unpaid time. Invalid moments do not count against the 85 percent response rate. Non-responses are moments that have not been completed by sampled participants. In the event that an 85 percent return rate is not met, all non-returned moments will be included and coded as non-allowable codes/non-Medicaid.

The time study questionnaires will be kept open no longer than two (2) school days after the end of the time study period to ensure the accuracy of the time. To ensure that enough moments are received to have a statistically valid sample, Colorado will over sample at a minimum of fifteen percent (15 percent) more moments than needed for a valid sample size.

To assist in reaching the statewide goal of 85-percent compliance, The Department monitors the districts to make sure they are properly returning sampled moments. If a district has non-returns greater than 15 percent and greater than five (5) moments for a quarter, the district may receive a

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warning letter from The Department. If the same district is in default the next quarter after being warned, they may not be able to participate for a one-year period of time. As a hypothetical example, if a district has non-returns greater than 15 percent and greater than five (5) moments for the quarters ending December 31 and March 31 of the same fiscal year, the district may not be allowed to claim for the remainder of that fiscal year. If such a penalty is imposed, the district is required to return any payments received for that fiscal year under the SHS Program. In addition, if compliance is not achieved after two consecutive quarters, The Department may implement the following sanctions:

- Noncompliant districts will not be able to claim for MAC for the remainder of the fiscal year beginning with the second quarter of non-compliance.
- Noncompliant coordinators will be required to complete SHS Program Compliance Training prior to resuming full program participation.

RMTS Training

District Coordinator Training (RMTS Process and Compliance)

The Department will review and approve all RMTS training material used by the vendor. Once the training material has been approved by The Department the vendor will provide initial training for the coordinators, which will include an overview of the RMTS/cost reporting system and information on how to access and input information into the RMTS/cost reporting system. It is essential for the coordinators to understand the purpose of the time studies, the appropriate completion of the RMTS, the timeframes and deadlines for participation, and that their role is crucial to the success of the program. Sampled participants are to be provided detailed information and instructions for completing and submitting the time study detail of the sampled moment. All training materials will be accessible to coordinators. In addition, annual training will be provided to the coordinators to cover topics such as RMTS program updates, process modifications and compliance issues.

Sampled Participant Training

The primary purpose of staff training is to educate the sampled participants on the activity codes so he or she could accurately determine the appropriate activity code for the activity they were performing at the sampled moment. Since Colorado has implemented a centralized coding methodology, the training around the activity codes is no longer required since the sampled participants will not have to code their moment. The RMTS system includes training information on the program and the sampled participant's role in the program as well as how to complete the moment. The sampled participant must visit these screens prior to being able to document their moment. For these reasons, training of sampled participants will no longer be a requirement for completion of their moment.

SHS Time Study Review

The Department or its vendor shall perform reviews to monitor the integrity and accuracy of all of the time study data and results for the SHS Program. Quarterly reviews specifically related to the time study will be completed on at least 50 percent of the districts participating in the program.

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The reviews shall consist of verifying the following:

- District submission and certification of quarterly participant staff pool lists;
- District submission and certification of quarterly district calendars;
- The RMTS compliance rate level requirement of 85 percent has been met by each district.

In addition, annual reviews will be conducted on a sample provider on the staff pool list to verify applicable credentials or licensures. Should the Department or their vendor find discrepancies upon verifying the district’s quarterly time study updates, an email, requesting explanation, clarification, and/or correction of discrepancies may be requested. The Department may also pursue remedial action for districts that fail to meet SHS Program requirements or fail to correct problems identified during reviews. Sanctions the Department may impose include placing districts on “payment hold,” conducting more frequent comprehensive program compliance reviews, recoupment of funds, or ultimately, cancellation of the districts contract. Examples of actions that may cause sanctions include, but are not limited to:

- Failure to meet minimum the 85 percent compliance rate in response to the time study;
- Failure to cooperate with State, and/or Federal staff including the vendor during, reviews or other requests for information;
- Failure to maintain adequate documentation; and
- Failure to provide accurate and timely information to the State or its vendor.

The Department meets with the State’s vendor at least monthly or as needed to provide oversight and/or review district reports, quarterly time study results, and provider and/or contractor related issues.

Time Study Activities/Codes

Time study codes assist in the determination of time and associated costs related to and reimbursable under the SHS Program. The time study codes have been designed to reflect all of the activities performed by time study participants.

The time study codes are assigned indicators that determine allowability, Federal Financial Participation (FFP) rate, and Medicaid population. A code may have one or more indicators associated with it. These indicators should not be provided to time study participants. The time study code indicators are:

Code	Description
U	Unallowable – refers to an activity that is unallowable under the SHS Program. This is regardless of whether or not the population served includes Medicaid-enrolled individuals.
TM	Total Medicaid – refers to an activity that is 100 percent allowable under the SHS Program.

