New Mexico Medicaid Guide for School-Based Services

A Guide for Local Education Agencies, Regional Education Cooperatives, and Other State-Funded Education Agencies

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Section I Program Introduction, History & Overview

I. Introduction

Healthy children and youth have a better chance of achieving academic, social and personal success than children and youth who are singled-out by a health concern or disability that impacts their ability to participate in school. Because of their position in the daily lives of children, youth and their families, New Mexico schools are poised to offer unique advantages and opportunities that can help families access health information, medical and behavioral health services, and facts about Medicaid enrollment. Through the Medicaid School-Based Services (MSBS) program, New Mexico schools also offer key health and health-related services that are designed to integrate and maintain active learning for Medicaid-eligible children and youth with special education and health care needs.

The MSBS program, formerly known as Medicaid in the Schools (or MITS), was added in 1994 as a Medicaid-covered benefit for children and youth from age three through age 20. For a school to receive reimbursement for services through the MSBS program, each Medicaid-eligible recipient must receive an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) that specifies the services required to treat (through correction, amelioration, or the prevention of deterioration) his or her identified medical condition(s).

The MSBS program vision, core beliefs and goals are:

Vision

All children and youth in New Mexico schools will be healthy and successful.

Core Beliefs

- Children and youth must be healthy in order to be successful in school.
- Schools are a critical link to children and youth's access to health care.
- Comprehensive health focuses on the whole child and includes, but is not limited to, mental/behavioral, dental, physical, and vision health.
- When comprehensive health services are readily and locally available at school, they can increase students' and families' access to needed care and result in improved student success.
- Families are integral to the success of the MSBS program.
- Public and private partnerships, collaboration and funding are necessary in order for comprehensive health services to be available at or linked through schools.
- Active participation of state agencies (the Human Services Department, Department of Health, Public Education Department, and Children, Youth and Families Department), families and the schools is essential for the MSBS program to function successfully.
- Funds generated by the MSBS program will be used to support school health and health-related services for all children and youth.

Program Goals

1. To increase children and youth's access to comprehensive health services through the MSBS program.
2. To increase and maximize the financial resources available for school-based services.
3. To increase collaboration among schools, families, community providers, and state agencies, where each partner has a defined role and demonstrates commitment and accountability to the MSBS program.

4. To develop and implement standards for providing or linking through schools school-based comprehensive health services.
5. To develop and implement a long-range plan for helping to ensure sustainability of a comprehensive MSBS program.
6. To enroll students onto the Medicaid Program.

Multiple resources were used in developing New Mexico's MSBS program, including, but not limited to, the 42 CFR, Part 43, Center for Medicare and Medicaid Services (CMS) *Medicaid School-Based Administrative Claiming Guide* of May 2003; the New Mexico State Plan; the regulation for New Mexico Medicaid School-Based Services for Recipients Under 21 Years of Age at Section 8.320.6; information from other states, including Iowa, Wisconsin, Florida, Michigan, Louisiana, Texas, Missouri, Washington, and Ohio; and the experiences of individuals who worked with the former MITS program in New Mexico. The *New Mexico Medicaid Guide for School-Based Services* (referred to hereafter as the Guide) represents the program that was developed in New Mexico with consideration given to these references and citations.

II. Background

Pursuant to the requirements of the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act of 1973, New Mexico schools deliver a broad range of educational, social and medical services that are needed to ensure a free and appropriate public education to children and youth who have disabilities. In New Mexico, the MSBS program includes a number of direct medical services, including: physical, occupational, audiological, and speech therapies; mental health services; social services; nutritional assessments and counseling; transportation; case management; and nursing services. All of these services are reimbursable by Medicaid if they are determined to be medically necessary in accordance with Medicaid policy and are part of the Medicaid-eligible recipient's IEP or IFSP for the treatment of an identified medical condition.

In addition to coverage of direct services, the MSBS program has historically allowed participating Local Education Agencies (LEAs), Regional Education Cooperatives (RECs) and other State-Funded Education Agencies (SFEAs) to claim reimbursement for certain allowable administrative activities; however, the Human Services Department Medical Assistance Division (HSD/MAD) discontinued the practice of administrative claiming on September 30, 2002. This generated momentum for a redesign of the MSBS program among both state agency and school district representatives, who determined that they would work together to resolve the key issues surrounding administrative claiming, including the codes, cost allocation methodology and time study model, and to reinstate an administrative claiming component of the MSBS program that would be effective, accurate and efficient. Administrative claiming was reinstated as part of the MSBS program on November 1, 2004.

III. Schools as Medicaid Providers

Federal Medicaid law does not mandate that schools be reimbursed for health and health-related services that are provided to Medicaid-eligible children; however, passage of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) clarified that federal Medicaid matching funds are available and may be used for health-related services that are covered under the Medicaid State Plan when those services are provided under the auspices of IDEA as part of an IEP or IFSP, as under the MSBS program in New Mexico. Federal Medicaid reimbursement for health and health-related services provided to students receiving special education, and for outreach and care coordination activities provided to all students, may be generated by LEAs, RECs or SFEAs. These entities may draw down Medicaid reimbursement for the federal share of costs for health and health-related services that are provided to students who are Medicaid recipients.

At the core of the MSBS program is the capacity of an LEA, REC or SFEA to secure the support of other agencies in the community. These supportive entities play a central role in the development of a collaborative plan designed to reinvest federal revenue generated through Medicaid into school-linked and community-based services that target helping children, youth and their families. Federal Medicaid funding generated by the schools is returned, or "passed through", to the LEA, REC or SFEA by HSD/MAD. In turn, the schools are required to agree in advance to reinvest this funding into community services that are part of a broad collaborative plan. The details of this collaborative planning process are explained in a Governmental Services Agreement (GSA) entered into by the LEA, REC or SFEA and HSD/MAD. A template copy of the GSA can be found in the Appendix section of this Guide at **Appendix A**.

IV. Linkage Between Schools and Health Care in their Communities

Another way in which MSBS-participating LEAs, RECs and SFEAs, as Medicaid providers, are required to interact with their communities is through the development of relationships with the health care resources in their communities at large, such as primary care providers (PCPs) and care coordinators for students enrolled in *Salud!* (New Mexico's Medicaid managed care program), and Indian Health Service (IHS) providers for Native American students who are enrolled in fee-for-service Medicaid. Because schools can play such a decisive role in the lives of children, youth and their families, they are able to link children and youth to health care and other services that might not otherwise be accessible. The MSBS program recognizes that most New Mexico communities have existing networks for ensuring health care to children and youth that include physicians and dentists in private practice, community health centers and maternal and child health programs, as well as the schools.

