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DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Education-Based Medicaid Administrative Claiming (NEBMAC) Guide

September 1, 2017

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF MEDICAID AND LONG-TERM CARE

GUIDANCE DOCUMENT

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Pursuant to

Neb. Rev. Stat. 84-901.03

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II. INTRODUCTION

This Nebraska Education-Based Medicaid Administrative Claiming (NEBMAC) Guide is effective for the quarter beginning September 1, 2017. All Nebraska public school districts and Educational Service Units (ESU's) are eligible to participate in the NEBMAC program. Effective June 1, 2017, Nebraska transitioned the NEBMAC program to a competitively procured statewide contractor for purposes of program administration in coordination and under the direction of HHS. Additional changes are now being presented to accommodate the state moving to a cost based reporting methodology for its direct service program which results in some changes to the time study process as outlined in this document.

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

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

The specific purpose of this Guide is to:

- Help schools and ESU's prepare appropriate claims for administrative costs under the Medicaid program;
- Ensure that the Medicaid program pays only for appropriate school-based administrative activities and that such activities are carried out effectively and efficiently;
- Protect the fiscal integrity of the Medicaid program by providing a clear articulation of the requirements for school-based administrative claiming;
- Help ensure consistency in the application of federal administrative claiming requirements and adherence to the provisions of the Centers for Medicare & Medicaid Services' (CMS) "Medicaid School-Based Administrative Claiming Guide";
- Promote the flexibility afforded in the implementation of the Medicaid program;
- Assist in the implementation of operational and oversight functions; and
- Provide technical assistance for the intended audience.

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

Expenditures for direct school-based health services that are within the scope of Medicaid coverage and furnished to Medicaid eligible children may be claimed as "medical assistance" and are not within the scope of the administrative claims discussed in this guide (See Section II – Medicaid in the School Setting). Expenditures for administrative activities in support of these school-based services including outreach and coordination may be claimed as costs of administering the Nebraska Medical Assistance Program. These claims are the subject of this Guide. The Guide is intended to help public school districts and Educational Service Units (ESU's) better understand when Medicaid reimbursement can be obtained for the administrative costs of school-based health services and how to prepare and submit appropriate claims for FFP.

At the national level, CMS reviews and assesses states' administrative claiming programs in accordance with applicable federal Medicaid law and regulations. CMS provides technical assistance to [Nebraska] DHHS to ensure ongoing integrity of the administrative claiming process. The development and implementation of the NEBMAC program is a collaborative process, as appropriate, involving the relevant entities: school districts, Educational Service Units, [Nebraska] DHHS, Nebraska Department of Education (NDE) and the federal government. [Nebraska] DHHS is responsible for the operation of Nebraska's Medicaid program so it is important for schools ESU's, and the Nebraska Department of Education to work closely with [Nebraska] DHHS for policy and technical assistance. This collaboration will help to ensure compliance with administrative claiming requirements. [Nebraska] DHHS is responsible for ensuring that applicable policies are applied uniformly throughout the state and that claims are submitted to CMS in conformance with such requirements.

The Medicaid program provides significant state operational and programmatic flexibility under federal regulation and oversight but federal Medicaid requirements only provide a framework for state Medicaid programs. Nebraska establishes and administers its Medicaid program within this framework. Therefore, even though federal Medicaid requirements are administered by CMS, schools need to contact and work through [Nebraska] DHHS.

The NEBMAC Program Coordinator, an employee of DHHS, provides oversight of the NEBMAC program and helps to ensure compliance with all local and federal regulations. The Program Specialist duties include, but are not limited to:

Training/Compliance

- Respond to requests for information from Local Education Agencies and ESUs.
- Maintain and disseminate all NEBMAC training materials, including the approved NEBMAC Claiming Guide.
- Ensure all policies and procedures related to the administration of the NEBMAC program are in compliance with state and federal guidelines.
- Provide guidance on proper coding to DHHS contractor and supply necessary training materials as requested.
- Attend training sessions with DHHS contractor, provide any updates to the program and answer questions.

Claim Review

- Review claims for completeness
- Verify all necessary supporting documentation is included and/or available for review
- Verification of the quarterly Participant List
- Submission and certification of MAC financial cost reporting
- Review of applied Indirect Cost Rate and Medicaid Eligibility Rate
- Submission and review of individual district claims
- Review claims to ensure that all claimed expenses are allowable
- Notify school districts of any errors and return or adjust claims accordingly

Time Study Review

- Review the Random Moment Time Study (RMTS) compliance rate, ensuring each school district achieves the 85% participation level as required by CMS.
  - Send a letter of warning to any school district not achieving the minimum compliance level.
  - Monitor the subsequent quarter to ensure compliance at the defined standards.
- For non-compliant entities, DHHS may deny both current claims and may prohibit the entity from claiming MAC expenses for the remainder of the fiscal year.

The Program Specialist will randomly select 5% of the sampled responses to ensure validity and appropriate coding.

State of Emergency Response

In the event there is a "state of emergency" or other disaster declared in the State of Nebraska that results in prolonged school closures that impact the schools' ability to participate in the RMTS as defined in the "Random Moment Sampling (RMTS) Time Study Methodology" section of this document, DHHS will apply the summer quarter claiming methodology to quarters occurring during the "state of emergency" including the quarter in which the state of emergency is declared and through the quarter in which the state of emergency period ends. The RMTS will not be applied during the impacted quarter(s) and claiming will be based on the average of the quarters that were completed. DHHS will provide the Centers for Medicaid & Chip Services (CMCS) with an official copy of the declaration of emergency within 15 days, and implement the procedures defined above.

III. MEDICAID IN THE SCHOOL SETTING

Medicaid is a critical source of health care coverage for children. The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provision (also known in Nebraska as HEALTH CHECK or Well-Child) is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. A primary goal of HEALTH CHECK is to establish a medical home for each child. A medical home is the primary care provider who manages a coordinated, comprehensive, continuous health care program to address the child's primary health needs. The medical home should provide or make arrangements for after- hours care and coordinate the child's specialty needs. The medical home should follow the screening periodicity schedule guidelines published by the American Academy of Pediatrics and perform periodic screens when medically necessary. The purpose of this Guide is to explain how Nebraska public school districts and Educational Service Units can be involved in the HEALTH CHECK program as administrative agents of the Medicaid Division and receive Medicaid reimbursement for providing administrative outreach and services coordination to students who are eligible or potentially eligible for Medicaid services. This program allows Nebraska's schools to become an "administrative arm" of the Medicaid agency through the assurance of health care coordination of students.

Even when appropriate health care services exist within a community, many beneficiaries of public health care programs do not readily access the primary and preventive services they or their children need. Among the primary reasons for the failure of persons to access services are: (a) the child in need is not being recognized as eligible for Medicaid which could fund the services needed; and (b) there is no system operating, however informal, to ensure that the services needed are identified and provided. By providing administrative outreach and care coordination, school-staff work to erase the "barriers-

to-access" that may exist. However, administrative care coordination does not include the full development, implementation and monitoring of a care- or treatment-plan for individual students. Other providers of [Nebraska] DHHS including managed care plans, managed care organizations and public health nurses are responsible for primary care planning and management in some areas of the state. School districts are expected to coordinate services with all [Nebraska] DHHS providers.

Many of the administrative activities discussed in this Guide that are claimable to Medicaid are those associated with and in support of the provision of medical services reimbursable under Medicaid. (See Section IV.C). There are other administrative activities not associated with covered Medicaid medical services which may be covered in schools. These include Medicaid outreach, facilitating Medicaid eligibility determinations, medical/Medicaid related training and general administration (See Activity Codes, Section IV. C).

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

- *IDEA-related health services*: The Individuals with Disabilities Education Act (IDEA) was passed to "assure that all children with disabilities have available to them… a free appropriate public education (FAPE) which emphasizes special education and related services designed to meet their individual needs." IDEA authorizes federal funding to states for medical services provided to children through a child's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP) including children who are covered under Medicaid. In 1988, Section 1903(c) of the Act was amended to permit Medicaid payment for medical services provided to Medicaid eligible children under IDEA and included in the child's IEP/IFSP.
  Nebraska is referred to as a "Birth-mandate State" since Nebraska R.R.S. §79-1132 requires that special education and related services are to be provided for infants and toddlers upon verification of a disability (ies). An infant or toddler with disabilities is a child, two years of age or younger, who needs early intervention (known in Nebraska as Early Development Network) services because they are experiencing developmental delays in one of the following areas: cognitive development; physical development; communication development; social or emotional development, adaptive development or has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. Services are provided through an IFSP) that is developed and implemented for each infant or toddler who is determined to be eligible for early intervention (EI) or Early Development Network (EDN) services. The plan is based on multidisciplinary evaluation and any other relevant information. Provision of these services "to meet the unique needs of the child" is done so at no cost to the child or family and is to begin immediately upon verification of the disability which may be as early as birth.
- *"Section 504" - related health services: Section 504 of the Rehabilitation Act of 1973 requires* local school districts to provide or pay for certain services to make education accessible to children with disabilities. These services may include health care services similar to those covered by IDEA and Medicaid. These services are typically described in a Section 504 plan and are provided free of charge to eligible individuals.
- *General health care services*: These services are typically mandated by the school district or state and include health care screenings, vision exams, hearing tests, a scoliosis exam, et cetera and provided free of charge to all students. Services provided by the school nurse (e.g., attending to a child's sore throat, dispensing medicine, etc.) may also fall into this category. These general health care services often resemble EPSDT/Health Check/Well-Child services.

Federal matching funds are available under Medicaid for the cost of administrative activities that directly support efforts to identify and enroll potentially eligible persons into Medicaid and that directly support the provision of medical services covered under the Nebraska Medical Assistance Program (NMAP/Medicaid). To the extent that school employees perform administrative activities that are in support of the Nebraska Medicaid Program, federal reimbursement may be available.

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

The direct medical services are paid by the Nebraska Medical Assistance Program (NMAP/Medicaid) and referred to as "Medicaid in Public Schools" (MIPS). Currently, Occupational Therapy (OT), Physical Therapy (PT) and Speech/Language Pathology/Therapy (SLP/ST) related services are claimed for reimbursement by public school districts, with an intended expansion of services effective September 1, 2017 to include Nursing Services, Vision Services, Mental and Substance Abuse Services, Personal Assistance Services and Transportation Services. Associated costs are excluded from any calculation of administrative costs and the administrative claim.