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PM	<p>Proportional Medicaid – refers to an activity, which is allowable as Medicaid administration under the SHS Program, but for which the allocable share of costs must be determined by the application of the proportional Medicaid share (using the Medicaid Enrollment Rate (MER) and the IEP ratio). The proportional Medicaid share will be determined for each district.</p> <ul style="list-style-type: none"> • For Free Care (cost settlement process) and MAC, the Medicaid share is determined as the ratio of Medicaid-enrolled students to total students, i.e. the MER. • For the Direct Service (cost settlement process), the Medicaid share is defined as the ratio of Medicaid-enrolled special education students with an IEP/IFSP to the total special education students with an IEP/IFSP, i.e. the IEP ratio.
R	<p>Reallocated – refers to those general administrative activities which must be reallocated across the other activity codes on a pro rata basis. These reallocated activities are reported under General Administration.</p>

The following time study codes are to be used for the Random Moment Time Study:

Code	Code Text Prov Services	Activity PROVISION OF SERVICES	Direct Service Indicator	MAC Indicator
1A	Outreach	Non-Medicaid Outreach	U	U
1B	Outreach	Medicaid Outreach	U	TM/50%
2A	Enrollment	Facilitating Non-Medicaid Eligibility Determination	U	U
2B	Enrollment	Facilitating Medicaid Eligibility Determination	U	TM/50%
3	Educational Services	School Related and Educational Services	U	U
4A	DirNonIEP	Direct Medical Services- Not Covered as IDEA/IEP Services, Not Covered on a Medical Plan of Care	U	U
4B	DirMedIEP	Direct Medical Services- Covered as IDEA/IEP Services, Not Covered on a Medical Plan of Care	PM (IEP Ratio)	U
4C	DirMedFreeCare	Direct Medical Services – Covered on a Medical Plan of Care, Not Covered as IDEA/IEP service	PM (MER)	U
5A	Transportation	Transportation Non-Medicaid	U	U
5B	Transportation	Medicaid Transportation	U	PM/50%

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6A	Translation	Non-Medicaid Translation Services	U	U
6B	Translation	Medicaid Translation	U	PM/50%
7A	Planning	Non-Medical Program Planning, Policy Development, and Interagency Coordination	U	U
7B	Planning	Medical Program Planning, Policy Development, and Interagency Coordination	U	PM/50%
8A	Training	Non-Medical/Medicaid Related Training	U	U
8B	Training	Medical/Medicaid Related Training	U	PM/50%
9A	Referral	Referral, Coordination, and Monitoring of Non-Medicaid Services	U	U
9B	Referral	Referral, Coordination, and Monitoring of Medicaid Services	U	PM/50%
10	GA	General Administration	R	R
11	Unallowable	Not Paid/Not Worked	U	U

These activity codes represent direct service and administrative activity categories that are used to code all categories of claims. Detailed code definitions and examples may be found starting on page 29.

SHS Medicaid Enrollment Calculation

Participating districts are required to regularly submit claims to The Department for direct services rendered, according to the guidelines in The Department Specialty Provider Billing Manual in the SHS Program Manual. At the end of each fiscal year, the district must submit a cost reconciliation report based on annual costs. The Department’s vendor prepares the time study results and the IEP ratio and MER in order to complete the cost settlement process as outlined in Attachment 4.19B of the approved Colorado Medicaid State Plan.

The SHS Program’s annual claim uses an IEP ratio and MER as one of the steps in determining total allowable costs, as described in Section 4.19B of the approved Colorado Medicaid State Plan. An IEP ratio is determined for each participating district. When applied, this IEP Ratio discounts the Direct Service cost pool by the percentage of IEP Medicaid students for the time associated with Activity Code 4B. The names, gender, and birthdates of students with an IEP/IFSP are identified from the December 1 Count Report each year filed annually by each district to CDE and matched against the December 1st Medicaid enrollment file from The Department to determine the percentage of IEP/IFSP students enrolled in Medicaid. The numerator of the rate is the students

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with an IEP/IFSP that are enrolled in Medicaid and the denominator is the total number of students with an IEP/IFSP.

Costs associated with several Medicaid administrative activities performed by the districts are adjusted by the district's MER. The MER reduces these counts to the amount for services specific to Medicaid-enrolled individuals. The MER for the MAC program is calculated on an annual basis. The names, gender and birthdates of students are identified from the October 1st Student Count Report each year filed annually by each district to CDE and matched against the October 1st Medicaid enrollment file from The Department to determine the percentage of students enrolled in Medicaid. The numerator of the MER is the total number of Medicaid-enrolled students in the district and the denominator is the total number of students enrolled in the district. The costs of these activities are claimable as administrative activities but only to the extent that they are directed toward the Medicaid-enrolled population. This MER will also be used to discount the Direct Service Cost Pool for the time associated with Activity Code 4C.

Financial Data

The financial data to be included in the calculation of the MAC claim are to be based on actual expenditures incurred during the quarter. These costs must be obtained from actual detailed expenditure reports generated by the district's financial accounting system.

2 C.F.R. 225 specifically defines the types of costs: direct costs, indirect costs and allocable costs that can be included in the program. It provides principles to be applied in establishing the allowability of certain items of cost. These principles apply whether a cost is treated as direct or indirect. The following items are considered allowable costs as defined and cited below by 2 C.F.R. 225.

Direct Costs

Typical direct costs identified in 2 C.F.R. 225 include:

- Compensation of employees or contractors;
- Staff training and professional development; and
- Travel expenses incurred

Indirect Costs

Indirect costs included in the claim are computed by multiplying the costs by the district's approved unrestricted indirect cost rate. These indirect rates are district specific and developed by the district's State cognizant agency, CDE, and are updated annually. The methodology used by the respective State cognizant agency to develop the indirect rates has been approved by the cognizant federal agency, as required by the CMS guide. Indirect costs are included in the claim as reallocated costs.