Additionally, most of New Mexico's Medicaid-enrolled children and youth receive benefits through one of the *Salud!* managed care organizations (MCOs) and the statewide entity (SE) for behavioral health services that have developed collaborative relationships with these community providers and programs. By working to develop relationships with the *Salud!* MCOs and health resources in their communities, the schools can help facilitate the connection between students and the services they need while improving the overall system of care available to children and youth, and reducing service duplication.

V. Medicaid Services for Children and Youth with Special Health Care Needs

Each of the *Salud!* MCOs is contractually obligated to make visible efforts to identify and provide services to individuals who fall into a category called Children with Special Health Care Needs (CSHCN), who may also be eligible to receive treatment under the MSBS program. This requirement reflects both the strong commitment of HSD/MAD to increase access to care for children and youth in this particularly vulnerable population, and the significant need for progress in reaching their families. HSD/MAD recognizes that the schools provide a critical access point for the *Salud!* MCOs in achieving these goals, since many times the schools are the first point-of-contact for CSHCN children, youth and their families.

Historically, New Mexico schools have been successful at providing multiple health and health-related services to their students. Since the passage of P.L. 94-142, schools have been required to provide certain health and health-related services to students who have both disabilities and special education needs. HSD/MAD believes that schools are favorably poised to assist all children and youth, including those who are Medicaid-eligible, in accessing the care they need. Schools are involved not only in the early identification of health conditions, but also in the coordination of services with community resources and health care providers and in the provision of follow-up activities once a student has been referred for treatment.

VI. Medicaid Reimbursements to the School Districts

The cost of health-related services has traditionally been borne by LEAs, RECs and SFEAs through a mix of federal, state and local funding sources. However, under IDEA, federal law entitles children and youth with disabilities to a free and appropriate public education; therefore, schools cannot charge disabled students or their parents for any of the services that are provided under this mandate.

Federal Medicaid funds may be reimbursed to LEAs, RECs and SFEAs for the MSBS program for both direct services and administrative activities. The rates assigned to direct versus administrative claims are different, as are the billing and reimbursement processes for each.

Direct Services

Medicaid direct services that are provided by professional personnel who meet qualifications set by HSD/MAD are reimbursable at adjusted and various rates, if there are state dollars available for providing the services. The state's share is matched with federal dollars at an amount that is generally between 70 and 80 percent in New Mexico.

Administrative Services

By contrast, administrative activities are reimbursable at a 50 percent matching rate with federal dollars. These activities 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. The amount that a school district may bill for administrative activities is based on a time-study model approved by HSD/MAD and CMS.

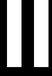
VII. Purpose of the Guide

This Guide is designed to provide MSBS program information to New Mexico's LEAs, RECs, SFEAs, state agencies, and other interested entities, concerning the correct and appropriate methods to follow in providing and seeking reimbursement for Medicaid school-based services, both direct and administrative, provided to students with IEPs and IFSPs. Additional information about the Medicaid program and related eligibility and service policies is contained in the Medicaid State Plan and the Medicaid Policy Manual. It is the obligation of each MSBS-participating LEA, REC and SFEA to ensure that they are in compliance with current Medicaid policy pertaining to the services they render. This Guide does not supersede Medicaid policy, and is not to be used in lieu of Medicaid policy. The information contained in this Guide will be updated at least annually to reflect changes made to the MSBS program or overall Medicaid program.

Specifically, this Guide is written to address key issues related to the MSBS program, namely:

- To outline the steps required for schools and their ancillary personnel to become MSBS program providers;
- To describe the direct services and administrative activities for which Medicaid reimbursement may be claimed by LEAs, RECs and SFEAs;
- To discuss the qualifications of the individuals providing Medicaid-reimbursable services in the schools;
- To explain the procedures for claiming reimbursement for direct services and administrative activities; and
- To summarize the programmatic expectations of LEAs, RECs and SFEAs that participate in the MSBS program

Section



II Steps to Becoming a MSBS Provider

There are five steps that a Local Education Agency (LEA), Regional Education Cooperative (REC) or other State-Funded Education Agency (SFEA) must take to become a Medicaid School-Based Services (MSBS) program provider. These steps, which are outlined in detail in this Guide, include: submission of a letter of intent; entering into a Governmental Services Agreement (GSA) with the Human Services Department/Medical Assistance Division (HSD/MAD); establishing a collaborative plan; developing and submitting a Medicaid Outreach plan, and completing a provider participation application through the Medicaid fiscal agent, Affiliated Computer Services (ACS). Together, these actions ensure that an LEA, REC or SFEA and its providers are prepared to provide and bill for services through the MSBS program, and that HSD/MAD and other state agencies are prepared to fulfill their obligations to school districts and to each other relating to the MSBS program.

I. Letter of Intent

The first step that an LEA, REC or SFEA must take in the process to become a MSBS program provider is to submit a letter of intent. This letter should be written to HSD/MAD and should be signed by the district superintendent, president of the school board, the chairperson of the LEA, REC or SFEA council, or other LEA, REC or SFEA representative. The letter should indicate the district's interest in working collaboratively with health and human services providers in the local community to develop services that will support children and their families, and in using Medicaid as a resource for providing health and health-related services to children and youth through the MSBS program.

The letter of intent should be mailed to:

HSD/MAD School Health Office
P.O. Box 2348
Santa Fe, NM 87504-2348

Once HSD/MAD has reviewed the letter, a packet of information that includes a copy of this Guide, four original copies of the GSA, a Medicaid provider participation agreement, and a checklist for the Collaborative and Medicaid Outreach Plans will be sent to the LEA, REC or SFEA.

II. Governmental Services Agreement

For an LEA, REC or SFEA to become approved as a MSBS program provider, it must enter into a GSA with HSD/MAD. This agreement details the respective responsibilities of HSD and the LEA, REC or SFEA concerning program administration, billing and payment. It also explains program parameters such as confidentiality requirements and the dispute resolution process. A template copy of the GSA can be found in the Appendix section of this Guide at **Appendix A**.

Once the individual with signatory authority at the LEA, REC or SFEA has signed and dated all four original copies of the GSA, **all four original copies** should be mailed to:

HSD/MAD School Health Office
P.O. Box 2348
Santa Fe, NM 87504-2348

The original copies will then be forwarded to the HSD Cabinet Secretary, Office of General Counsel, Administrative Services Division, and Department of Finance and Administration for final approval and signature. One original GSA, complete with signatures, will then be mailed back to the LEA, REC or SFEA for its records.

III. Collaborative Plan / Medicaid Outreach Plan

One of the most important steps that an LEA, REC or SFEA must take to become approved as a MSBS program provider is to develop a Collaborative and Medicaid Outreach plan that provides HSD/MAD with written evidence of the LEA's, REC's or SFEA's partnership with local community health and human services providers to deliver and expand health and health-related services. In summary, the Collaborative and Medicaid Outreach plan should be designed to identify community health needs and list strategies for meeting those needs. It must accompany the GSA as an attachment for the GSA to be considered for approval. Collaborative and Medicaid Outreach plans must be reviewed, amended as necessary, and submitted to HSD/MAD every two years.