As prescribed in the Medicare Catastrophic Coverage Act [of 1988] (MCCA), Medicaid covers these direct services only under the following conditions:

- Services are identified in the child's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP) to meet the his/her unique needs as required to provide a Free Appropriate Public Education (FAPE);
- Services are medically necessary and included in a Medicaid covered category (speech therapy, physical therapy, etc.);
- Services are included in Nebraska's plan or available under EPSDT; and
- Medical services are only claimed for those provided to Medicaid eligible students.

IV. AGREEMENTS

A. General

Any public school district or Educational Service Unit (ESU) may participate in Medicaid administrative claiming (NEBMAC). School districts and ESU's receiving payment for Medicaid administrative activities being performed in the school setting are acting as agents for the Nebraska Department of Health and Human Services. Such activities may be paid under Medicaid only if they are necessary for the proper and efficient administration of the Nebraska Medicaid Program. Both ESU's and public school districts may claim related costs as long as the costs are allowable according to the NEBMAC Guide. Additionally, claimed costs must be incurred by the participating entity and all other elements of a proper claim must be present.

In Nebraska, DHHS is the only entity that may submit claims to CMS in order to receive FFP for allowable Medicaid costs. This requirement necessitates that every participating agency be covered, either directly or indirectly, through an intergovernmental agreement which describes and defines the relationship between public school districts/Educational Service Units conducting claimable activities, [Nebraska] DHHS and NDE. Such intergovernmental agreements must be in place in order to claim federal matching funds.

As of the beginning (September 1) of the 2017-18 school fiscal year, all participating public school districts and ESU's will participate in the NEBMAC program utilizing HHS' competitively procured statewide contractor for purposes of program administration in coordination and under the direction of HHS.

ESUs may provide contracted service providers to their member districts, and in some instances the same provider may work in several districts and the ESU. For purposes of the NEBMAC Program and to avoid duplication of staff reporting, ESU contracted providers may only be included once on the ESUs list of staff eligible to participate in the NEBMAC program. ESU's making administrative claims shall use an average of their member school districts' Medicaid eligibility rates weighted for enrollment but may only include their own cost-pool expenditures in order to calculate claims pursuant to this methodology.

Each public school district and ESU participating in Medicaid administrative claiming shall separately maintain the financial accounting records in accordance with the [United States] Office of Management and Budget (OMB) requirements and standards 2 CFR Part 225) for purposes of audits.

V. PRINCIPLES OF ADMINISTRATIVE CLAIMING

A. General

ESU, school or school district employees perform administrative activities that directly support the Medicaid program. Some or all of the costs of these administrative activities may be reimbursable under Medicaid. However, an appropriate claiming mechanism must be used. The random moment time study (RMTS) is used for identifying and categorizing Medicaid administrative activities and direct service activities performed by 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/NEBMAC. (See Section V.B), and is used in the calculation of MIPS Cost Settlements

The time-study, including the activity codes, represent the actual duties and responsibilities of participating ESU, school and school district employees, consistent with the operational principles discussed below (See Section IV.C for activity codes).

Effective September 1, 2017, activity codes listed in Section IV shall be used. No alteration of the activity codes is acceptable.

B. Operational Principles

1. Proper and Efficient Administration

According to the federal statute, in order for the cost of any activities to be allowable and reimbursable under Medicaid, activities must be necessary for the proper and efficient administration of the plan (referring to the Medicaid state plan) and the costs must be reasonable and necessary.

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

2. Claiming for Allowable Activities Only

Medicaid can only pay for administrative expenditures related to, or in support of health care services that are included in the state Medicaid plan or services which are reimbursed under Medicaid for Medicaid eligible individuals. For example, where school employees assist a Medicaid-eligible child to obtain medical services that are included in the child's IEP or IFSP, if the provider furnishing the medical services is not participating in Nebraska's Medicaid program or is not part of a managed care organization (MCO) participating in Nebraska's Medicaid program, FFP is not available for the services; furthermore, FFP is not available for the administrative activities to assist the child in accessing such services. These activities are not claimable because they are not considered in support of the operation of the Medicaid state plan (even if the services are included in Nebraska's Medicaid program).

3. Capture 100 Percent of Time

In order to ascertain the portion of time and activities that are related to administering the Medicaid program, DHHS must approve the allocation methodology. Effective September 1, 2013, the approved allocation methodology for Nebraska LEAs is the use of Random Moment Time Studies (RMTS).

To participate in the statewide NEBMAC and MIPS Cost Settlement programs, an LEA or ESC must require certain district staff to participate in a quarterly RMTS time study that covers the period for which claimed administrative and direct service activities were performed. This time study in turn, provides the basis for calculating amounts owed to the districts for these activities.

While many school district staff participate in administrative activities that are eligible for reimbursement by Medicaid, most do so only for a portion of their normal workday and at varying intervals. The time study allows LEA staff to document what they were doing during their sampled moment and determine what portion of the day was spent on Medicaid-covered activities. Details on how to conduct the time study are discussed in Section V, Claiming Issues, of this guide.

In order to ensure that all of the time-study participants are appropriately reflected in the time-study, staff classifications and associated supporting documentation (such as position descriptions) for time-study participants have been reviewed and considered in developing the time-study activity codes. This ensures that the unique responsibilities and functions performed by participants, as well as special factors and programs applicable to the participating ESU's, schools or school districts are accounted for and included in the time-study codes. As these codes were formulated, they were compared against staff classifications and supporting

position descriptions to ensure that all functions being performed are identified and incorporated into the codes. (See also Section V.A Documentation.)

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

The time-study activity codes must capture all of the activities performed by the time-study participants as indicated by Principle 2 and distinguish Medicaid activities from similar activities that are not Medicaid reimbursable. For example, a school employee who provides referrals for both Medicaid and non-Medicaid programs needs to appropriately allocate his or her time between these programs. This can be accomplished through the use of "parallel" time-study activity codes. In the above example, a time-study would include an activity code such as "Non-Medicaid Outreach" and its parallel code "Medicaid Outreach" (See Codes 1.a and 1.b in Section IV.C) or "Referrals to Non-Medicaid Enrolled Providers and Referral, Coordination and Monitoring of Non-Medicaid Services" and a parallel code such as "Referral, Coordination and Monitoring of Medical Services to Medicaid Enrolled Providers" (see Codes 8.a and 8.b in Section IV.C). Using a parallel coding structure ensures that the time-study captures 100 percent of the time spent on referrals and allocates it to the appropriate program. As noted in Section V.B.5, all staff in the sample universe are to be trained on proper coding procedures including reporting activities under the parallel codes before sampling begins.

5. 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, districts 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. Just as DHHS must provide assurances to CMS and of non-duplication through its administrative claims and the claiming process, districts must provide like assurances to [Nebraska] DHHS. Furthermore, in no case should a school district or ESU claim or be paid more than the actual cost of that program or claiming unit including state, local and federal funds.

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

- An activity that has been or will be paid as a medical assistance service or as a service of another non-Medicaid program (See Section IV.B Principle 6 on performing direct services vs. administrative activities);
- An activity that is included as part of a managed care rate and is reimbursed by the managed care organization.

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

Coordination of activities is intended to mitigate the duplicate performance of services or administrative activities and is discussed in Principle 6 (Coordination of Activities).

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

Any mechanism under which managed care rates are set and adjusted addresses the activities and services being furnished in the school setting.

6. Coordination of Activities

In addition to avoiding duplicate payments as discussed above in Principle 5, duplicate performance of activities must also be avoided. Under Principle 1, allowable administrative activities must be necessary "for the proper and efficient administration of the Nebraska Medicaid Program as well as for the operation of all governmental programs. Therefore, it is important that the school not perform activities that are already being offered or should be provided by other entities or through other programs. As appropriate, [Nebraska] DHHS, schools carefully coordinates efforts of NDE, providers, community and non-profit organizations and other entities related to the activities performed.

All agencies and persons involved must take whatever steps are necessary to ensure that appropriate coordination occurs among providers. These assurances are included in language implementing Medicaid managed care contracts. In addition, schools are required under IDEA to provide services listed in a child's IEP or IFSP. Therefore, Medicaid managed care contracts contain provisions that specifically exclude these services from the capitation rate paid to cover the costs of providing other medical services to Medicaid eligible children.

The following are examples of activities that are or need to be coordinated:

- Activities performed by an MCO for Medicaid enrollees such as case management functions. To avoid duplication of these functions by school personnel, coordination mechanisms are established between the school and appropriate entities, such as the MCO and [Nebraska] DHHS.
- Payment rate setting mechanism. [Nebraska] DHHS and schools coordinate their activities, payments to providers, third party payers and rate setting mechanisms to ensure that duplicate payments are not made and that medical services and administrative activities are provided as efficiently and effectively as possible. For example, MCO payment rates are adjusted to reflect the activities and services being furnished in the school setting.
- An activity that is provided/conducted by another governmental component. For example, it is not necessary for EPSDT educational materials, such as pamphlets and flyers which have already been developed by [Nebraska] DHHS to also be developed by schools. It would be inefficient in the allocation of Medicaid program and school resources to do so. In order to avoid this, ESU's and school districts/schools coordinate and consult with [Nebraska] DHHS to determine the appropriate activities related to EPSDT and the availability of existing materials.

7. Performing Direct Services v. Administrative Activities

School employees often perform both direct services (e.g., medical, vocational or social services, teaching) and administrative activities (e.g., outreach or care coordination). The time-study and activity codes capture and clearly distinguish direct services from administrative activities. Direct services like those addressed by Nebraska's MIPS program have different funding sources, claiming mechanisms and documentation requirements related to each program or type of activity and therefore should not be claimed as an administrative expense. The RMTS activity codes are designed to capture all administrative activities and direct services that may be performed in the school but only some of those activities are reimbursable under Medicaid. The time-study methodology identifies costs of medical and other direct services like OT, PT and SLP. Proper application of the time-study methodology will ensure that those costs are not included in claims for Medicaid administrative activities.

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

As indicated in Principle 4, payments for allowable Medicaid administrative activities must not duplicate payments that have been or should have been included as part of direct medical services, capitation rate or through some other state or federal program as specified in 2 CFR Part 225. It is the school district's and ESU's responsibility to ensure there is no duplication in a claim prior to submitting a claim to [Nebraska] DHHS.