The Department shall ensure that costs included in the MAC financial data are not included in the district's unrestricted indirect cost rate, and no costs will be accounted for more than once.

Unallowable Costs

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Costs that may not be included in the claim are:

- Direct costs related to staff that are not identified as eligible time study participants
- Costs that are paid with 100 percent federal funds

Revenue Offset

Expenditures included in the MAC claim are often funded with several sources of revenue. Some of these revenue sources require that expenditures be offset, or reduced, prior to determining the federal share reimbursable by Medicaid. These “recognized” revenue sources requiring an offset of expenditures are:

- Federal funds (both directly received by the district and pass through from State or local agencies such as IDEA, Title I, etc.)
- State expenditures that have been matched with federal funds (including FFS). Both the State and federal share must be used in the offset of expenditures.
- Third party recoveries and other insurance recoveries

Claim Certification

Districts will only be reimbursed the federal share of any MAC billings. The Chief Financial Officer (CFO), Chief Executive Officer (CEO), Executive Director (ED), Superintendent (SI) or other individual designated as the financial contact by the district will be required to certify the accuracy of the submitted claim and the availability of matching funds necessary. The certification statement will be included as part of the claim and will meet the requirements of 42 C.F.R. § 433.51.

Districts will be required to maintain documentation that appropriately identifies the certified funds used for MAC claiming. The documentation must also clearly illustrate that the funds used for certification have not been used to match other federal funds. Failure to appropriately document the certified funds may result in non-payment of claims.

TIME STUDY CODING INSTRUCTIONS

After RMTS sampled participants log their moment, it is the coders responsibility to categorize the response. The coding structure as seen starting on page 29 will determine whether the activities logged are claimable, non-claimable, an allocated expense or a cost that can be claimed.

All time study results are aggregated statewide and applied equally to districts participating in the SHS Program.

Code Descriptions

The coder uses the following detailed descriptions of each activity to determine how to properly code each participant’s answer.

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PROVISION OF SERVICES

CODE 1A. OUTREACH – FACILITATING NON-MEDICAID OUTREACH

Use this code when the participant is performing activities that inform individuals about non-Medicaid social (Supplemental Nutrition Assistance Program and Title IV-E), vocational, general health and educational programs (including special education) and how to access them; describing the range of benefits covered under these non-Medicaid social, vocational, and educational programs and how to obtain them. Both written and oral methods may be used. This code includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Informing families about wellness program and how to access those programs;
- Scheduling and promoting activities which educate individuals about the benefits of healthy life-styles and practices;
- Conducting general health education programs or campaigns addressed to the general population;
- Conducting outreach campaigns directed toward encouraging persons to access social, educational, legal, or other services not covered by Medicaid;
- Assisting in early identification of students with special medical/dental/mental health needs through various child find activities; and
- Outreach activities in support of programs that are 100 percent funded by State general revenue.

CODE 1B. OUTREACH – FACILITATING MEDICAID OUTREACH

Use this code when the participant is performing specific activities to inform eligible individuals about Medicaid and EPSDT benefits and how to access the program. Information includes a combination of oral and written methods that describe the range of services available through Medicaid and EPSDT, the cost (if any), location, how to obtain services, and the benefits of preventive health care. This code includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- 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;
- Interpreting materials about Medicaid to persons with students within the district boundaries who are illiterate, blind, deaf, or who cannot understand the English language;
- Informing foster care providers of foster children residing within district

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- boundaries about the Medicaid and EPSDT program;
- Informing Medicaid eligible pregnant students about the availability of EPSDT services for students under the age of 21 (including children who are eligible as newborns);
 - Utilizing brochures approved by the State Medicaid agency, designed to effectively inform eligible individuals about the benefits Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and services, and about how and where to obtain services;
 - 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;
 - Providing information about EPSDT in the schools that will help identify medical conditions that can be corrected or ameliorated by services covered through Medicaid;
 - Informing children and their families about the early diagnosis and treatment services for medical/mental health conditions that are available through the Medicaid program;
 - Providing information regarding Medicaid managed care programs and health plans to individuals and families and how to access that system;
 - Encouraging families to access medical/dental/mental health services provided by the Medicaid program; and
 - Facilitating access to Medicaid when a staff knows that a child does not have appropriate health care, this does not include child find activities directed to identifying students with educational handicapping conditions.

CODE 2A. ENROLLMENT – FACILITATING NON-MEDICAID ENROLLMENT OR ELIGIBILITY DETERMINATION

Use this code when the participant is assisting an individual or family to make application for programs such as TANF, Food Stamps, WIC, day care, legal aid, and other social or educational programs and referring them to the appropriate agency to make application. Both written and oral methods may be used. Include related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Explaining the eligibility process for non-Medicaid programs;
- Assisting the individual or family in collecting/gathering information and documents for the non-Medicaid program application;
- Assisting the individual or family in completing the application;
- Developing and verifying initial and continuing eligibility for the Free and Reduced Lunch Program. When a district employee is verifying a student's eligibility or continuing eligibility for Medicaid for the purpose of developing, ascertaining, or continuing eligibility under the Free and Reduced Lunch program, report that activity under this code; and
- Providing necessary forms and packaging all forms in preparation for the Non-Medicaid eligibility determination.