An effective collaborative plan should address a number of key components. These may include, but are not limited to:

- Processes used and organizations and individuals involved in developing the plan. These entities may include, but are not limited to: local private and public medical, behavioral, social service, and oral/dental care providers; grass roots community leaders and organizations; community members or businesses; and teachers, parents and school support staff. It is expected that the efforts outlined in the collaborative plan will compliment any existing integrated planning efforts that are already underway in the community.

- Processes used to assess community needs and establish priorities for the improvement and expansion of support services to all children and youth.

- Common goals, both short-and long-range, for achieving improved outcomes for children, youth and their families.

- Procedures that will be used for fiscal and programmatic accountability purposes. Fiscal accountability is essential so that Medicaid revenues may be tracked accurately in accordance with the GSA and collaborative plan, while programmatic accountability should be expressed to facilitate specific measurable outcomes.

- Possible barriers that might be presented during implementation of the plan and potential strategies for managing them.

- Letters of agreement or support, and existing cooperative plans as supportive documentation.

- Names of individuals or groups that will be responsible for achieving the identified outcomes, and strategies to determine whether the outcomes were met.

A Medicaid outreach plan must include how the LEA, REC, or other SFEA will inform, assess and enroll families seeking Medicaid coverage and must be a part of the Collaborative Plan. The Medicaid Outreach Plan must specifically address the following:

- Identify the individual(s) within or working with the LEA, REC, SFEA who will maintain active Presumptive Eligibility/Medicaid On-Site-Application-Assistance (PE/MOSAA) certification and perform PE/MOSAA activities;
- Establish a goal number of PE/MOSAA applications per year, based on the LEA's, REC's, SFEA's student population and health insurance demographics; and

- Describe the LEA's, REC's or other SFEA's commitment to reporting Medicaid outreach and enrollment statistics to HSD quarterly, as set forth below.

Report Medicaid outreach and enrollment statistics to HSD quarterly, including: the number of PE/MOSAA applications completed during the preceding quarter; the names and identifying information of individuals for whom PE/MOSAA applications were completed during the preceding quarter; the dates that PE/MOSAA applications were sent to the HSD Income Support Division (ISD) during the preceding quarter; a listing of events and initiatives targeting families for Medicaid enrollment held by the LEA, REC or other SFEA during the preceding quarter; and the number of family referrals to non-Medicaid public assistance programs made during the preceding quarter.

HSD/MAD will work collaboratively with PED to review an LEA's, REC's or other SFEA's Collaborative and Medicaid Outreach plans, and to recommend approval for inclusion as a MSBS program provider.

IV National Provider Identifier

The National Provider Identifier (NPI) is a federally-mandated identification number issued to health care providers. All individual and organizational health care providers that are HIPAA-covered entities must obtain an NPI to identify themselves on billing transactions. MSBS related service providers, if previously required to have a Medicaid number, must now have an NPI in order to bill.

Providers may apply for their own NPI or they may authorize the school district to obtain an NPI for them. To learn more about the National Provider Identifier go to https://nppes.cms.hhs.gov

V Provider Participation Agreement

In addition to the signed GSA, collaborative plan, and Medicaid outreach plan, an LEA, REC or SFEA must submit a provider participation application to HSD/MAD. A template copy of the provider participation application form and process can be found in the Appendix section of this Guide at **Appendix B**.

Once the GSA has been signed, the completed provider participation application will be processed for approval. Once approved, the LEA, REC or SFEA will receive a packet of information, including a group provider number and billing resources from the HSD/MAD fiscal agent, Affiliated Computer Systems (ACS).

As with all Medicaid-participating group providers such as clinics and hospitals, each rendering provider (the provider who actually delivers the service) must also be identified. To do this, a provider participation application should be completed by each of the district's following rendering providers: occupational and physical therapists, speech language pathologists, social workers, audiologists, speech-language pathology clinical fellows, and case managers. Rendering providers should submit their provider participation agreements with a copy of their certification(s) or license(s). The following provider types must submit a copy of both their board license **and** PED license: occupational and physical therapists, speech pathologists, speech-language pathology clinical fellows, licensed registered nurses, licensed practical nurses, licensed marriage & family therapists (LMFTs), licensed professional clinical counselors (LPCCs), licensed mental health counselors (LMHCs), licensed master's level independent social worker (LISWs), licensed master's level social worker (LMSWs), licensed bachelor's level social worker (LBSWs), and school psychologists.

Some providers do not require a rendering provider number. These include: occupational and physical therapy assistants, speech-language pathology apprentices and paraprofessionals, licensed registered nurses, licensed practical nurses, licensed psychiatric clinical nurse specialists, licensed nutritionists, registered dieticians, and licensed bachelor's social workers. LEAs, RECs or SFEAs may

bill for services rendered by these providers using their LEA, REC or SFEA group provider number and/or the supervising provider's number.

Initial applications must be submitted to the HSD/MAD School Health Office for an initial review. After the district has received approval and a group provider number, applications for rendering providers may be processed.

Many rendering providers may already have a Medicaid number (NPI). In these cases, the rendering provider must be affiliated with the LEA, REC or SFEA group provider number in order to bill for services under that LEA, REC or SFEA. To become affiliated, the LEA, REC or SFEA must submit a letter, on its letterhead, to the Medicaid fiscal agent, ACS, requesting that the rendering provider be associated with the LEA, REC or SFEA. Copies of the provider's certifications and licenses should be included with the letter. The letter must be signed by both the rendering provider and an authorized representative of the LEA, REC or SFEA, and mailed or faxed to:

ACS, Inc.
Attn: Provider Enrollment
1720-A Randolph Rd, SE
Albuquerque, NM 87106
FAX: (505) 246-9085

Each rendering provider will receive his or her own provider Medicaid number and (NPI).This Medicaid number and (NPI) will be used by the LEA, REC or SFEA to bill Medicaid for services provided only by that individual or for services rendered by a provider that they supervise. The LEA, REC or SFEA should bill Medicaid using its group provider number (NPI) with a reference to the rendering provider. As individual rendering providers change, each new rendering provider must submit an application and receive a rendering provider number (NPI). It is the responsibility of the LEA, REC or SFEA to identify rendering providers who have left employment with the district and are no longer authorized to provide services. A letter of disaffiliation should be sent to ACS at the address listed above.

Once the LEA, REC or SFEA becomes a MSBS program provider, it must notify ACS in writing of any changes in its provider status. These might include changes in contact information, the area in which services are being provided, or taxpayer identification numbers. The LEA's, REC's or SFEA's group provider number should always be included in any written correspondence. Notice of changes should be sent to ACS at the address listed above.