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, should not be claimed as an administrative expense. For example, when a school provides medical services such as OT, PT and/or SLP, practitioners (therapists) should not bill separately for the cost of a referral as an administrative expense through MIPS or any other Public Assistance (PA) program. These activities are properly paid as part of the medical service/therapy and reimbursed at the Federal Medical Assistance Percentage (FMAP), nor may these activities be claimed as an additional cost through administrative case management which is defined below.

a. Case Management as Administration

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

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

- Medicaid eligibility determinations and redeterminations;
- Medicaid intake processing;
- Medicaid preadmission screening for inpatient care;

- Prior authorization for Medicaid services;
- Utilization review; and
- Medicaid outreach.

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

While some case management activities may fall within the scope of both administrative and targeted case management, claims may not be made for the same costs both as targeted case management and administrative case management per the duplicate payment provision discussed above.

b. Case Management as a Service

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

c. Allocable Share of Costs

i. Medicaid Eligibility Rate (MER)

Many school-based medical activities are provided both to Medicaid and non-Medicaid eligible students. Therefore, costs applicable to these activities must be allocated to both groups. This allocation of costs involves the determination and application of the proportional share of Medicaid students to the total number of students. Development of the proportional Medicaid share, which is sometimes referred to as the Medicaid Eligibility Rate (MER), Medicaid percentage, allocable share or discount rate, should relate to and be based on the claiming unit (the entity submitting the claim). [Nebraska] DHHS and the NDE work with the schools and ESU's to determine the MER for the claiming unit.

Annually, districts are required by State statute to submit to NDE, student information as of the last Friday in September. Beginning in the fall of 2005, NDE began annually capturing names, dates of birth, and gender data for their Nebraska Staff and Student Record System (NSSRS). A file of Medicaid eligible recipients is then compared to NDE's file (by school district) in order to identify the number

of Medicaid eligible students in each district. Dividing the number of matches identified for each district by the total number of students in each district results in the proportional Medicaid share for each district for that school year (Sep-Aug).

In order to determine the MER for participating ESU's, total number of matches identified for all districts within the ESU is divided by the total number of students in all districts within the ESU. The result is the proportional Medicaid share for that ESU.

The proportional Medicaid share is then applied to the total costs of a specific activity for which the claiming unit is submitting claims for FFP. This process is necessary to ensure that only the costs related to Medicaid eligible children are claimed to Medicaid. Note that not all activities are subject to the proportional Medicaid share. Activities such as outreach and facilitating eligibility determinations are not discounted at all while others are totally unallowable and therefore discounted in total (100%).

ii. Provider Participation Rate

Through the use of time-studies that contain specific activity codes, costs of school personnel are distributed to certain activities (time-study codes) to determine the administrative cost allocable to the Medicaid program. The participation rate is based on the four (4) criteria listed below and the universe of activity codes used in the time-study as a group must capture the following categories of costs:

(1) **Unallowable** - the activity is unallowable as administration under the Medicaid program;
(2) **100% Medicaid Share** - the activity is solely attributable to the Medicaid program and as such is not subject to the application of the Medicaid share percentage. This is sometimes referred to as "not discounted";
(3) **Proportional Medicaid Share** - the activity is allowable as administration under the Medicaid program but the allocable share of costs must be determined by applying the percentage of the Medicaid eligible population or MER for each school district or ESU included in the time-study This is sometimes referred to as "discounted"; or
(4) **Reallocated Activities** - those activities that are reallocated across other codes based on the percentage of time spent on allowable/unallowable administrative activities.

OMB 2 CFR Part 200 - Super Circular states that "a cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective **in accordance with relative benefits received"** (emphasis added). To establish the proportional Medicaid share, Medicaid eligible students must be determined and counted for each school/school district or ESU that is submitting a claim. This number serves as the numerator in a fraction with the denominator being the total number of students in the same entity. This fractional value is the MER and is then applied to the total costs applicable to the proportional Medicaid share time-codes to determine the costs applicable to Medicaid administrative

activities. Note that the number of those Medicaid eligible and the total number of students must be identified for the same time period. For example, total enrollment at the opening of school in August compared with Medicaid enrollment in November may not be used. Section 7.a above further describes the MER as it is calculated for Nebraska School Districts and ESU's. See IV.7.a for further explanation of Nebraska's method of gathering information for MER calculations.

$$\textbf{Medicaid Costs} = \left(\frac{\text{Number of Students In the School District Eligible for Medicaid}}{\text{Total Number of Students In the School District}} \right) \times \textbf{Costs to be allocated}$$

In the following example, administrative claims are developed on a school district basis. The purpose of applying a proportional Medicaid share is to determine the amount to be allocated between Medicaid and non-Medicaid students. The following example establishes how much of the costs related to the activity should be allocated to Medicaid. The amount of federal financial participation rate is currently 50% for all allowable administrative services. This percentage is used to determine the appropriate claim based on the activity costs that are allocable to Medicaid.

Example of Medicaid share**:**

- Gross Claimable Amount = $1,500
- Number of Medicaid Students in District = 1,000
- Number of Total Students in District = 5,000
- Activity = Referral, Coordination and Monitoring of Medicaid Services (Proportional Medicaid /50 Percent Federal Financial Participation)
- Medicaid Share Factor:Number of Medicaid Students District

÷	Total Students in District
=	1,000/5,000
=	**20 percent**

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

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

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

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

8. Enhanced FFP Rates

Claiming for Translation and Interpretation Services

CMS policy permits reimbursement at the standard 50% federal matching rate for translation/interpretation activities that are claimed as an administrative expense, so long as they are not included and paid for as part of the rate for direct services. With the enactment of CHIPRA in 2009, States were given the option to claim a higher matching rate for translation/interpretation services (75% under Medicaid; 75% or the State's enhanced FMAP + 5%, whichever is higher, under CHIP) that are claimed as administration and are related to enrollment, retention and use of services under Medicaid and CHIP for certain populations.

9. Individual Education Program (IEP) and Individualized Family Service Plan (IFSP) Activities

Section 411(k) (13) of the Medicare Catastrophic Coverage Act [of 1988] (MCCA) (Public Law (P.L.) 100-360) amended Section 1903(c) of the Act (42 U.S.C. 1396b(c)) to permit Medicaid payment for services provided to children under the Individuals with Disabilities Education Act (IDEA) through an Individual Education Program (IEP). IDEA provisions require school staff to perform a number of education-related activities that can generally be characterized as ChildFind, evaluation (initial), reevaluation and development of an IEP (See also Appendix A). Nebraska schools have a responsibility to develop and implement an Individualized Family Service Plan (IFSP) for each infant or toddler who has a verified disability and is thereby determined to be eligible for early intervention (IDEA "Part C")

services. Likewise, schools are responsible for developing and implementing an IEP for each child from three (3) to 21 who has a verified disability and is thereby determined to be eligible for "Part B" Special Education services. See *IDEA-related health services* in Section II (Medicaid in the School Setting) for additional information.

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

ChildFind: All children with disabilities residing in the state who are in need of special education and related services must be identified, located and evaluated.

Initial Evaluations and Reevaluation: Before special education and related services are provided, an initial evaluation must be conducted by the responsible public school district (usually the resident district) in order to determine whether a child has a disability and their special/specific educational needs. A re-evaluation is a determination as to whether the child continues to be disabled and is performed in regards to the continuation of the educational needs of the child. These evaluations are usually initiated by the Student Assistance Team (SAT) and performed by a Multidisciplinary [evaluation] team (MDT) as outlined in NDE's "Regulations and Standards for Special Education Programs." More commonly known in Nebraska as "Rule 51," these regulations may be found at Title 92 Nebraska Administrative Code (NAC) Chapter 51.

Individual Education Program (IEP): IEP's are addressed in Appendix A to the Guide.

Individualized Family Service Plan (IFSP): IFSP's are addressed in Appendix A to the Guide.

Schools conduct activities listed above for the purpose of fulfilling education-related services as mandated by IDEA. As such, associated costs of these activities are not allowable as administrative costs covered by the Medicaid program. In developing and reporting under the time-study activity codes, education-related activities must be clearly identified and distinguished as non-Medicaid activities. In general, these activities could be reported under time-study Codes 1.a, 2.a or 3 in Subsection C.

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

Various education-related statutes obligate schools to furnish or make payment for services provided in the school setting for which Medicaid payment is not available. Section 1903(c) of the Act clarifies that Medicaid payment is available for medical services contained in a child's IEP or IFSP established under IDEA so long as the child is eligible and the services are otherwise reimbursable under Medicaid but no other education-related statutes obligate Medicaid payment. For example, Section 504 of the Rehabilitation Act of 1973 requires local school districts to provide or pay for certain services to make education accessible to children with impairments; these services are described in a Section 504 plan. The 1903(c) exception is

very specific and does not extend to services provided pursuant to a Section 504 plan. Education agencies such as school districts are required to pay for Section 504 services and there is no provision to make the education agencies secondary to Medicaid. Consequentially, federal Medicaid funds are not available for these services.

IDEA is described further in Appendix A to this Guide.

10. Review and Approval of Program and Codes by CMS

CMS reviews claims made by [Nebraska] DHHS, particularly in situations involving the establishment of a new program in the state such as a school-based administrative claiming program in order to determine the allowability of such claims for federal matching funds. Furthermore, as discussed below and in Section V.D on Cost Allocation Plans, [United States] DHHS's Division of Cost Allocation (DCA), in coordination and consultation with CMS, is required to approve public assistance cost allocation plans (CAP's). CAP's must incorporate, by reference, time-study and cost allocation methodology adopted by [Nebraska] DHHS for schools to develop and document claims submitted to [Nebraska] DHHS.

Federal regulations (42 CFR 433.34) require that a single state agency have an approved public assistance CAP under the Medicaid state plan and on file with [United States] DHHS that meets certain regulatory requirements (Subpart E of 45 CFR Part 95). In Nebraska, that single state agency is [Nebraska] DHHS. As indicated in Subpart E of 45 CFR Part 95 and referenced in 2CFR Part 225, Attachment D, a state's public assistance CAP is an official document which describes the procedures that the state uses in identifying, measuring and allocating state agency costs incurred in support of all programs administered or supervised by the state such as Temporary Assistance for Needy Families (TANF), Medicaid, Food Stamps, Child Support Enforcement (CSE), adoption assistance, Foster Care and Social Service Block Grant (SSBG).