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CODE 2B. ENROLLMENT – FACILITATING MEDICAID ENROLLMENT OR ELIGIBILITY DETERMINATION

Use this code when the participant is assisting children and families in establishing Medicaid eligibility, by making referrals to The Department for eligibility determination, assisting the applicant in the completion of the Medicaid application forms, collecting information, and assisting in reporting any required changes affecting eligibility. Includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Referring an individual or family to the local assistance office to make an application for Medicaid benefits;
- Verifying an individual's current Medicaid eligibility status for purposes of the Medicaid eligibility process;
- Explaining the Medicaid eligibility process to prospective applicants;
- Providing assistance to the individual or family in collecting required information and documents for the Medicaid application;
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination;
- Referring an individual or family to the local Assistance Office to make application for Medicaid benefits;
- Assisting the individual or family in completing the Medicaid application; and
- Participating as a Medicaid eligibility outreach outstation.

CODE 3. EDUCATIONAL SERVICES – SCHOOL RELATED AND EDUCATIONAL ACTIVITIES

Use this code when the participant is performing any other school-related activities that are not Medicaid related, such as social services, educational services, teaching services; employment and job training. These activities include the development, coordination, and monitoring of a student's education plan. This code also includes all related paperwork, clerical activities, or staff travel required to perform these activities.

Examples:

- Providing general curriculum instruction to students;
- Developing lesson plans or curriculum;
- Evaluating curriculum and instructional services, policies, and procedures;
- Monitoring student academic achievement;
- Developing, coordinating, and monitoring the academic portion (related to the educational program) of the IEP for a student, which includes ensuring annual reviews of the IEP are conducted, parental sign-offs are obtained, and the academic portion of the actual IEP meetings with the parents. (If appropriate, this would also refer to the same activities performed in support of an IFSP.);

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- Monitoring academic progress related to an IEP/IFSP;
- Providing individualized academic instruction (math or reading concepts) to a special education student;
- Conducting external relations related to school educational issues/matters;
- Testing, correcting papers;
- Compiling grades and report cards;
- Providing general supervision of students (playground, lunchroom);
- Disciplining students or referring students for discipline;
- Performing clerical activities related to instruction services or curriculum;
- Providing general nutrition and health education to students;
- Completing classroom attendance reports;
- Compiling, preparing, and reviewing reports on textbooks or attendance;
- Reviewing the academic record of new students;
- Enrolling new students or obtaining registration information;
- Conferring with students or parents about discipline, academic matters or other school-related issues not related to an individualized plan;
- Administering achievement tests (CSAP, CSAP-A);
- Activities related to the educational aspects of meeting immunization requirements for school attendance;
- Enrolling new students or obtaining registration information;
- Evaluating curriculum and instructional services, policies, and procedures;
- Testing to assess specific learning disabilities or English language proficiency;
- Participating in or presenting training related to curriculum or instruction (e.g., language arts workshop, computer instruction); and
- Providing IDEA-mandated child find activities.

**CODE 4A. DIRECT MEDICAL SERVICES - NOT COVERED AS IDEA/IEP SERVICES,
NOT COVERED ON A MEDICAL PLAN OF CARE**

Use this code when the participant is providing direct client care services for which medical necessity has not been determined or for a service that is being provided by someone for which the service is not in their scope of practice. This code includes pre and post activities associated with the actual delivery of the direct client care services, e.g., paperwork or staff travel required to perform these services.

Examples:

- Administering first aid;
- Screening services conducted by non-qualified providers;
- Mental health services conducted by non-qualified providers; and
- Nursing services conducted by non-qualified providers.

CODE 4B. DIRECT MEDICAL SERVICES – COVERED AS IDEA/IEP SERVICES

IDEA/IEP SERVICES

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Use this code when district staff (employees or contracted staff) provide direct client services as covered services delivered by districts under the SHS Program. These direct client services may be delivered to an individual and/or group in order to ameliorate a specific condition and are performed in the presence of the student(s). This code includes the provision of all IDEA/IEP medical (i.e. health-related) services.

All IDEA and/or IEP direct client care services when the student is present:

- Providing health/mental health services as covered in the student's IEP.
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports as covered in the student's IEP.

Examples:

- Audiologist services including evaluation and therapy services (only if included in the student's IEP);
- PT services and evaluations (only if included in the student's IEP);
- OT services and evaluations (only if included in the student's IEP);
- Speech Language Therapy and evaluations (only if included in the student's IEP);
- Psychological services, including evaluations
- Counseling services, including therapy services (only if included in the student's IEP);
- Providing personal aide services (only if included in the student's IEP);
- Nursing services and evaluations (only if included in the student's IEP), including skilled nursing services on the IEP and time spent administering/monitoring medication only if it is included as part of an IEP and documented in the IEP;
- Physician services and evaluation, including therapy services (only if included in the student's IEP); and
- Social Work services and evaluation, including therapy services (only if included in the student's IEP).

This code also includes pre and post time directly related to providing direct client care services when the student is not present. Examples of pre and post time activities when the student is not present include: time to complete all paperwork related to the specific direct client care service, such as preparation of progress notes, translation of session notes, review of evaluation testing/observation, planning activities for the therapy session, travel to/from the therapy session, or completion of billing activities.