Rendering providers must have a current New Mexico Regulation and Licensing Department (RLD) or other valid state license on file at ACS to maintain an active Medicaid enrollment status. The new license must be submitted to ACS within 90 days of the expiration date of the last license. The license should be sent to ACS at the address listed above or faxed to ACS/Provider Enrollment at (505) 246-9085. Failure to submit the license will result in termination of the provider's Medicaid number.

A reverification document for each enrolled provider must be completed and returned to ACS every two years. ACS will send the document to be completed and signed by the provider. Failure to submit the reverification document will result in termination of the provider's Medicaid number.

VI. Compliance with State and Federal Guidelines

HSD/MAD is firmly committed to administering a MSBS program that is effective in the lives of recipients, is "user-friendly" to participating schools and their providers, and is compliant with both state and federal law. Together with HSD/MAD and New Mexico's LEAs, RECs and SFEAs, there are a number of entities that have key responsibilities to the MSBS program and who play a critical role in effecting positive outcomes for school-age children and youth. The regulations for New

Mexico's MSBS program (MAD 8.320.6) may be found in the Appendix section to this Guide at **Appendix C**.

The federal Centers for Medicare and Medicaid Services (CMS) are charged with dispensing federal Medicaid funds to HSD/MAD for the provision of services to Medicaid-eligible populations and the administration of Medicaid programs at the state level. In turn, to ensure federal funding, HSD/MAD must abide by CMS' guidelines and regulations concerning the flow of program dollars, reporting deadlines, quality, and service delivery. For the MSBS program, these guidelines preclude reimbursement for the costs of Medicaid-covered services and activities that are generally available to all students without expense and for which no other sources of reimbursement are pursued. For example, Medicaid cannot pay for routine school-based vision and hearing screens or for other primary and preventive services that are given to all students on a cost-free basis.

VII. Identification of Medicaid Eligible Children

Each MSBS-participating LEA, REC or SFEA is expected to validate the recipient's Medicaid eligibility prior to billing. Because a recipient's eligibility may not be continuous from month to month, it is critical that the LEA, REC or SFEA, as a provider of services, be able to document that the recipient was Medicaid-eligible during the time for which the claim was submitted.

To inquire about a recipient's eligibility, enrolled providers may contact the ACS Automated Voice Response System (AVRS) at 1-800-820-6901 24 hours a day/7days a week. To ensure confidentiality, the provider will need to provide AVRS with the LEA, REC or SFEA group provider number and the recipient's name, date of birth and social security or Medicaid identification number.

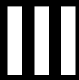
Providers are encouraged to use ACS' Web Portal to inquire about a recipient's eligibility. Log on to http://nmmedicaid.acs-inc.com/ for more information and to register as a Web Portal user.

VIII. Medicaid Application Process and Presumptive Eligibility

For a child less than 18 years old to receive Medicaid, a family member or legal guardian must apply for benefits on their behalf, unless the child is legally emancipated or has qualifying extenuating circumstances. Applications are processed at local offices of the HSD Income Support Division (ISD). To find out the location of the nearest HSD/ISD office, the LEA, REC or SFEA may contact HSD at 1-888-997-2583 or visit the HSD web site at: http://www.hsd.state.nm.us/isd/fieldoffices.html

Because the approval process is not immediate, many LEAs, RECs or SFEAs may have Presumptive Eligibility (PE) workers who are certified to receive Medicaid applications and make temporary coverage determinations on site (also called Medicaid On-Site Application Assistance or MOSAA). These applications are then forwarded to HSD/ISD for official eligibility determination; however, in the meantime, individuals who are presumed to be eligible may receive Medicaid services until the last day of the following month. PE/MOSAA determinations can be done every six months. School districts who wish to receive training for their employees to become PE/MOSAA determiners should call Robyn Reede, PE/MOSAA Trainer, at (505)476-6802, or send her an e-mail at robyn.reede@state.nm.us.

The LEA, REC, SFEA will document PE/MOSAA efforts in their quarterly Medicaid Outreach-Enrollment Site Summary Report and in the Medicaid Outreach Plan.



Section III

Billing for Direct Services

I. Covered Direct Services

In accordance with Medicaid School-Based Services (MSBS) program regulations at 8.320.6.13 (which can be found in the Appendix section to this Guide at **Appendix C**), a Local Education Agency (LEA), Regional Education Cooperative (REC) or other State-Funded Education Agency (SFEA) that is approved as a Medicaid provider may be reimbursed for certain health services provided to Medicaid recipients. These services must meet several conditions to be eligible for payment through the MSBS program, including:

- The services provided must be medically necessary and coordinated with the recipient's primary care provider (PCP);
- The services must be necessary to the treatment of the recipient's specific identified medical condition and meet the needs specified in the Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP).
- The services listed on the Individualized Treatment Plan (ITP) section of the IEP or IFSP must be signed by the child's PCP and be developed together with a team of qualified physical therapists, occupational therapists, speech therapists, audiologists, nurses, and/or behavioral health providers;
- The frequency and duration of services billed to Medicaid may not exceed what is specified in the IEP or IFSP; and
- Parental Consent must be obtained for services listed in the IEP or IFSP in order to bill for Medicaid. Consent means that the parent has been fully informed of all information relevant to the activity for which consent is sought. The parent understands and agrees in writing. CFR300.0 (Code of Federal Regulations) as does NMAC6.31.2.9 (New Mexico Administrative code) requires parental consent. For more information about IDEA requirements, contact the Special Education Bureau of the New Mexico Public Education Department (PED) at (505) 827-6541.

Reimbursement is made directly to the LEA, REC or SFEA, even when therapy providers offer services under contract to the LEA, REC or SFEA.

Under the MSBS program, direct services include:

- **Initial evaluations** that result in an IEP and subsequent **re-evaluations**.

- **Therapies**, including: Physical, occupational and audiological therapies and speech language pathology required for treatment of an identified medical condition.

- **Mental health services**, including: counseling, evaluation and therapy required for treatment of an identified medical condition. These services include regularly scheduled and structured counseling or therapy sessions for recipients, either independently, with their parents or guardians, or with other family groups. Mental health services may be furnished by:

    - A licensed independent social worker (LISW);
    - A licensed marriage and family therapist (LMFT);
    - A licensed professional clinical counselor (LPCC);
    - A psychiatric clinical nurse specialist (CNS);
    - A psychiatrist, psychologist or psychologist associate; or

  - A licensed bachelor's level social worker, (LBSW) licensed master's level social worker, (LMSW) or licensed mental health counselor (LMHC) supervised by a Ph.D., Psy.D., Ed.D., or LISW.

- **Nutritional assessments and counseling** that are provided by a licensed nutritionist or dietician for a recipient who has been referred for a nutritional need. A nutritional assessment consists of an evaluation of the nutritional needs of individuals based on appropriate biochemical, anthropomorphic, physical, and dietary data, including a recommendation for appropriate nutritional intake.