Furthermore, there are certain items that must be in the public assistance CAP which [Nebraska] DHHS must submit before providing FFP to school districts for administrative claiming. The public assistance CAP makes explicit reference to the methodologies, claiming mechanisms, interagency agreements and other relevant issues pertinent to the allocation of costs and submission of claims by LEA's, (school districts and ESU's).

[Nebraska] DHSS works with its regional CMS office in Kansas City, on an ongoing basis to assure a proper and accurate Cost Allocation Plan is in place and is properly applied as described above and further required by [United States] DHHS's CMS.

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

C. <u>Activity Codes: Descriptions and Examples</u>

1. Introduction

When staff perform duties related to the proper administration of Nebraska's Medicaid program (NMAP), federal funds (FFP) may be accessed for the costs of providing these administrative services. To identify the cost of providing these administrative services and

direct services, time-studies of must be conducted. The time-study identifies the time spent on the Medicaid administrative activities that are allowable and reimbursable under the Medicaid program. Effective September 1, 2017, coding scheme/activity codes as listed below must be used and may not be modified.

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

a. <u>Application of FFP rate</u>

50 percent Refers to an activity that is allowable as administration under the Medicaid program and claimable at 50 percent.

75 percent Refers to the Enhanced FFP rate allowable under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law No. 111-3, enacted on February 4, 2009 for translation or interpretation services.

b. <u>Unallowable Activities</u>

U Refers to an activity that is unallowable as administration under the Medicaid program and therefore claimable only at zero (0) percent. This is regardless of whether or not the population served includes Medicaid eligible individuals.

c. <u>Application of Medicaid Share</u>

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

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

d. <u>Reallocated Activities</u>

R Refers to those general administrative activities performed by time-study participants which must be reallocated across other activity codes on a pro rata basis. These reallocated activities are reported under Code 9, "General Administration." Note that certain functions such as payroll, maintaining inventories, developing budgets, executive direction, etc., are considered overhead and therefore are only allowable through the application of an approved indirect cost rate.

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

Code	Activity	Reimbursement
CODE 1.a	Non-Medicaid Outreach	U
CODE 1.b	Medicaid Outreach	TM/50 Percent FFP
CODE 2.a	Facilitating Application for Non-Medicaid Programs	U
CODE 2.b	Facilitating Medicaid Eligibility Determination	TM/ 50 Percent FFP
CODE 3	School-Related and Educational Activities	U
CODE 4.a	Direct Medical Service not on IEP	U
CODE 4.b	Direct Medical Service on an IEP	U
CODE 5.a	Transportation for Non-Medicaid Service	U
CODE 5.b	Transportation-Related Activities in Support of Medicaid Covered Services	PM/50 Percent FFP
CODE 6.a	Non-Medicaid Translation	U
CODE 6.b	Translation Related to Medicaid Services	PM/75 Percent FFP
CODE 7.a	Program Planning, Policy Development and Interagency Coordination Related to Non-Medical Services	U
CODE 7.b	Program Planning, Policy Development and Interagency Coordination Related to Medical Services	PM/50 Percent FFP
CODE 8.a	Non-Medical/Non-Medicaid Related Training	U
CODE 8.b	Medical/Medicaid Related Training	PM/50 Percent FFP
CODE 9.a	Referral, Coordination and Monitoring of Non-Medicaid Services	U
CODE 9.b	Referral, Coordination and Monitoring of Medicaid Services	PM/50 Percent FFP
CODE 10	General Administration	R
CODE 11	Non Paid, Non Work	N/A

The following activity codes represent a set of activity categories including administrative and direct services that are used and adapted to reflect Nebraska's specific program titles, etc. These codes were developed in accordance with the principles discussed in other sections of this Guide and must be used by schools effective September 1, 20017.

TIME STUDY CODE DESCRIPTIONS

1A. Non-Medicaid Outreach – U

All participating time-study participants should use this code when performing activities that inform individuals about their eligibility for **non-Medicaid** social, vocational and outreach programs (including special education) and how to access them; describing the range of benefits and how to obtain them. Both written and oral methods may be used. Includes 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. Providing information related to the applications for non-Medicaid programs. (e.g., foster care family coordination, WIC referrals, local shelters, emergency food assistance, day care, and indigent programs).
3. Scheduling and promoting activities that educate individuals about the benefits of healthy life styles and practices.
4. 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.).
5. Conducting campaigns that encourage persons to access social, educational, legal or other services not covered by Medicaid.
6. Assisting in early identification of children with special medical/dental/mental health needs through various child find activities. (e.g., contacting a nurse to communicate the child's needs, completing observations on students to determine needs, etc.).
7. Outreach activities in support of programs that are 100 percent funded by state general revenue.
8. Developing outreach materials such as brochures or handbooks for these programs.
9. Making arrangements with presenters of health education programs.
10. Parent conferences on truancy, drugs, gangs, etc.

1B. 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 providing information to parents of potentially eligible children on how to apply for Medicaid or information on how to reenroll children who are already eligible and whose eligibility is soon to expire. Education about Medicaid may only be conducted for the populations served by the school districts, i.e., students and their parents or guardians.

1. Informing Medicaid eligible and potential Medicaid eligible children and families about the benefits and availability of services provided by Medicaid (including preventive treatment and screening) including services provided through the ESPDT 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 New Mexico Human Services Department Medical Assistance Division (HSD/MAD), the Medicaid agency). As appropriate, school developed education materials should have prior approval of the HSD/MAD.
3. Distributing literature about the benefits, eligibility requirements, and availability of the Medicaid program, including EPSDT.

4. Assisting HSD/MAD to fulfill the education 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) 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.

2A. Facilitating Application for Non-Medicaid Programs – U

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

1. Explaining the eligibility process for non-Medicaid programs, including IDEA.
2. Assisting the individual or family collect/gather information and documents for the non-Medicaid program application (e.g., foster care family coordination, WIC referrals, local shelters, emergency food assistance, day care, Indigent programs etc.).
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.

2B. Facilitating Medicaid Eligibility Determination – TM/50 Percent

School staff should use this code when assisting an individual with the Medicaid eligibility process. Includes 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, 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 Income Support Division Office to make application for Medicaid benefits.
7. Assisting the individual or family in collecting/gathering required information and documents for the Medicaid application.

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

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. Includes related paperwork, clerical activities, or staff travel required to perform these activities.

1. Providing classroom instruction (including lesson planning).
2. Testing, correcting papers.
3. Developing, coordinating, and monitoring the Individualized Education Program (IEP) for a student, which includes ensuring annual reviews of the IEP are conducted, parental sign-offs are obtained, and the actual IEP meetings with the parents, except for the development of the medical component, e.g., the individualized treatment plan, of the IEP. (This would also refer to the same activities performed in support of an Individualized Family Service Plan (IFSP).)
4. Compiling attendance reports.
5. Performing activities that are specific to instructional, curriculum, and student-focused areas.
6. Reviewing the education record for students who are new to the school district.
7. Providing general supervision of students, e.g., playground, lunchroom.
8. Monitoring student academic achievement.
9. Providing individualized instruction (e.g., math concepts) to a special education student.
10. Conducting external relations related to school educational issues/matters.
11. Compiling report cards.
12. Carrying out discipline.
13. Performing clerical activities specific to instructional or curriculum areas.
14. Activities related to the educational aspects of meeting immunization requirements for school attendance.
15. Compiling, preparing, and reviewing reports on textbooks or attendance.
16. Enrolling new students or obtaining registration information.
17. Conferring with students or parents about discipline, academic matters or other school related issues.
18. Evaluating curriculum and instructional services, policies, and procedures.
19. Participating in or presenting training related to curriculum or instruction (e.g., language arts workshop, computer instruction).
20. Translating an academic test for a student.

4A. Direct Medical Services, Not Covered as IDEA/IEP Service – U

This code should be selected when school district staff are providing direct client care services that are not IDEA and/or not IEP services. This code includes the provision of all non-IDEA/IEP medical services reimbursed through Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. 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 of non-IDEA and/or non-IEP direct client care services as follows:

1. Medical Screenings (including scoliosis), Vision Screenings, Hearing Screenings, Dental Screenings, EPSDT Screenings, and nurse consults for non-Direct Service services;
2. Administering first aid;
3. Administering medication other than those medications outlined in the IEP as direct client care nursing services under the Direct Service program, e.g., providing immunizations;
4. Making referrals for and/or coordinating medical or physical examinations and necessary medical evaluations not covered as direct client care services under the Direct Service Program, as a result of a direct medical service;

4B. Direct Medical Services, Covered as IDEA/IEP Service – U

This code will be assigned when school district staff (employees or contracted staff) provides direct client services as covered services delivered by school districts under the Direct Service 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. It also includes functions performed pre and post of the actual direct client services (when the student may not be present), for example, paperwork, or staff travel directly related to the direct client services. Examples of activities reported under this code, include IDEA/IEP direct client services with the Student/Client present:

1. Audiologist services, including evaluation and therapy services (only if included in the student's IEP);
2. Physical Therapy services, including evaluation and therapy services (only if included in the student's IEP);
3. Occupational Therapy services, including evaluation and therapy services (only if included in the student's IEP);
4. Speech Language Pathology Therapy services, including evaluation and therapy services (only if included in the student's IEP);
5. Counseling Services, including counseling, evaluation, and therapy services (only if included in the student's IEP);
6. Nutritional Assessments and Counseling (only if included in the student's IEP);
7. 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. Medicaid administration would not include those that are provided to the entire student population, i.e. administration of aspirin, but are specifically those called for in the IEP;
8. Case Management Services, including medical/functional assessments and developing a comprehensive plan of care; and
9. Specialized Transportation 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/client 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 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.

5A. Transportation for Non-Medicaid Programs – 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. Includes 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.

5B. 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. Includes related paperwork, clerical activities or staff travel required to perform these activities. See Section VI for a more detailed and thorough discussion of Medicaid transportation policy.

1. Scheduling or arranging transportation to Medicaid covered services.

6A. Non-Medicaid Translation –

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

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.

6B. Translation Related to Medicaid Services – PM/75 Percent FFP

Translation may be allowable as an administrative activity, if it is not included and paid for as part of a medical assistance service. However, translation must be provided either by separate units or separate employees performing solely translation functions for the school, and it must facilitate access to Medicaid covered services. School employees who provide Medicaid translation services should use this code. Includes related paperwork, clerical activities or staff travel required to perform these activities.

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. This includes alternative languages, Braille, sign language and translation due to illiteracy.
2. Developing translation materials that assist individuals to access and understand necessary care or treatment covered by Medicaid.