Examples:

- Pre and post activities associated with physical therapy services, for example, time to build a customized standing frame for a student or time to modify a student's wheelchair desk for improved freedom of movement for that client;
- Pre and post activities associated with speech language pathology services, for example, preparing lessons for a student to use with an augmentative

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- communicative device or preparing worksheets for use in group therapy sessions;
- Updating the medical/health-related service goals and objectives of the IEP;
 - Travel to the direct service/therapy;
 - Paperwork associated with the delivery of the direct care service, as long as the student/client is not present. Such paperwork could include the preparation of progress notes, translation of session notes, or completion of billing activities; and
 - Interpretation of the evaluation results and/or preparation of written evaluations, when student/client is not present. (Assessment services are billed for testing time when the student is present, for interpretation time when the student is not present, and for report writing when the student is not present.)

CODE 4C. - DIRECT MEDICAL SERVICES – COVERED ON A MEDICAL PLAN OF CARE, NOT COVERED AS IDEA/IEP SERVICE

Use this code when district staff (employees or contracted staff) provide covered direct medical services under the SHS Program when documented on a medical plan other than an IEP/IFSP or where medical necessity has been otherwise established. These direct services may be delivered to an individual and/or group in order to ameliorate a specific condition and are performed in the presence of the student(s).

All medical services with the student present including:

- Providing health/mental health services as covered in the student’s medical plan other than an IEP/IFSP;
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports as covered in the student’s medical plan other than an IEP/IFSP; and
- Covered services for which medical necessity has been determined.

The list of services corresponds to all of the services outlined in the Medicaid State Plan. This includes:

- Audiologist services including evaluation and therapy services (only if included in the student’s medical plan);
- Physical Therapy services and evaluations (only if included in the student’s medical plan);
- Occupational Therapy services and evaluations (only if included in the student’s medical plan);
- Speech Language Therapy services and evaluations (only if included in the student’s medical plan);
- Counseling services, including therapy services (only if included in the

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- student's medical plan or when medical necessity has been determined);
- Nursing services, evaluations, and administering / monitoring medication (only if medical necessity has been determined including skilled nursing services on the medical plan and time spent administering/monitoring medication.);
- Physician services and evaluation, including therapy services (only if included in the student's medical plan);
- Social Work services and evaluation, including therapy services (only if included in the student's medical plan); and
- All EPSDT covered services such as screenings, immunizations, etc. or services in which medical necessity has been determined.

This code also includes pre and post time directly related to providing direct medical services when the student is not present. Examples of pre and post time activities when the student/client is not present include: time to complete all paperwork related to the specific direct service, such as preparation of progress notes, translation of session notes, review of evaluation testing/observation, planning activities for the therapy session, travel to/from the therapy session, or completion of billing activities.

General examples that are considered pre and post time:

- Updating the medical/health-related service goals and objectives of the medical plan of care;
- Travel to the direct service/therapy;
- Paperwork associated with the delivery of the direct care service, as long as the student/client is not present. Such paperwork could include the preparation of progress notes, translation of session notes, or completion of billing activities; and
- Interpretation of the evaluation results and/or preparation of written evaluations, when student/client is not present. (Assessment services are billed for testing time when the student is present, for interpretation time when the student is not present, and for report writing when the student is not present.)

Code 5A. - Transportation for Non-Medicaid Services

Use this code when the participant is 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.

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

CODE 5B. - TRANSPORTATION RELATED TO MEDICAID SERVICES

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Use this code when the participant is 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 cost of the transportation, but rather the administrative activities involved in providing transportation. Include related paperwork, clerical activities or staff travel required to perform these activities. An example is:

- Scheduling or arranging transportation to Medicaid-covered services.

Note: Staff that may arrange transportation that may be included in the RMTS include, but are not limited to, Program Administrators, Special Education Support or other staff at the district who are responsible for arranging specialized transportation for students to receive medical services. However, job titles of staff that provide these types of services vary by district.

CODE 6A. TRANSLATION – NON-MEDICAID TRANSLATION SERVICES

Use this code when the participant is providing translation service for non-Medicaid activities. This code includes related paperwork, clerical activities or staff travel required to perform the activities.

Examples:

- Arranging for or providing translation services (oral or signing services) that assist the individual to access and understand social, educational, and vocational services;
- 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; and
- Developing translation materials that assist individuals to access and understand social, educational, and vocational services.

CODE 6B. TRANSLATION – MEDICAID TRANSLATION SERVICES

Use this code when translation services are not included and paid for as part of a medical assistance service and must be provided with 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 district does not need to have a separate administrative claiming unit for translation. This code includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

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

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CODE 7A. PLANNING – NON-MEDICAL PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION

Use this code when the participant is performing activities associated with the development of strategies to improve the coordination and delivery of non-medical services to school age students when performing collaborative activities with other agencies. Non-medical services may include social services, education, and vocational services. This code includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Identifying gaps or duplication of non-medical services to school age students and developing strategies to improve the delivery and coordination of these services;
- Developing strategies to assess or increase the capacity of non-medical school programs;
- Monitoring the non-medical delivery systems in schools;
- Developing procedures for tracking families' requests for assistance with non-medical services and providers;
- Evaluating the need for non-medical services in relation to specific populations or geographic areas;
- Analyzing non-medical data related to a specific program, population, or geographic area;
- 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;
- Defining the relationship of each agency's non-medical service to one another;
- Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services and State mandated health screening to the school populations;
- Developing medical referral sources; and
- Coordinating with interagency committees to identify, promote and develop non-medical services in the school system.