- **Transportation services** for recipients who must travel from the school to receive a covered service from a Medicaid provider because the service is unavailable in the school setting. Transportation services are reimbursable when provided on the date of a scheduled medical service. They are also reimbursable for transporting disabled students to and from the school on the date of a scheduled service if the recipient requires transportation in a modified vehicle that meets the recipient's needs.

- **Case management services** that are furnished in the school setting to recipients who are considered to be "medically at-risk", a term that refers to individuals who have a diagnosed physical or mental health condition with a high probability of impairing their cognitive, emotional, neurological, social or physical development. Case management services must be coordinated with the recipient's managed care organization (MCO) if the recipient is enrolled in the *Salud!* program. Examples of case management activities that are covered under the MSBS program include:

  - Assessments of the recipient's medical, social and functional abilities every six months, unless more frequent reassessment is indicated by the recipient's condition;
  - Developing and implementing a comprehensive plan of care that helps the recipient retain or achieve a maximum degree of independence;
  - Mobilizing "natural helping" networks, such as family members, church members, community organizations, support groups, friends and the school; and
  - Coordinating and monitoring the delivery of services, evaluating the effectiveness and quality of services, and revising the plan of care as necessary.

  Recipients have the freedom to choose a case management service provider. Medicaid pays for only one case management provider to furnish services during a given time period. If a recipient has a case manager or chooses a case manager who is not employed or under contract with the LEA, REC, or SFEA, the LEA, REC, SFEA must coordinate with the case manager in the development of the Individualized Treatment Plan (ITP).

- **Nursing services** that are required to treat an identified medical condition that qualifies a recipient for an IEP or IFSP. Nursing services require professional nursing expertise and must be provided by a licensed registered nurse (RN) or licensed practical nurse (LPN) in accordance with the New Mexico Nurse Practice Act. Emergency nursing services are also covered, when they are referenced in the IEP or IFSP and relate to the recipient's identified medical condition.

  The procedure codes for MSBS-covered direct services and their Medicaid reimbursement rates may be found in the Appendix section of this Guide at **Appendix D**.

II. Non-Covered Services

The services that are provided in the school setting under the MSBS program are subject to certain limitations and restrictions, similar to those set for other Medicaid services. Specifically, these include:

- Services that are classified as educational;
- Services to non-Medicaid eligible individuals;
- Services provided by practitioners outside their area of expertise;
- Vocational training services that are related exclusively to specific employment opportunities, work skills or work settings;
- Services that duplicate those furnished outside of the school setting, unless determined to be medically necessary and given prior authorization by the Human Services Department/Medical Assistance Division or its designee;
- Transportation services that a recipient would otherwise receive in the course of attending school; and
- Transportation services for a recipient with special education needs under the Individuals with Disabilities Education Act (IDEA) who rides the regular school bus to and from school with other non-disabled children.

III. Individualized Treatment Plan

The ITP is the medical portion of an IEP or IFSP and should be designed to state the medical needs, objectives, duration, service, and provider type of any reimbursable medical treatment to be provided under the MSBS program. The ITP is developed pursuant to the recipient's health history, medical and educational evaluations, and recommendations of his or her PCP, if applicable. The ITP should be developed by the LEA, REC or SFEA, together with recipients, their families, and the appropriate service providers. It is a plan of care that should be agreed upon by the recipient's parents or legal guardians, evaluating therapists, IEP or IFSP committee, and teacher. The recipient's PCP must review and sign the ITP at least annually.

IV. Documentation Requirements

To ensure compliance with state and federal regulations, the LEA, REC or SFEA should maintain adequate records to document service delivery for **six** years from the date of service. At a minimum, records documenting the provision of one of the services covered by the MSBS program should include:

- The name of the LEA, REC or SFEA;
- The recipient's name, date of birth and Medicaid number/unique identifier;
- The date and location of the service;
- The procedure code for the service;
- A description of the service provided, including the diagnosis code and level of service;
- Signatures and credentials of the rendering provider(s) (when the rendering provider works under the supervision of another provider, the supervisor must also initial the document); and
- The document showing involvement of the student's PCP or documentation of the LEA's, REC's or SFEA's good faith attempt to obtain a response from the PCP in accordance with Section III, Part VI of this Guide.

Documentation should support the medical necessity of the service in accordance with the Medicaid regulation for medically necessary services found in the Medicaid General Provider Policy at MAD 8.302.1.7, which may be found in the Appendix section of this Guide at **Appendix E**.

A quality assurance checklist was developed by the HSD/MAD School Health Office to assist schools in ensuring that they meet all of the required documentation standards for the MSBS program. This tool may be found in the Appendix section to this Guide at **Appendix F**.

V. Provider Licensure and Supervisory Requirements

To participate in the MSBS program and receive reimbursement, an LEA, REC or SFEA must be enrolled as a participating Medicaid provider. Individual service providers that are employed by or are under contract with the LEA, REC or SFEA must be authorized to enter into separate Medicaid provider participation agreements by meeting licensing and other qualification criteria. The steps that must be taken by the LEA, REC or SFEA and by individual providers are specified in detail in Section II, Part IV of this Guide.

Eligible direct service providers and their qualifications include:

- **Physical therapists** and **physical therapy assistants** who are licensed by the Physical Therapy Board under the New Mexico Regulation and Licensing Department (RLD) and who meet licensure requirements of the Public Education Department (PED). Physical therapy assistants must work under the supervision of a licensed physical therapist.

- **Occupational therapists** and **occupational therapy assistants** who are licensed by the Occupational Therapy Board under RLD and who meet licensure requirements of PED. Occupational therapy assistants must work under the supervision of a licensed occupational therapist.

- **Speech pathologists, audiologists** and **speech language pathology apprentices** who are licensed by the Board of Speech-Language Pathology and Audiology under RLD and who meet licensure requirements of PED. Speech language pathology apprentices must work under the supervision of a licensed speech pathologist.

- **Social work practitioners** who are:

  - Licensed by the Social Work Examiners Board as master's level independent social work practitioners; or
  - Licensed by the Social Work Examiners Board and supervised by a licensed Ph.D., Psy.D, Ed.D or LISW.
  - Social work practitioners must meet licensure requirements of PED.

- **Psychologists** who are:
  - Psychologists (Ph.D., Psy.D. or Ed.D.) licensed by the New Mexico Psychologist Examiners Board; or
  - Master's level practitioners licensed by the New Mexico Psychologist Examiners Board as psychologist associates or licensed by PED as school psychologists and supervised by a psychiatrist or Ph.D., Psy.D. or Ed.D. who is licensed by the New Mexico Psychologist Examiners Board
  - Psychologists must meet licensure requirements of PED. Level One School Psychologists must be supervised by a Ph.D., Psy. D. or Ed. D. Levels Two and Three School Psychologists do not require supervision.