7A. Program Planning, Policy Development and Interagency Coordination Related to Non-Medical Services – U

School staff should use this code when performing activities associated with developing strategies to improve the coordination and delivery of non-medical services to school age children. Non-medical services may include social services, educational services, vocational services, and state or state education mandated child health screenings provided to the general school population. Employees who position description includes program planning, policy development, and interagency coordination may use this code. If schools so choose, they may be explicit in the position descriptions with respect to the specific functions. Includes related paperwork, clerical activities or staff travel required to perform these activities.

1. Identifying gaps or duplication of non-medical services (e.g., social, vocational educational and state mandated general health care programs) to school age children and developing strategies to improve the delivery and coordination of these services.
2. Developing strategies to assess or increase the capacity of non-medical school programs.
3. Monitoring the non-medical delivery systems in schools.
4. Developing procedures for tracking families' requests for assistance with non-medical services and the providers of such services.
5. Evaluating the need for non-medical services in relation to specific populations or geographic areas.
6. Analyzing non-medical data related to a specific program, population, or geographic area.
7. Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of nonmedical 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.

7B. Program Planning, Policy Development and Interagency Coordination Related to Medical Services – PM/50 Percent FFP

This code should be used by school staff when performing activities associated with the development of strategies to improve the coordination and delivery of medical/dental/mental health services to school age children and adolescents, and when performing collaborative activities with other agencies and/or providers. Employees who position description includes program planning, policy development, and interagency coordination may use this code. If schools so choose, they may be explicit in the position descriptions with respect to the specific functions. This code refers to activities such as planning and developing procedures to track requests for services; the actual tracking of requests for Medicaid services would be coded under Code 9B. Includes related paperwork, clerical activities or staff travel required to perform these activities.

1. Identifying gaps or duplication of medical/dental/mental services to school age children and developing strategies to improve the delivery and coordination of these services.
2. Developing strategies to assess or increase the capacity of school medical/dental/mental health programs.

3. Monitoring the medical/dental/mental health delivery systems in schools.
4. Developing procedures for tracking families' requests for assistance with medical/dental/mental services and providers, including Medicaid. (This does not include the actual tracking of requests for Medicaid services.)
5. Evaluating the need for medical/dental/mental services in relation to specific populations or geographic areas.
6. Analyzing Medicaid data related to a specific program, population, or geographic area.
7. Working with other agencies and/or providers that provide medical/dental/mental services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligibles, and to increase provider participation and improve provider relations.
8. Working with other agencies and/or providers to improve collaboration around the early identification of medical/dental/mental problems.
9. Developing strategies to assess or increase the cost effectiveness of school medical/dental/mental health programs.
10. Defining the relationship of each agency's Medicaid services to one another.
11. Working with Medicaid resources, such as HSD/MAD and Medicaid managed care organizations, 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 HSD/MAD to identify, recruit and promote the enrollment of potential Medicaid providers.
14. Developing medical referral sources such as directories of Medicaid providers and managed care organizations, which will provide services to targeted population groups.
15. Coordinating with interagency committees to identify and promote recipients' access to Medicaid EPSDT services.

8A. 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. Includes related paperwork, clerical activities, or staff travel required to perform these activities.

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.

8B. 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 Medicaid training 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.

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 Medicaid school-based direct services and administrative requirements.

9A. Referral, Coordination & Monitoring of Non-Medicaid Services – U

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

1. Making referrals for and coordinating access to social and educational services such as child care, employment, job training, and housing.
2. Making referrals for, coordinating, and/or monitoring the delivery of state education agency mandated child health screens (e.g., vision, hearing, scoliosis).
3. Making referrals for, coordinating, and monitoring the delivery of scholastic, vocational, and other non-health related examinations.
4. Making referrals for, coordinating, and monitoring the delivery of services that are provided to all students in the school.
5. Gathering any information that may be required in advance of these non-Medicaid related referrals.
6. 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.
7. Monitoring and evaluating the non-medical components of the individualized plan as appropriate.

9B. 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 direct medical service, e.g., patient follow-up, patient assessment, patient counseling, patient education, patient consultation, and billing activities, should be reported under Code 4A/4B, Direct Medical Services.** Includes 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, periodic screens, and appropriate immunization but not referrals for state-mandated health screening or other primary and preventive services provided free of charge to all students.
4. Referring students for necessary medical health, mental health, or substance abuse services covered by Medicaid.
5. Arranging for any Medicaid covered medical/dental/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/mental health need.

6. Gathering any information that may be required in advance of medical/dental/mental health referrals.
7. Participating in a meeting/discussion to coordinate or review a student's needs for health related services covered by Medicaid.
8. Providing follow-up contact to ensure that a child has received the prescribed medical/dental/mental health services covered by Medicaid.
9. Coordinating the delivery of community based medical/dental/mental health services for a child with special/severe health care needs.
10. Coordinating the completion of the prescribed services, termination of services, and the referral of the child to other Medicaid service providers as may be required to provide continuity of care.
11. Providing information to other staff on the child's related medical/dental/mental health services and plans.
12. Monitoring and evaluating the Medicaid service components of the IEP as appropriate.
13. Coordinating medical/dental/mental health service provision with managed care plans as appropriate.

10. General Administration – R

1. Taking lunch, breaks, leave, or other paid time not at work.
2. Establishing goals and objectives of health-related programs as part of the school's annual or multi-year plan.
3. Reviewing school or district procedures and rules.
4. Attending or facilitating school or unit staff meetings, training, or board meetings.
5. Performing administrative or clerical activities related to general building or district functions or operations.
6. Providing general supervision of staff, including supervision of student teachers or classroom volunteers, and evaluation of employee performance.
7. Reviewing technical literature and research articles.
8. Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.

11. Not-Paid/Not-Worked – R

Non-paid time/non-work time is time during the school work day for which a participant in the time study is not working AND is not being compensated. Examples of activities reported under this code:

1. Part-time/Contracted staff whose sampled moment occurs during non-scheduled work hours.
2. Staff member takes an unpaid day off during the sampled moment
3. Non-paid sick time.
4. Non-paid leaves of absence.
5. No longer employed by the program

VI. CLAIMING ISSUES

A. <u>Documentation</u>

The time-study methodology and instructions, as well as the cost allocation requirements issued to the schools stipulate the documentation schools and ESU's must maintain to support claims submitted to [Nebraska] DHHS. The documentation for administrative activities must clearly

demonstrate that the activities/services directly support the administration of the Medicaid program. In accordance with federal statutes, state regulations and the Nebraska Medicaid plan, claimants (school districts, and ESU's) are required to maintain/retain adequate source documentation to support all Medicaid payments for administrative claiming. The basis for this requirement can be found in federal statute and regulations. See Section 1902(a)(4) of the Act and 42 CFR 431.17 as well as 45 CFR 74.53 and 42 CFR 433.32(a) requiring source documentation to support accounting records and 45 CFR 74.20 and 42 CFR 433.32(b-c) regarding the retention period for records. The administrative claiming records must be made available for review by state and federal staff or their designees upon request during normal working hours (Section 1902(a)(4) of the Act implemented at 42 CFR 431.17). It is the district's responsibility to ensure that claims submitted are in conformance with the applicable policies and in conformance with such requirements.

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

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

The burden of proof and validation of time-study sample results remains the responsibility of the schools/ESU. To meet this requirement, the RMTS survey ***include space*** for a brief narrative description of the Medicaid activity, function or task being performed.

Additional guidance regarding documentation for compensation of salary and wages is found in OMB 2 CFR Part 200 - Super Circular OMB 2 CFR Part 200 - Super Circular makes a distinction between documentation of costs and the methods/ mechanisms for allocating such costs. While costs must be documented at least on a monthly basis, time-studies which are conducted for purposes of allocating costs can occur on a quarterly basis or some other statistically valid time frame. ASMB C-10, U.S. Department of Health and Human Services' implementation guide for OMB 2 CFR Part 225, provides further guidance on the requirements and circumstances dictating the frequency of time and effort reporting. Other principles related to documentation and documentation requirements that apply in addition to the above requirements are:

- The documentation related to salaries and wages, including personnel activity reports, is required;
- Accounting records should be supported by source documentation such as canceled checks, electronic funds transfers, paid bills, payrolls, contract and sub grant award documents;
- The documentation related to foster care payments and administrative costs is required;

- Case management services based on time-studies are an acceptable form of documentation for a given period;
- Costs must be verified as being incurred in a particular federal program;
- Undocumented personnel costs are not allowed; and
- Adequate documentation for labor costs is required.

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

B. Components of the Random Moment /Time-Studies

1. Random Moment Sampling Methodology

To determine the proportion of claims for administrative activities in support of the NEBMAC program, proportion of claims for direct service activities, and the proper allocation of costs, DHHS utilizes a Random Moment Time Study (RMTS) time study methodology that is monitored and administered at the state level by DHHS staff and its selected contractor. Details concerning the RMTS process and the individuals who may participate are described below.

2. Time Study Participants

Any LEA or ESU staff member who spends part of their working time performing program-related administrative or direct service activities, and meets the eligibility criteria, is eligible for inclusion in one of two cost pools for purposes of the time study.

When a district constructs the list of staff that is included in the time study, it determines first whether the individuals in those positions perform administrative and/or direct service activities that support the NEBMAC and MIPS programs and then includes them in the appropriate category. Each category of staff will fall into one of two mutually exclusive cost pools. The purpose of two cost pools is to group staff into "like" categories.

- Cost Pool 1 is made up of direct service/therapy personnel and is the same listing of providers currently in the State plan.

- Cost Pool 2 is made up of staff involved in administrative activities rather than direct service activities. Staff that are 100% federally funded should be excluded from participation in the program, e.g. staff whose salary and benefits are paid entirely from IDEA or other federal funds.

The following categories of staff have been identified as appropriate participants for the time studies. All staff will be reported into one of two cost pools: "Cost Pool 1" or "Cost Pool 2". The two cost pools are mutually exclusive, i.e., no staff should be included in both pools. The following provides an overview of the eligible categories in each cost pool.

The MSBS program includes a number of direct medical services, also known as Direct Services that may include: physical, occupational, speech therapies, etc. These services are reimbursable by Medicaid if they are determined to be medically necessary in accordance with Medicaid policy, are part of the Medicaid-eligible recipient's IEP or IFSP for the treatment of an identified medical condition, and are provided by a qualified professional. Staff that fall under this description and are involved in these types of activities are included in Cost Pool 1.