CODE 7B. PLANNING – MEDICAL PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION

Use this code when the participant is performing activities associated with the development of strategies to improve the coordination and delivery of medical/dental/mental health services to school age students, and when performing collaborative activities with other agencies and/or providers. 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 9B., Referral, Coordination and Monitoring of Medical Services. This code includes related paperwork, clerical activities or staff travel required to perform these activities.

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Examples:

- Developing strategies to assess or increase the capacity of school medical/dental/mental health programs;
- Monitoring the medical/dental/mental health delivery systems in schools;
- Developing procedures for tracking family's requests for assistance with medical/dental/mental health services and providers, including Medicaid. (This does not include the actual tracking of requests for Medicaid services);
- Evaluating the need for medical/dental/mental health services in relation to specific populations or geographic areas;
- Analyzing Medicaid data related to a specific program, population, or geographic area;
- Working with other agencies providing medical/dental/mental health services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligible, and to improve collaboration around the early identification of medical problems;
- Working with other agencies and/or providers to improve collaboration around the early identification of medical/dental/mental problems;
- Developing strategies to assess or increase the cost effectiveness of school medical/dental/mental health programs;
- 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;
- Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services to the school populations;
- 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;
- Coordinating with interagency committees to identify, promote and develop EPSDT services in the school system;
- Identifying gaps or duplication of medical/dental/mental health services to school age students and developing strategies to improve the delivery and coordination of these services; and
- Working with the State Medicaid agency to identify, recruit and promote the enrollment of potential Medicaid providers.

CODE 8A. TRAINING – NON-MEDICAL/MEDICAID RELATED TRAINING AND PROFESSIONAL DEVELOPMENT

Use this code when the participant is 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. This code includes related paperwork, clerical activities, or staff travel required to perform these activities.

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Examples:

- Participating in or coordination training that improves the delivery of services for programs other than Medicaid; and
- Participating in or coordinating training that enhances IDEA child find programs.

CODE 8B. TRAINING – MEDICAL/MEDICAID RELATED TRAINING AND PROFESSIONAL DEVELOPMENT

Use this code when the participant is coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefit of medical/Medicaid related services, how to assist families to access such services, and how to more effectively refer students for those services. This code includes related paperwork, clerical activities, or staff travel required to perform these activities.

Examples:

- Participating in or coordination training that improves the delivery of medical/Medicaid related services;
- 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); and
- Participating in training on administrative requirements related to medical/Medicaid services.

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

Use this code when the participant is making referrals for, coordinating, and/or monitoring the delivery of non-medical, such as educational services. This code includes related paperwork, clerical activities, or staff travel necessary to perform these activities.

Examples:

- Making referrals for and/or coordinating access to social and educational services such as child care, employment, job training, and;
- Making referrals for, coordinating, and/or monitoring the delivery of SEAs mandated child health screens;
- Making referrals for, coordinating, and/or monitoring the delivery of scholastic, vocational, and other non-health related examinations;
- Gathering any information that may be required in advance of these non-Medicaid related referrals; and
- Participating in a meeting/discussion to coordinate or review a student's needs for scholastic, vocational, and non-health related services not covered by Medicaid.

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**CODE 9B. REFERRAL - REFERRAL, COORDINATION AND MONITORING OF
MEDICAID SERVICES**

Use this code when the participant is 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 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 4A - Direct Medical Services - Not Covered as IDEA/IEP Services, 4B- Direct Medical Services - Covered as IDEA/IEP Services or 4C- Direct Medical Services – Covered on a Medical Plan of Care, Not Covered as IDEA/IEP service. This code includes related paperwork, clerical activities, or staff travel necessary to perform these activities.

Examples:

- Identifying and referring adolescents who may be in need of Medicaid family planning services;
- Making specific medical referrals for and/or coordinating medical or physical examinations and necessary medical/dental/mental health evaluations;
- Making referrals for and/or scheduling EPSDT screens, interperiodic screens, and appropriate immunization, but not to include the State-mandated health services;
- Referring students for necessary medical health, mental health, or substance abuse services covered by Medicaid;
- 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;
- Gathering information that may be required in advance of these medical/dental/mental health referrals;
- Participating in a meeting/discussion to coordinate or review a student's needs for health-related services covered by Medicaid;
- Developing, coordinating, and monitoring the medical portion of the IEP/IFSP for a student, which includes the medical portion of the actual IEP/IFSP meetings with the parents, time spent developing the medical services plan on the IEP/IFSP, and writing of the medical service goals of the IEP/IFSP;
- Providing follow-up contact to ensure that a child has received the prescribed medical/dental/mental health services;
- 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 for continuity of care;
- Providing information to other staff on the child's related medical/dental/mental health services and plans;
- Monitoring and evaluating the Medicaid service components of the IEP as appropriate; and

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- Coordinating the delivery of community based medical/dental/mental health services for children with special/severe health care needs.