- **Physicians** and **psychiatrists** who are licensed by the Board of Medical Examiners.

- **Case managers** who:
  - Have a bachelor's degree in social work, counseling, psychology, nursing, or a related health or social services field from an accredited institution, and who have one year of experience in serving medically at-risk children or youth;
  - Have a registered or practical nurse license; or
  - Have a bachelor's degree in another field, but who have two years of direct experience in serving medically at-risk children or adolescents.
  - Case managers must be registered as Case Managers with ACS.

- **Licensed professional clinical counselors** who are licensed by the New Mexico Counseling and Therapy Practice Board under RLD and who meet licensure requirements of PED.

- **Licensed marriage and family therapists** who are licensed by the New Mexico Counseling and Therapy Practice Board under RLD.

- **Licensed psychiatric clinical nurse specialists** who are licensed by the New Mexico Board of Nursing.

- **Licensed nutritionists or registered dieticians** who are licensed by the New Mexico Nutrition and Dietetics Practice Board and who meet licensure requirements of PED.

- **Licensed registered and practical nurses** who are licensed by the New Mexico Board of Nursing and who meet licensure requirements of PED.

- **Licensed mental health counselors** who are licensed by the New Mexico Counseling and Therapy Practice Board under RLD and are supervised by a Phd.D., Psy.D., or Ed. D.

A document outlining, who may participate in the MSBS program as a direct service provider, and their licensure and supervision requirements, may be found in the Appendix section of this Guide at **Appendix G**.

Contact information for RLD may be found at www.rld.state.nm.us.The PED Licensure Unit may be reached at (505) 827-6587.

VI. Coordination with Primary Care Providers

In New Mexico, most of the children and youth who are enrolled in Medicaid receive physical health benefits through one of four *Salud!* managed care organizations (MCOs) and have a designated physician or nurse practitioner that is called their PCP. The role of the PCP is to provide a "medical home" for the recipient, to maintain the recipient's medical records, and to make referrals or authorize treatment that may be required as the result of diagnostic or routine screening visits, such as the Tot-to-Teen Healthcheck.

PCP participation is critical to the overall success of the MSBS program. PCPs are asked to review and sign at least annually the ITP portion of a recipient's IEP or IFSP. In some school districts, particularly those in larger urban areas or in areas with busy PCP practices, ensuring PCP involvement has posed a challenge. A school district may make a "good faith" effort to obtain the review and signature of a student's PCP by following and documenting certain steps. These steps are outlined in the Medicaid School-Based Services Procedure for Involving a Student's Primary Care Provider, which can be found in the **Appendix H** of this Guide.

VII. Claiming Medicaid Reimbursement for Direct Services

For an LEA, REC or SFEA to receive reimbursement for the IEP direct services and therapies described in Section III, Part I of this Guide, it must meet several criteria. In summary, the LEA, REC or SFEA must:

- Be an approved and enrolled Medicaid provider (refer to Section II of this Guide);
- File claims for reimbursement to the Medicaid fiscal agent, Affiliated Computer Services (ACS), within 120 days of the date that the service was provided; and
- Submit electronic claims for reimbursement on the 837P Health Care Encounter form.

Direct service billing forms may be purchased at any office or forms supply location. Web-based electronic billing is available at no cost to providers through the New Mexico Medicaid program. Training and technical assistance in how to bill for direct services is available to all MSBS-participating LEAs, RECs or SFEAs from ACS. ACS provider services staff may be reached at 1-800-299-7304, ext 190.

An LEA, REC or SFEA should bill for the direct services that are provided by staff who meet the professional requirements listed in Section III, Part V of this Guide. For example, an LEA, REC or SFEA would be responsible for submitting speech therapy claims provided by speech therapists in accordance with the child's IEP, when that child is Medicaid-eligible.

To receive reimbursement for services, an LEA, REC or SFEA should have well-developed Medicaid claim procedures in place. The documentation requirements discussed in Section III, Part IV of this Guide are designed to prepare districts for a potential onsite audit by HSD/MAD, the Centers for Medicare and Medicaid Services (CMS), or the U.S. Department of Health and Human Services Office of Inspector General, and to ensure that billing is done only for enrolled staff. In contrast to many other Medicaid programs, services provided under the MSBS program do not require prior approval once the service is specified in the recipient's IEP or IFSP and coordinated with the recipient's PCP.

VIII. Remittance Advice and Resubmission of Claims

To ensure payment on a claim, all of the required fields on the CMS 1500 form (08/05 version) if billing on paper, or the 837P Health Care Encounter form if billing electronically, must be complete and accurate. If the form is incomplete or incorrectly completed, the claim may be denied for payment. If an LEA, REC or SFEA receives a remittance advice showing that the claim was denied, the same claim may be corrected and resubmitted to the Medicaid fiscal agent, ACS.

Resubmission of denied claims must be submitted within **180 days** of the denial date on the remittance advice. A copy of the remittance advice page showing the denial must be attached to the claim as proof of timely filing. If filing electronically, corrected claims may be resubmitted electronically within the original **120-day time period** without proof of timely filing. Requests for adjustments on paid claims must be submitted to ACS using the Adjustment/Void Request form. Specific instructions can be obtained from the fiscal agent by contacting ACS provider services at 1-800-299-7304.

Once a claim has been approved and processed for payment, a remittance advice that shows the status of all claims that the district has submitted to ACS will be available online at http://nmmedicaid.acs-inc.com Remittance advices are critical for tracking correctable errors for resubmitted denied claims. A remittance advice newsletter containing important billing information is available online every Monday. LEAs, RECs and SFEAs should review the remittance advice newsletter regularly to keep up-to-date on any changes regarding MSBS direct service billing processes. Questions about remittance advices may be directed to ACS provider services.

X. Provider Compliance

The documentation requirements Section III, Part IV, and the other program requirements listed throughout Section III, are designed to ensure that participating LEAs, RECs and SFEAs comply with all MSBS program guidelines, policies and regulations for direct health services. Each MSBS site will be reviewed once every four years for program compliance or as needed.

- The LEA, REC or SFEA will be required to submit a Corrective Action Plan (CAP) to HSD/MAD within 30 working days of the date of receipt of the site review letter to remedy the immediate noncompliance issue(s);

The LEA, REC or SFEA may be referred to the Medical Assistance Division Quality Assurance Bureau for a prospective and/or retrospective audit. The following may occur after an audit by the Medicaid Quality Assurance Bureau:

- If indicated, funds owed may be recouped from the LEA, REC or SFEA;
- In all cases, the LEA, REC or SFEA has the option to appeal through HSD/MAD's administrative hearing process pursuant to the Medicaid provider hearing regulations; and
- If indicated, the LEA, REC or SFEA may be terminated from participation in the MSBS program, as set forth in Medicaid General Provider Policies, 8.302.1 (refer to **Appendix E**).