In addition, school staff may be involved in administrative services in support of the Medicaid Program although they are not involved in the provision of direct services or direct-service providers. These activities may include, but are not limited to: Medicaid outreach; facilitating Medicaid eligibility determinations; translations related to Medicaid services; program planning, policy development, and interagency coordination related to medical services; medical/Medicaid-related training; referral, coordination, and monitoring of Medicaid services; and scheduling referrals for medical services. Staff that fall under this description are considered "non-Direct Service" providers and are included in Cost Pool 2.

3. Sample Universe

A basic step in the development of an approvable time-study is the determination of the sample universe. That is, school district staff/person(s) who will participate in (be sampled under) the time-study. All staff will be reported into one of two cost pools: "Cost Pool 1" or "Cost Pool 2", and the following provides an overview of the eligible categories in each cost pool.

4. Cost Pool 1

Staff that participate in administrative activities and are eligible to submit claims for the Direct Service (DS) Program are included in Cost Pool 1. The RMTS Study will also be utilized to determine Direct Service cost reimbursement. Cost Pool 1 staff includes:

Occupational Therapist, Licensed
Occupational Therapy Asst, Licensed
Occupational Therapy Paraprofessional (Supervised)
Physical Therapist, Licensed
Physical Therapy Assistant, Licensed
Physical Therapy Paraprofessional (Supervised)
Physician
Psychologist, Provisionally Licensed
Psychologist, Licensed
Independent Mental Health Practitioner, Licensed (LIMHP)
Mental Health Practitioner, Licensed (LMHP)
Mental Health Practitioner, Provisionally Licensed (PLMHP)
Alcohol and Drug Counselor, Licensed (LADC)
Alcohol and Drug Counselor, Provisionally Licensed
Behavioral Analyst, Board Certified

Behavioral Analyst Assistant, Board Certified
Behavioral Technician, Registered
Registered Nurse (RN), Licensed
Practical Nurse (LPN), Licensed
Health Technician (Supervised)
Health Paraprofessional (Supervised)
Audiologist, Licensed
Speech Pathologist, Licensed
Personal Assistant Service Provider
Optometrist, Licensed

5. Cost Pool 2

Staff included in Cost Pool 2 are non-Direct Service personnel that are involved in administrative activities. In addition to the categories listed below, if an LEA or ESU identifies a staff member who typically or potentially performs allowable Medicaid administrative functions: the district may seek permission from the DHHS Program Manager to include those additional staff members.

Aides
Bilingual Specialist
Counselor
Diagnostician
Interpreter
Orientation and Mobility Specialist
Principal/Asst Principal
Program Specialist
Special Education Administrator/Asst
Special Education Teacher
Speech Paraprofessional (Supervised)
Student Services Personnel
Social Worker, Bachelors Level (BSW)
Social Worker, Masters Level (MSW)
Teacher Endorsed with Speech and Language

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

It may also be appropriate to exclude certain other workers from the study. For example, medical staff hired by the schools as contractors and reimbursed on a fixed fee basis such as audiologists paid a set amount for each hearing test performed and others who do not perform

any other administrative activities should not be included in the time-study. Such workers should not be included in the sample universe and therefore their costs would be excluded from the base to be allocated.

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

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

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

6. Sampling

Once compiled statewide, each cost pool is sampled to identify participants in the RMTS time study. The sample is selected from each statewide cost pool, along with the total number of eligible time study moments for the quarter. 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 using a statistically valid random sampling technique, with an individual from the total pool of participants.

Each time the selection of a moment and the selection of a 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 moment 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 documentation submitted by the employee.

7. Process for Participating in the RMS Time Study

The RMS time study model is used to measure the percentage of time school district staff spends in performance of Medicaid administrative and direct service activities by sampling and assessing the activities of a randomly selected cross-section of individuals included in Cost Pool 1 and Cost Pool 2. These individuals are queried at random over a billing quarter about their activities during a specified moment on a certain date. The results of these queries are then tallied and averaged for the quarter; these averages total the reimbursable amount that each school district is eligible to receive for that quarter. The sampling period is defined as the same three-month period comprising each quarter of the federal calendar.

To participate in the state-administered RMS, the steps outlined below are followed:

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

8. Identify Total Pool of Time Study Participants

Prior to the beginning of each quarter, participating LEAs and ESUs submit a staff roster (Participant List) providing a comprehensive list of staff eligible to participate in the RMS time study.

This list may include vacant positions that are planned to be filled during the reporting quarter. If a vacant position is filled during the quarter, the individual will complete the time study (if sampled), and actual costs incurred for the position during the quarter are eligible to be reported. If a vacant position is not filled during the quarter, then any sampled time study moments are coded to Code 11 "Not Worked/Not Paid" and no costs are eligible to be reported. If a position becomes vacated during the quarter and is later filled with a direct replacement, the direct replacement will complete the time study (if sampled), and the proportional costs incurred for both the original participant and direct replacement are eligible to be reported. If the vacated position is not filled during the quarter, then any sampled time study moments are coded to Code 11 "Not Worked/Not Paid" and only those proportional costs eligible during the period staff received compensation can be reported.

The 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 two "cost pools" as previously defined. Once the roster of eligible staff is submitted it cannot be updated or changed once the RMTS period begins.

9. Identify Total Pool of Time Study Moments

The sampling period is defined as the three-month period comprising each quarter of the state Fiscal Year calendar. The following are the quarters followed for the Administrative Claiming program and a time study is performed for each of the quarters, except for the June 1 - August 31 quarter (summer quarter):

- September 1 – November 31
- December 1 – February 28
- March 1 – May 31

- June 1 – August 31

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 total pool of moments for the quarter is reduced by the exclusion of weekends, holidays and hours during which employees are not scheduled to work. Standard working hours are determined by DHHS, provided to the contractor, and consistently applied across the LEAs and ESUs.

10. Randomly Select Moments and Randomly Match Each Moment to a Participant

Once compiled statewide, each cost pool is sampled to identify participants in the RMTS time study. The sample is selected from each statewide cost pool, along with the total number of eligible time study moments for the quarter. 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 using a statistically valid random sampling technique, with an individual from the total pool of participants.

Each time the selection of a moment and the selection of a 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 moment 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 documentation submitted by the employee.

11. Sampling Requirements

In order to achieve statistical validity, maintain program efficiencies and reduce unnecessary district administrative burden an efficient sampling methodology will be used.

CMS policy permits a 5% precision level for random moment time study results that are used to claim MAC expenditures, as stated in the CMS May 2003 Medicaid School-Based Administrative Claiming Guide. However, CMS policy requires a higher 2% precision level for medical assistance (MAP) expenditures claimed under the cost based reporting methodology for its Direct Service Program. As a result, the following sampling methodology is defined for each Cost Pool.

12. Sampling Methodology - Cost Pool 1 (Direct Service & Administrative Providers)

Statistical calculations show that a minimum sample of 2401 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. Invalid moments are moments not returned or inaccurately coded.

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

$$ss = \frac{Z2 * (p) * (1-p)}{c2}$$

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

$$\text{new ss} = \frac{ss}{1 + \frac{ss-1}{pop}}$$

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 15% will be used to account for unusable moments.

N=	Sample Size Required	Sample Size plus 15% Oversample
100,000	2345	2697
200,000	2373	2729
300,000	2382	2739
400,000	2387	2743
500,000	2390	2745
750,000	2393	2752
1,000,000	2395	2754
3,000,000	2399	2759

>3,839,197	2401	2761

13. Sampling Methodology - Cost Pool 2 (Administrative Services Providers Only)

CMS policy permits a 5% precision level for random moment time study results that are used to claim MAC expenditures, as stated in the CMS May 2003 Medicaid School-Based Administrative Claiming Guide. The RMTS sampling methodology for Cost Pool 2 must meet federal reporting and documentation requirements, and is designed to permit a level of precision of +/- 5% (five percent) with a 95% (ninety-five percent) confidence level for activities. Calculations show that a minimum sample of 385 completed moments each quarter is adequate to obtain this precision when the total pool of moments is greater than 222,639. Additional moments of a 15% oversample should be selected each quarter to account for any lost moments (observations that cannot be used for analysis, i.e., incomplete moments or moments selected for staff no longer at the district, etc.).

Moments not returned by the school district will not be included in the database unless the return rate for valid moments is less than 85%. If the statewide return rate of valid moments is less than 85%, all non-returned moments will be included and coded as non-Medicaid.

To assure that districts are properly returning sample moments, districts' return percentages for each quarter will be analyzed. If an individual district has non-returns greater than 15% and greater than five (5) sampled moments for a quarter, HHS may take appropriate action using sanctions, which may include but not be limited to conducting more frequent monitoring reviews, eliminating the school district's claimed portion of federal funds, or ultimately, termination of the school district's participation.

Nebraska requires a state-wide response for the time-study survey of at least 85%. Moments that have been inaccurately coded shall be returned to the district/ESU for correction and every effort shall be made to obtain the corrected valid moment from the district/ESU. Moments not returned or not accurately completed and subsequently resubmitted shall not be included in the data base. If the return rate of valid moments is less than 85%, non-returned moments shall be included and coded as non-allowable until an 85% compliance rate is obtained. To ensure that enough moments are received to have a statistically valid sample, a minimum of 15% over-sampling should be used. Districts/ESU must submit completed moments within five (5) working days after the sampled moment. To assure that districts/ESU's are properly returning sample moments, return percentages for each quarter shall be analyzed (See Item 7 below for further Validation requirements).

The State shall be notified of any district/ESU that has non-returns greater than 15% and more than five (5) moments for a quarter. The State in turn will issue a warning in writing to the district/ESU requesting that a corrective action plan be submitted to the State within thirty (30) days of the warning letter. The plan should detail the district/ESU's methodology for increasing its response rate. If the district/ESU has a non-response rate greater than 15% for two (2) successive time-study periods, it will not be able to participate for the entire fiscal year (Sep-Aug) and must return any payment made for the defaulted fiscal year.

14. Treatment of Summer Period

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

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

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

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

In Nebraska, school staff members are often paid for a nine-month school year but their salaries paid over 12 months. Sampling during the 9 months, therefore, identifies activity related to salaries better than a sample over the 12-month period. In lieu of using the standard time-study concept during the fourth (summer – June, July, August) quarter, school districts may use an average of the time-study results from the preceding three (3) quarters. The fourth quarter encompasses the summer months when a systematic sampling would find few school staff at work. This sampling average will be applied to the fourth fiscal quarter's financial information to formulate the claim.