CODE 10 - GENERAL ADMINISTRATION

Use this code when the participant is performing activities not directly assignable to program activities. Include related paperwork, clerical activities, or staff travel time required to perform administrative 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:

- Taking lunch, breaks, leave, vacation, sick, or other paid time off not at work;
- Establishing goals and objectives of health-related programs as part of the school's annual or multi-year plan;
- Ordering supplies;
- Reviewing school or district procedures and rules;
- Attending or facilitating board meetings or other district meetings;
- Performing administrative or clerical activities related to general building or district functions or operations;
- Providing general supervision of staff, including supervision of student teachers or classroom volunteers, and evaluation of employee performance;
- Reviewing technical literature and research articles; and
- Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.

CODE 11 UNALLOW – UNPAID TIME OFF

Use if the participant indicates that the moment occurred at a time when he or she was not scheduled to work, including unpaid days off.

5. Overview of New Policy Flexibilities Described in this Guide

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Topic Area	Flexibility
Billing using CPEs	<p>Roster Billing Methodology: Allow States to compute a rate that is representative of multiple services delivered. LEAs would multiply that rate, on a quarterly or monthly basis, by the number of Medicaid-enrolled students that receive a covered service within the service period. These quarterly/monthly payments would then be reconciled to actual costs at the end of each year. The roster billing approach presents a streamlined process compared to billing for individual claims.</p>
Billing using CPEs	<p>Per Child, Per Month (PCPM) or Per Service, Per Month Rate: Allow States to create an interim rate that can be 1/12th of the provider’s previous year’s actual costs, which would be paid out each month on a PCPM basis. Alternatively, an average cost per service could be paid as an interim payment where each service rate (for a set of services furnished to all beneficiaries) is based on an average calculation of expected costs per visit for several different types of services (e.g., physical therapy, occupational therapy, nursing, behavioral health, etc.) provided to all beneficiaries during the covered period. These monthly payments would then be reconciled to actual costs at the end of each year.</p>
Billing using CPEs	<p>Option to Not Submit Bills for Each Service: If a State chooses either roster billing or PCPM methodology, schools in the State would not be required to submit a bill for each service to Medicaid as long as interim rates are paid, and payments are reconciled to actual costs at the end of each year. Regardless of which interim billing methodology a State chooses, schools still are required to document and maintain records of each service delivered. Interim payments help to ensure that Medicaid-covered services have been provided and documented throughout the year and that schools have adequate cash flow.</p>
Billing using CPEs	<p>Clarifying Restrictions on Bundled Payment Rates: A 1999 State Medicaid Director’s Letter (SMDL) prohibited the use of bundled rates in school-based settings based on concerns over service documentation and financial oversight. The SMDL was issued prior to States implementing reconciled cost methodologies as the predominant method to pay for school-based services. This guide clarifies that bundled interim rates where the interim payments are reconciled to actual cost are allowable as long as providers maintain auditable documentation of each service a student receives for purposes of Medicaid reimbursement.</p>

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Billing in FFS using IGTs or appropriations - not reconciled to cost	Fee Schedule Rates that Exceed the Community Rate: Allow State Medicaid agencies to pay higher fee schedule rates for services offered in schools, as long as the State Medicaid agency demonstrates that the rate is economic and efficient as required by section 1902(a)(30)(A) of the Social Security Act (the Act).
Billing in general, for any payment methodology	This guide also addresses the following additional billing and payment topics: Encourages States to ensure that payment goes directly to schools to pay for providers and that any fees to run the program or offset contractor costs (e.g., to run a time study) charged by the State Medicaid agencies remains small. Highlights how States can use Medicaid grant awards via federal financial participation (FFP) to support positions at State Medicaid agencies and SEAs to support SBS. Advises schools not to pay school-based health services contractors on a contingency fee basis. Identifies parental consent requirements under the Family Educational Rights and Privacy Act (FERPA) and Part B of IDEA.
Documentation	De-identified Data: Allow LEAs and school-based providers to furnish some de-identified or masked data to support Medicaid Enrollment Ratios (MERs) or other allocation statistics. Permitting this type of de-identified data can help support schools in responding to audits. However, this does not supersede the requirement to provide the minimum documentation for Medicaid services (see below). CMS expects State Medicaid agencies and LEAs who want to use this option to seek out CMS and ED for best practices.
Allocations to Medicaid	More General Allocation Ratio: Historically, most school-based providers that were reimbursed actual costs utilized an IEP based ratio to allocate costs to Medicaid at the LEA level: number of Medicaid-enrolled students with an IEP receiving medical services / number of students with an IEP receiving medical services. This guide discusses the allowability of a more general ratio: number of Medicaid-enrolled students / Total number of students in the LEA. This approach eliminates the burden of producing documentation related to non-Medicaid enrolled students with an IEP. See the cost section, <i>General Requirements for Billing, Claiming, and Accounting for SBS Medical and Administrative Costs</i> , for more information on the MER.