Section IV Billing for Administrative Services

In addition to reimbursing Local Education Agencies (LEAs), Regional Education Cooperatives (RECs) and State-Funded Education Agencies (SFEAs) for direct health services that are part of a child's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP), the Medicaid School-Based Services (MSBS) program also reimburses LEAs, RECs and SFEAs for the costs of certain administrative activities that directly support efforts to provide health-related services to Medicaid-eligible children and youth with special education and health care needs. These administrative activities include, but are not limited to: providing information about Medicaid programs and how to access them; facilitating the eligibility determination process; assisting recipients in obtaining transportation and translation services when necessary to receive health care services; making referrals for Medicaid-reimbursable services; and coordinating and monitoring medical services that are covered by Medicaid. These and other activities that may be reimbursed under the MSBS program are described in detail in this Section of the Guide.

The Administrative Claim is based on the LEA's, REC's or SFEA's Medicaid eligibility rate, which is figured by the following:

- LEA, REC, or SFEA submit their 40-day count to the Medicaid Schools Health Office annually. The 40-day count plus any confidential student information **must** be submitted through the MOVE IT DMZ portal, which is the MAD secure email system.
- The School Health Office matches the 40-day count through the Medicaid data warehouse
- The percentage of Medicaid eligible recipients will be used on the LEA's REC's or SFEA's claim

I. Administrative Claiming Time Study

A LEA, REC, and SFEA must participate in Direct Service billing in order to be eligible to participate in Administrative Claiming. To participate in the MSBS administrative claiming program, a LEA, REC or SFEA must require certain district staff to participate in a quarterly time study that covers the period for which claimed administrative 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 MSBS program staff to determine this proportion. Components of the administrative claiming time study include:

- Administering a random moment sampling (RMS) methodology;
- Participating in the time study;
- Coding the time study; and
- Completing the claim form.

II. Random Moment Sampling

The RMS time study model is used to measure the percentage of time that LEA, REC and SFEA staff spends in performance of Medicaid-reimbursable administrative activities by sampling and assessing the activities of a randomly selected cross-section of individuals. 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, taken

together with the LEA's, REC's or SFEA's allocation of costs and Medicaid eligibility rate, determine the amount that the LEA, REC or SFEA is eligible to receive for administrative activities during the sampled quarter. The sampling period is defined as the same three-month period comprising each quarter of the calendar:

- First Quarter: January 1-March 31
- Second Quarter: April 1-June 30
- Third Quarter: July 1-September 30
- Fourth Quarter: October 1-December 31

The HSD/MAD School Health Office administers New Mexico's RMS system. In summary, the RMS system works as follows:

- The LEA, REC or SFEA sends an electronic list of staff (Employee File Writer) that will be included in the time study to the HSD/MAD School Health Office. This must be received at least **45 days prior** to the beginning of the quarter to be studied. Details regarding who may participate in the time study and instructions for completing the electronic list are discussed in Section IV, Part III of this Guide. Instructions for completing the Employee File Writer may be found in the Appendix section of this Guide at **Appendix L**.

- The School Health Office uses an electronic database to randomly select observation moments that are concurrent with the entire reporting period. These moments are then paired with randomly selected members of the total staff participating in the time study for that quarter.

- The sampling methodology is constructed so that each staff person in the time study receives an equal chance of being included in each sample observation. The sampling occurs with replacement, so that after a staff person and a moment are selected, that person is returned to the potential sampling universe. This ensures independence of sample moments.

- After the random sample of identified staff moments has been generated, a sample roster is printed in the form of master and location control lists. Questionnaires are printed and placed into individual sealed envelopes that include: the employee's name and identification number; the LEA, REC or SFEA identification number; the employee's job code and description; the employee's cost center and description; and the date and time of the employee's sample moment. A copy of the RMS questionnaire may be found in the Appendix section of this Guide at **Appendix I**.

- The School Health Office distributes the control lists and sample questionnaires to the designated RMS coordinators at the LEAs, RECs and SFEAs **two weeks prior** to the beginning of the quarter. Each sampled moment is identified on its respective control list in chronological order by the name of the staff person to be sampled and the date and time during which the observation is to take place. The RMS coordinator at the LEA, REC or SFEA uses this control list to monitor the status of each questionnaire so that appropriate follow-up contacts can be made for overdue observations or missing data. RMS coordinators at the LEAs, RECs and SFEAs also receive a calendar showing the dates for distribution of forms to sampled staff and the deadlines for returning forms to the HSD/MAD School Health Office.

- The local RMS coordinator at each LEA, REC or SFEA distributes the questionnaires to sampled staff. The coordinator should allow sufficient time for the questionnaire to arrive at the recipient's location no earlier than 2 days prior to the random moment. The employee being sampled must include a detailed description of the activity they

are performing during the sampled moment. Specifically, the RMS questionnaire asks:

- "Who was with you?"
- "What were you doing?"; and
- "Why were you doing this activity".

Participants should complete only the areas labeled "Activity", then sign and date the form, including their credentials and daytime telephone number. **Participants must not fill in the bubble at the top of the form.**

- Participants send completed forms back to their local LEA, REC or SFEA coordinator. The local RMS coordinator or other appropriately trained school district staff member then assigns the appropriate activity code to the form based on the sampled staff member's response to the "Activity" sections of the questionnaire. The administrative activity codes are discussed further in Section IV, Part IV of this Guide, and may be found in the Appendix section at **Appendix J**.

- The local RMS coordinator at the LEA, REC or SFEA returns coded questionnaires to the HSD/MAD School Health Office, keeping copies of the questionnaires for their files. **Questionnaires are due back to the HSD/MAD School Health Office by the end of the second full week after the sample moment**, in accordance the annual RMS calendar distributed to the LEAs, RECs and SFEAs at the beginning of the quarter.

- Each LEA, REC or SFEA is **required** to return at least **85 percent** of the total number of RMS sample forms sent by the HSD/MAD School Health Office in order to be able to submit an administrative claim for the quarter.

- The HSD/MAD School Health Office reviews the coded questionnaires for accuracy and, upon approval of the assigned code, scans the questionnaires into the RMS database. After the sampling period has ended, the RMS database tallies the coded forms and calculates the totals for each activity code.

- The HSD/MAD School Health Office enters the results for the quarter into the claim form for each LEA, REC or SFEA that submitted an employee file writer prior to the beginning of the quarter. The claim forms are then sent to each LEA, REC or SFEA coordinator for completion. Details concerning the claim form are discussed in Section IV, Part V of this Guide.

- The HSD/MAD School Health Office reviews the LEA's, REC's or SFEA's claim form for accuracy. Upon approval, the claim is sent to the HSD, Administrative Services Division (ASD) for processing of payment and a check is issued to the LEA, REC or SFEA.