15. Time-Study Documentation

As with all administrative costs that are related to time-study activities, there must be documentation of the costs for which FFP will be claimed under Medicaid. Documentation to be retained must support and include the following: sample universe determination, sample selection, sample results, sampling forms, cost data for each school district and summary sheets showing how each school district's claim was compiled. All claims by the LEA's and schools are summarized and submitted to DHHS for payment. The individual sample sheets may or may not be kept locally. Sometimes individual sheets are maintained locally while summary records are maintained at a central location.

[Nebraska] DHHS allows operational flexibility for validating the results of time-studies related to administrative activities. For example, administrative claims could be compared to parallel claims for direct services under Medicaid. However, regardless of the validation mechanism that is employed, appropriate documentation supporting claims must be maintained and available for audit purposes. DHHS and CMS work together to develop an acceptable validation mechanism.

16. Training for Staffing Time-study

All staff in the sample universe should be adequately trained before completing a sampled moment. Periodic staff education is essential for proper administration of the Medicaid EPSDT and NEBMAC programs. All district staff should become aware of the EPSDT program and its health benefits to eligible students through district-wide in-service awareness programs.

Without proper NEBMAC program training, data collected and used to generate billable charges will have little, if any, validity or reliability. Absent such, districts could not substantiate their charges and some or all funds paid would likely be disallowed and recouped. The procedures recommended herein and those which are to be included in the methodology are intended to assure the development of a complete, valid and reliable record of employee time and effort regarding program billings.

The objective of training staff for participation in the RMTS is to teach the:

1. Goals and overview of the NEBMAC program;
2. Instructions regarding the accurate completion of the RMTS time survey; and Importance of the accuracy of the participants' documentation to the district's overall effort.

It is important that the cost-pool staff realize what NEBMAC, outreach to children and wellness education means to them. Training should prepare the sampled participant to understand the purpose of the time-study and to be able to accurately document their activity during their sampled moment. Staff should know the difference between health related and other activities. Professional staff must understand the distinctions between the performance of administrative activities and direct medical services.

Time study participants are notified via email to participate in the time study and of their sampled moment. Sampled participants will be notified of their sampled moment no earlier than forty-eight (48) hours prior to their sampled moment. At the prescribed moment, each

sampled participant is asked to record and submit his/her activity for that particular moment. The sampled moment has a three (3) day response window. After the three (3) day response time has expired, the participant's login will not work and they will no longer be able to respond to the time study.

All staff training materials used by school districts must be approved by [Nebraska] DHHS prior to use for compliance with State methodology. Failure to do so may invalidate claims. Notification of training sessions must be made by the school district or consultant to DHHS in advance of training so that Agency staff may observe.

17. Monitoring Process

Each school district or its contractor/consultant must maintain separate audit files for each quarter billed. The following documentation is required:

- Completed RMTS surveys;
- A copy of the summary of time-study compliance;
- School location and costs paid for each group member in the cost-pool master list, employees and contracted personnel;
- Upon request of the auditor, contracts of contracted employees;
- Any computations or allocations used in reimbursement calculations and written explanations;
- A detailed listing of all revenues offset by the claim by source;
- Copies of training materials given to staff;
- Names of attendees and instructors for the training session given for that quarter;
- A completed quarterly claim; and
- Organizational charts, job descriptions or other documents establishing supervisory relationships ***must be available for audit.***

The above listed audit files should be retained by each school district for a period of five (5) years after the quarterly claim is filed with DHHS unless an ongoing audit or resolution of an audit exception in process. This data is essential to conducting periodic audits of billings. Lack of such documentation may lead to the disallowance of costs by DHHS and the school district or ESU could be forced to repay such costs.

18. Validation Process

In order to ensure that the time-study results are valid, the sampling methodology must be monitored for each participating school district and ESU. Yearly, sampling of claims of participating entities should be selected for review to verify time-study activities, statistics and claiming activities. Such reviews will include examination of calculations of time-study documents, processes and claim documents, and should involve 10% of the time study sample. DHHS employees or its agent may conduct these reviews. School districts will be notified in advance of any planned site visits in connection with reviews.

For each claim submitted for payment, DHHS also validates the claim calculations and the application of Medicaid Eligibility and indirect cost rates.

C. Offset of Revenues

Certain revenues must offset allocation costs in order to reduce the total amount of costs in which the federal government will participate. To the extent the funding sources have paid or would pay for the costs at issue, federal Medicaid funding is not available and the costs must be removed from total costs (See OMB 2 CFR Part 225, Attachment A, Part C., Item 4.a.). The following include some of the revenue-offset categories which must be applied in developing the net costs:

- All federal funds:
- All state expenditures which have been previously matched by the federal government including but not limited to Medicaid funds for medical assistance such as the payment rate for services under fee-for-service;
- Insurance and other fees collected from non-governmental sources must be offset against claims for Medicaid funds;
- All applicable credits must be offset against claims for Medicaid funds. Applicable credits refer to those receipts or reduction of expenditure type transactions that offset or reduce expense items allocable to federal awards as direct or indirect costs;
- A program may not claim any federal match for administrative activities if its total cost has already been paid by the revenue sources above. A government program may not be reimbursed in excess of its actual costs, i.e., make a profit.
- The administrative costs incurred by DHHS to administer the School Based Admin program are: salaries, benefits, operating costs, and allocated costs (per the Nebraska Cost Allocation Plan). These costs are reported on the CMS-64.10 Base Line 29.
- DHHS will refund 50% of that fee to CMS and will be reported on form CMS 64-10 Base, Line 19.
- DHHS will subtract the amount received for the 3% fee from the total paid to the schools as a cost allocation adjustment and report the net amount CMS 64.10 Base form, Line 19. This will occur each quarter as part of the normal cost allocation adjustment process prior to running the final cost allocation module (distribution) in Enterprise One (NIS).

D. Cost Allocation Plans

Requirements for the development, documentation, submission, negotiation and approval of public assistance cost allocation plans are set forth in Subpart E of 45 CFR Part 95 and ASMB C-10. All administrative costs (direct and indirect) are normally charged to federal awards by implementing the public assistance cost allocation plan (CAP). OMB 2 CFR Part 225, Cost Principles for State, Local and Indian Tribal Governments - Attachment D - extends these requirements to all federal agencies whose programs, including Medicaid, are administered by a state public assistance agency. 2CFR Part 225 policy is that state public assistance agencies will develop, document and implement and the federal government will review, negotiate and approve public assistance CAP's.

In accordance with the federal regulations indicated above and 2 CFR Part 225, a public assistance CAP must be amended and approved by the Division of Cost Allocation (DCA)

within DHHS before FFP is available for administrative claims in the Medicaid program. In this regard, public assistance CAP's must provide, in accordance with the approved interagency agreements, for reimbursement of the administrative activities performed in the school setting and for which claims will be made by the LEA's, school districts and schools to DHHS The public assistance CAP must make explicit reference to the methodologies, claiming mechanisms, interagency agreements and other relevant issues that will be used by the LEA's, school districts and schools for making such claims and appropriately allocating costs. CMS does not have direct authority for approval of the public assistance CAP's. That is the purview of the DCA. However, CMS works directly with the DCA in the public assistance CAP review and approval process. Under this process the DCA will not approve such public assistance CAP's without CMS review and approval of the methodologies referenced in the public assistance CAP. Therefore, referenced elements must be reviewed and approved by CMS before implementation of the school-based administrative claiming program and before the claiming of FFP.

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

The school-based administrative claiming program must be supported by a system that has the capability to isolate the costs directly related to the support of the Medicaid program from all other costs incurred by the school and that will ultimately be claimed by DHHS as administration. Such costs must comply with the cost allocation principles described in 2 CFR Part 225 which requires that costs be "necessary and reasonable" and "allocable" to the Medicaid program. Claims for the school district's indirect costs are only allowable when the entity has an approved indirect cost rate issued by the cognizant agency and costs are claimed in accordance with the rate

E. Administrative Claiming Implementation Plan

The implementation plan includes the following elements:

- **Treatment of Indirect Costs:** Indirect costs may be claimed at the restricted or non-restricted indirect cost rate approved by the cognizant agency responsible for approving such rates. With respect to school-based administrative costs, "cognizant agency" is the U.S. Department of Education or its delegate. In Nebraska, the cognizant agency is the Nebraska Department of Education. NDE's School Finance and Organizational Services section annually calculates indirect cost rates for each local education agency (districts and Educational Service Units), and submits the cost allocation plan to the U.S. Department of Education for approval. Once approved, restricted and unrestricted indirect cost rates are available at http://www.education.ne.gov/fos/ASPX/IndirectCost/Default.aspx. The school district must certify that costs claimed as direct costs do not duplicate those costs reimbursed through application of the indirect cost rate.

- **Certified Public Expenditures:** Administrative payments for school-based services will be made utilizing certified public expenditures (CPE) to satisfy the state match requirements under Medicaid. There are sufficient ***local*** funds to match Title XIX expenditures and the funds are not already being used to match federal funds of other federal programs or being reimbursed by other federal grants.

- **Description of Current Administrative Activities Paid by Medicaid:** Administrative case management will usually not include the full development, implementation and monitoring of a care or treatment plan for individual students. Other contractors/providers of DHHS, including managed care plans, managed care organizations and public health nurses are responsible for the primary care planning and management in some areas of the state. School districts will be made aware of the existence of such contractors/providers in their areas and are expected to coordinate with them.

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

F. Timely Filing Requirements:

Medicaid law requires that DHHS file a claim for FFP within a two-year period that begins on the first day of the calendar quarter immediately following the quarter in which the expenditure was made by the school district or ESU. Federal regulations indicate that a state agency's expenditure for administration is considered to have been made in the quarter the payment was actually made by DHHS. Therefore, we ask that school districts and ESU's file their claims within fifteen (15) months of the end of the quarter activities are/were provided.

G. State Law Requirements

The OMB 2 CFR Part 200 - Super Circular states: "To be allowable under federal grants, costs must meet the following criteria . . . . be authorized or not prohibited under state or local laws and regulations." Thus, FFP for school-based services and administrative outreach claims are not available if school districts and ESU's are not in compliance with state statutes. If there is a question of whether the school district or ESU is in violation of state law, a legal opinion should be sought.