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<p>Allocations to Medicaid</p>	<p>Using Time Study Moments as a 1-step Allocation Methodology: Within the overall cost identification process, application of a time study statistic on a statewide level is usually step 1 of 2 for allocating allowable costs to Medicaid. The second step is usually the application of the MER at an LEA specific level. Time studies are normally structured to identify time associated with activities that are medical in nature. For the first step, the time study statistics are applied to practitioners'/employees' salaries to allocate the portion of the practitioners'/employees' salary that is applicable to medical activities. For the second step, the MER is applied to the portion of the practitioners'/employees' salary that is applicable to medical activities to determine the portion of the practitioners'/employees' salary that is applicable to Medicaid.</p> <p>Instead of a 2-step process to allocate costs to Medicaid using a time study to allocate to medical services and then a MER to allocate to Medicaid, allow States to construct time study activity codes to capture time spent on Medicaid-allowable direct care services or administrative activities. The RMTS activity codes would be structured to define moments that are BOTH associated with the delivery of medical services and Medicaid-allowable activities- including both direct care services and administrative activities.</p>
<p>Time Studies using CPEs</p>	<p>Time Study (e.g., RMTS) Error Rate: CMS has historically required a +/- 2% error rate for the computation that factors into the number of random moments to be selected for time studies that are only applicable to Direct Medical services. With regard to time studies that are only applicable to State program administrative activities, CMS has allowed a +/- 5% error rate. Going forward, States and LEAs can now apply a +/- 5% error rate to the computation that factors into the number of random moments to be selected for all time studies. This will reduce the number of moments that will need to be sampled.</p>

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<p>Time Studies using CPEs</p>	<p>Time Study Notification and Response Window: Allow States to submit time study implementation plans that include up to a 2-day notification window and up to a 2-day response period for queried moments in their time studies for school-based providers, instead of a 0-day notification window and 2-day response window.</p> <p>Over the last several years, CMS has implemented a new policy as States submitted Time Study Implementation Plans for CMS approval. In an attempt to eliminate bias and error, CMS began to recommend up to 24 hours notification and a 2-day response period. Ideally, CMS would like all Time Study Implementation Plans to include no prior notification and a 2-day response period; however, CMS is aware of the many challenges States and LEAs face from funding to geography to technology when it comes to operationalizing a time study. As such, CMS will work with States and LEAs to reduce their upfront notification period and their response period as much as possible. In order to provide States and LEAs time to overcome barriers to immediately eliminate upfront notification and reduce the time study response period, CMS will allow States a transition period to come into compliance with this new requirement.</p>
<p>Provider Qualifications</p>	<p>SBS provider qualifications: Prior CMS guidance made it difficult for State Medicaid agencies to rely on ED provider qualifications or to establish different provider qualifications for school-based and non-school-based providers of the same Medicaid services. This guidance allows State Medicaid agencies to establish provider qualifications for school-based providers that differ from the qualifications of non-school-based providers of the same Medicaid services, as long as that State’s provider qualifications are not unique to Medicaid-covered services.</p>
<p>Third Party Liability</p>	<p>Third Party Reimbursement: Allow States to suspend or terminate efforts to seek reimbursement from a liable third party if they determine that the recovery would not be cost-effective pursuant to 42 C.F.R. §433.139(f), including for IDEA or 504-plan services. This could ease administrative burden at schools.</p>

Please note that the above flexibilities are options that States can leverage to ease burden as far as providing school-based Medicaid services. CMS is available to provide TA to States to best implement their programs. If you have questions regarding implementation of these options, please contact CMS at: SchoolBasedServices@cms.hhs.gov

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6. Acronym List

Acronym	Definition
ADL	Activities of Daily Living
BSCA	Bipartisan Safer Communities Act
C.F.R.	Code of Federal Regulations
CAP	Cost Allocation Plan
CAS	Cost Allocation Services
CHIP	Children’s Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMS	Centers for Medicare & Medicaid Services
CPE	Certified Public Expenditure
CPT	Current Procedural Terminology
DAB	Departmental Appeals Board
ED	Department of Education
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ESA	Education Service Agency
F&A	Facilities & Administrative
FAPE	Free Appropriate Public Education
FERPA	Family Educational Rights and Privacy Act
FFP	Federal Financial Participation
FFS	Fee-for-Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
G&A	General & Administrative
HCPS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HSI	Health Service Initiative
IADL	Instrumental Activities of Daily Living

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IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Program
IFSP	Individualized Family Service Plan
IGT	Intergovernmental Transfer
LEA	Local Educational Agency
MAC	Medicaid Administrative Claiming
MCP	Managed Care Plan
MER	Medicaid Enrollment Ratio
MMIS	Medicaid Management Information System
NEMT	Non-Emergency Medical Transportation
OIG	Office of Inspector General
OT	Occupational Therapy
PACAP	Public Assistance Cost Allocation Plan
PCCM	Primary Care Case Management
PCS	Personal Care Services
PII	Personally Identifiable Information
PT	Physical Therapy
RHC	Rural Health Clinic
RMTS	Random Moment Time Study
SAMHSA	Substance Abuse and Mental Health Services Administration
SBS	School-based Services
SEA	State Educational Agency
SED	Serious Emotional Disturbance
SMDL	State Medicaid Director Letter
SMM	State Medicaid Manual
SPA	State Plan Amendment
SUD	Substance Use Disorder
TAC	Technical Assistance Center
TA	Technical Assistance
TANF	Temporary Assistance for Needy Families

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TPL	Third Party Liability
UICR	Unrestricted Indirect Cognizant Agency Rate
VFC	Vaccines for Children
WIC	Women, Infants, and Children