H. Provider Agreements

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

agreement, costs of administrative activities in support of those services such as referrals by the school would not be reimbursable under Medicaid as administration.

I. Transportation as Administration

School-based administration claimed in Nebraska does not include actual transportation costs.

VII. APPENDIX A – General Federal Overview of the Medicaid and IDEA Programs and the Applicability of School-based Administrative Claiming to these Programs

A number of federal, state and local programs operate in the school setting, only some of which may focus on traditional education goals. Interaction and overlap among these programs often provide numerous benefits to children, although sometimes with an additional burden in administrative complexity on the part of program administrators. The following section contains a brief overview of the Medicaid program as it operates in the school environment and the Individuals with Disabilities Education Act (IDEA). These two (2) federal programs, Medicaid and IDEA, with distinct and separate statutory authorities, are closely linked in the school setting even though their underlying purposes and perspectives differ. In order to understand the procedures for claiming school-based administrative expenditures under Medicaid, it is important to consider both Medicaid and Education perspectives.

A. Medicaid

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

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

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

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

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

Administrative activities in support of services that are not included in an IEP or IFSP and that are provided to Medicaid children in schools are usually **not** Medicaid coverable because most of these services are generally provided free of charge to non-Medicaid children. Such services include primary and preventive services provided by nurses or other qualified professionals in the school setting such as dispensing medication, attending to acute non-emergent problems (sore throat, earache, etc.), well-child examinations and vision and hearing screenings. (Free-Care and TPL are addressed in Section IV.B Principle 12. and Section V.J of the Guide.)

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

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

a. EPSDT Screening

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

b. EPSDT Treatment

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

c. EPSDT Administrative Claiming

The EPSDT administrative requirements found in Section 1902(a)(43) of the Act (42 U.S.C. 1396a(a)(43)) are part of the legal basis and authority for obtaining FFP for administrative costs associated with health care provided in or by schools. The following administrative activities are a required part of any state's EPSDT program:

- informing Medicaid eligible individuals about the availability of EPSDT services;
- providing or arranging for the provision of EPSDT screening services;

- arranging for (directly or through referral to appropriate providers or agencies) needed corrective and ameliorative treatment;
- assisting families identifying and choosing Medicaid providers; and
- conducting follow-up to ensure children receive needed diagnosis and treatment.

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

3. Children's Health Insurance Program (CHIP)

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

Outreach activities related to a state's separate Title XXI CHIP program are funded under the state's available Title XXI CHIP allotments. However, outreach activities provided with respect to a CHIP-related Medicaid expansion are funded at the state's option either from the state's CHIP allotment or from regular Medicaid funding. Joint outreach efforts for Medicaid and CHIP may similarly be matched by either Medicaid or CHIP. Under the provisions of OMB 2 CFR Part 225 and associated regulations, costs that are common to more than one (1) program are generally allocated to the related programs in accordance with the relative benefits received by each program. However, CHIP statute(s) provide for an exception to this general cost allocation principle, allowing states some flexibility in claiming FFP for outreach activities. Detailed guidance on these state options is available on the CMS CHIP web site:

http://www.insurekidsnow.gov/index.html
Nebraska's outreach efforts are not administered through CHIP (Title XXI) but instead funded by its Title XIX (NMAP/Medicaid) program.

B. <u>Individuals with Disabilities Education Act (IDEA)</u>

1. Purpose of IDEA

The Individuals with Disabilities Education Improvement Act (IDEA) of 2004 (P.L. 108-446/20 USC 1400) is the most recent version of this important federal special education law. IDEA was passed to "assure that all children with disabilities have available to them… a free appropriate public education which emphasizes special education and related services designed to meet their individual needs." Specific principles in IDEA include:

- Free Appropriate Public Education (FAPE);
- Appropriate evaluation;
- Individualized Family Service Plan (IFSP) for infants and toddlers (B-2);

- Individual Education Program (IEP) for students with verified disabilities (3-21);
- Least restrictive environment;
- Parent and student participation in decision-making; and
- Procedural safeguards.

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

- "Special education" is defined at 34 Code of Federal Regulations (CFR) 300.26 to mean specially designed instruction which meets the unique needs of the child and includes instruction conducted in the classroom, in the home, in hospitals, in institutions, in other settings and instruction in physical education.
- "Related services" are defined at 34 CFR 300.34 as "transportation and such developmental, corrective and other supportive services as are required to assist a child with a disability to benefit from special education." "Related Services include:

  i. Counseling services;
  ii. Early identification and assessment of disabilities;
  iii. Interpreting services;
  iv. Medical services for diagnostic and evaluation purposes;
  v. Occupational therapy;
  vi. Orientation and mobility services;
  vii. Parent counseling and training;
  viii. Physical therapy;
  ix. Psychological services;
  x. Recreation;
  xi. Rehabilitation counseling services;
  xii. School health services;
  xiii. School nurse services;
  xiv. Social work services in schools; and
  xv. Speech-language pathology and audiology services.

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

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

- The services are medically necessary and included in a Medicaid covered category (speech therapy, physical therapy, etc.);
- All other federal and state Medicaid regulations are followed including those for provider qualifications, comparability of services and the amount, duration and scope provisions; and
- The services are included in the state's plan or available under EPSDT. Further discussion of school based medical services can be found in the guidance document, "Medicaid and School Health: A Technical Assistance Guide," issued by CMS in August 1997.

2. ChildFind

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

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

3. Evaluation and Assessment Activities

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

4. Individual Education Program (IEP)

For those Nebraska children identified and determined to be disabled in accordance with Section 602 of IDEA, an IEP must be developed by a team of individuals as defined in Section 614. In the case of a child with a disability, age Birth through two (2) years, under certain conditions, an Individualized Family Service Plan (IFSP) may be developed to serve as an IEP. The IEP is statutorily defined as a written statement for each child with a disability that, among other elements, includes:

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

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

a. Pre-IEP

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

b. Development of IEP

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

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

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

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

c. Review/Revision of IEP

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

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

A more detailed discussion of IEP's and the IDEA can be found in Section IV.

d. Individualized Family Service Plan (IFSP)

By Statute, Nebraska is a "birth mandate state." This means that school districts are responsible for the "special education" services required to meet the unique developmental needs of the infant or toddler from the point in time when the child's developmental disability is verified through processes prescribed in IDEA and further defined by the Nebraska Department of Education's "Regulations and Standards for Special Education Programs (Title 92 Nebraska Administrative Code Chapter 51).

For each infant and toddler (under 3 years of age) determined to be disabled in accordance with Section 602 of IDEA, an IFSP must be developed in accordance with Section 636 of the Act. The IFSP shall be in writing and contain:

- A statement of the child's present levels of physical development, cognitive development and adaptive development, based on objective criteria;
- A statement of the family's resources, priorities and concerns relating to enhancing the development of the family's infant or toddler with a disability;
- A statement of measurable results or outcomes expected to be achieved for the infant or toddler and the family;
- A statement of the specific early intervention services based on peer-reviewed research to the extent practicable and necessary to meet the unique needs of the infant or toddler and the family;
- A statement of the natural environments in which early intervention (Early Development Network in Nebraska) services will appropriately be provided;
- Projected dates for initiation of services and anticipated length, duration and frequency of services;
- Identification of the services coordinator who will be responsible for the implementation of the plan and coordination of other agencies and persons including transition services; and

- Steps to be taken to support the transition of the toddler with a disability to preschool or other appropriate services.

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

e. Pre-IFSP

Pre-IFSP activities include "ChildFind" activities designed to identify infants and toddlers in need of evaluation and assessment activities performed to determine if the child has a disability as defined by Section 602 of the IDEA and to determine the developmental needs of the infant or toddler and their family. There are no claimable administrative expenditures under Medicaid associated with these pre-IFSP activities. Medicaid does not pay for the IFSP team meetings or for costs related to attendance at those meetings by medical professionals. However, if a state has opted to include targeted case management in its Medicaid plan as a service, Medicaid may be able to pay for the activities of the child's case manager/services coordinator.

f. Development of IFSP

For states like Nebraska who choose to participate, development of an IFSP is a requirement of IDEA with the primary purpose being to facilitate the infant or toddler's development, to minimize their potential for developmental delay and to recognize the significant brain development that occurs during a child's first three (3) years of life. Medicaid does not pay for the administrative activities associated with the development of the IFSP because it is an education requirement. Once the IFSP is established and implemented, however, Medicaid may pay for administrative activities that are directly related to the provision of those Medicaid covered services identified in the IFSP and are furnished to Medicaid eligible children.

The IFSP is a written plan developed by a multidisciplinary team including the parents as required by Section 636 of IDEA.

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

g. Review/Revision of IFSP

The IFSP is to be evaluated once a year and the family shall be provided a review of the plan at six (6) month intervals or more often where appropriate based on the infant or toddler and family need(s). The IFSP can be revised at any time if the child is not making expected progress or if new factors arise.

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

VIII. APPENDIX B - CLAIM PROCESS/PROCEDURES

A. General

Claim preparation requires that the proper training has occurred of sampled staff that random moment time study (RMTS) surveys were completed correctly and the resulting data was accumulated without error. Salary and benefit information for those staff must be correct. The percentage of Medicaid enrolled and potentially eligible students must be accurate.

Claims are prepared once per quarter for that full quarter and must be submitted to [Nebraska] DHHS within one year after the end of each quarter. Claim quarters are defined as follows:

First (Fall quarter):	September 1 to November 30
Second (Winter quarter):	December 1, to February 28/29
Third (Spring quarter):	March 1, to May 31
Fourth (Summer quarter):	June 1, to August 31

B. Data Elements

1. Time-study Average: Percentage derived by dividing the amount of time determined in the time-study by the total work time for personnel in the sample cost-pool.
2. Total Personnel Related Costs: Total salaries, benefits and other allowable costs incurred during the quarter for those personnel in the cost-pool.
3. The federally approved cost allocation plan used to determine the non-restricted indirect cost rate, by which salaries and benefits are multiplied. The product of this reflects the “overhead” administrative expenses required to support the related personnel. NDE is the cognizant agency for indirect cost rates for all public school districts and ESU’s in Nebraska.
4. The Medicaid Eligibility Rate [MER] calculated for the school district or ESU.

C. Claim Calculation

Claim calculations will be formatted based on a claim template provided by DHHS’ vendor for the school districts and ESU’s. Submittal of the invoice and related information must contain all information required by DHHS.