III. Time Study Participants

When an LEA, REC or SFEA constructs the list of staff that should be included in the time study, it must determine first whether the individuals in those positions perform administrative activities that support the MSBS program, and second whether they are less than 100 percent federally funded.

Individuals whose positions are funded entirely by federal allocations are ineligible to participate in the time study.

Employees and contracted staff who may participate in the time study generally include, but are not limited to:

- Providers of direct health services;
- School health aides; and
- Program and staffing specialists.

For a complete list of positions that may be included in the time study, refer to the Appendix section of this Guide at **Appendix K**.

Certain individuals should **not** participate in the time study. In general, these include:

- Principals;
- Coaches;
- Non-special education teachers;
- Transportation staff;
- Janitorial staff; and
- Cafeteria workers.

IV. Coding the Time Study

There are 17 administrative activity codes that may be used to complete the time study. These are:

Code O1	Non-Medicaid Outreach (unallowable)
Code O2	Medicaid Outreach (allowable)
Code A1	Facilitating Application for Non-Medicaid Programs (unallowable)
Code A2	Facilitating Application for Medicaid Programs (allowable)
Code T1	Transportation for Non-Medicaid Programs (unallowable)
Code T2	Transportation for Medicaid Programs (allowable)
Code L1	Non-Medicaid Translation (unallowable)
Code L2	Translation Related to Medicaid Services (allowable)
Code P1	Program Planning, Policy Development and Interagency Coordination Related to Non-Medical Services (unallowable)
Code P2	Program Planning, Policy Development and Interagency Coordination Related to Medicaid Services (allowable)
Code Tr1	Non-Medical/Non-Medicaid Training (unallowable)
Code Tr2	Medical/Medicaid Related Training (allowable)
Code R1	Referral, Coordination and Monitoring of Non-Medicaid Services (unallowable)
Code R2	Referral, Coordination and Monitoring of Medical Services (allowable)
Code D	Direct Medical Services (billed as direct health services; unallowable as administration)
Code E	School-Related and Education Activities (unallowable)
Code GA	General Administration (reallocated across other activity codes on a pro rata basis)

In accordance with federal rules, the time study must incorporate a comprehensive list of the activities performed by staff whose costs are to be claimed under Medicaid. That is, the time study must reflect *all* of the time and activities, whether allowable or unallowable by Medicaid, performed by employees participating in the MSBS administrative claiming program. Therefore, for each reimbursable administrative activity code, there is a corresponding non-reimbursable activity code.

Each of the allowable time study codes may be reimbursed under the MSBS administrative claiming program at the 50 percent federal financial participation (FFP) rate. Unallowable activities are

disallowed as administration under the Medicaid program, regardless of whether the population served includes Medicaid-eligible individuals.

There are two codes (O2 and A2) that are 100 percent allowable as administration under the Medicaid program. Reimbursement for the remaining allowable codes is determined based on the application of the proportional Medicaid population in the LEA, REC or SFEA, also known as the Medicaid eligibility rate. For these codes, the Medicaid share is determined as the ratio of Medicaid eligible students to total students.

General administrative activities performed by time study participants must be reallocated across the other activity codes on a pro rata basis. These reallocated activities are reported under the General Administration code (GA).

A detailed description of the MSBS administrative activity codes can be found in the Appendix section of this Guide at **Appendix J**.

V. Completing the Claim Form

The claim form, which can be found in the Appendix section of this Guide at **Appendix M**, includes several components. In summary, these include:

- General data regarding the LEA's, REC's or SFEA's direct quarterly costs;
- Data regarding the LEA's, REC's or SFEA's capital allocation, including buildings and equipment;
- The time study percentages, which are assigned by the Medicaid School Health Office based on the RMS time study results for the quarter;
- The LEA's, REC's or SFEA's percentage of Medicaid-eligible recipients;
- Data regarding the LEA's, REC's or SFEA's quarterly salary and benefit costs;
- The administrative claim invoice, which considers the factors listed above; and
- The quarterly certification of state expenditures, which is signed by the LEA, REC or SFEA.

Detailed instructions regarding completion of the claim form can be found in the Appendix Section of this Guide at **Appendix N**.

The claim form is due to the HSD/MAD School Health Office no later than **45 days after the end of the billing quarter**. Time frames may be reduced further due to state fiscal year-end closing dates. Each LEA, REC or SFEA should identify the person who will be responsible for completing the claim form and provide their contact information to the HSD/MAD School Health Office.

VI. Offset of Revenues

Certain revenues must offset allocation costs to reduce the total amount of costs in which the federal government will participate. To the extent that 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. The following include some of the revenue offset categories that must be applied in developing the LEA's, REC's or SFEA's net costs:

- All federal funds;
- All state expenditures that have been previously matched by the federal government;
- Insurance and other fees collected from non-governmental sources;
- All applicable credits (those receipts or reduction-of-expenditure type transactions that offset or reduce expense items allocable to federal awards as direct or indirect costs); and

- Expenditures by which the total cost has already been paid by any of the revenue sources above. A government program may not be reimbursed in excess of its actual costs.

VII. Treatment of the 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 HSD/MAD School Health Office verifies the last day of the school year for each LEA, REC, or SFEA, and enters those dates to determine the final day of sampling for the quarter. RMS activities for the following school year will begin on the first day of school for each LEA, REC or SFEA.

VIII. Documentation of Administrative Activities

All LEAs, RECs or SFEAs that submit administrative claims must maintain separate files of all documentation used to construct claims for each quarter billed. Required documents include:

- The accounting information upon which the claim form is based, including the basis for any inclusion or exclusion of costs;
- A list of all revenues that were offset when calculating the claim;
- The enrollment lists used to determine the Medicaid eligibility rate;
- Time study documentation, including the sample pool participants by function, title, name, identification number, location, telephone number and code assigned to their activity;
- The completed quarterly claim;
- A copy of the warrant;
- Job descriptions of employees included in the sample pool;
- Proof of employee attendance for individuals included in the sample pool; and
- Any other supporting information used to substantiate the claim.

LEAs, RECs or SFEAs must ensure that these files are current, complete, accessible and secure. Administrative claim files must be maintained for a minimum of **six** years.

A quality assurance checklist was developed by the Medicaid School Health Office to assist schools in ensuring that they meet all of the required documentation standards for the MSBS program. The quality assurance checklist may be found in the Appendix section to this Guide at **Appendix F**.

IX. Administrative Claims Submission

MSBS-participating LEAs, RECs and SFEAs are responsible for submitting administrative claims in accordance with these guidelines:

- All staff involved in the preparation and certification of administrative claims, including the LEA's, REC's or SFEA's third-party billing agent(s), if applicable, must attend HSD/MAD-sponsored training sessions concerning MSBS and provider regulations, policies and procedures, the provision of Medicaid-reimbursable services and the preparation and submission of claims.

- All administrative claims must be prepared and submitted on forms developed and approved by HSD/MAD, in accordance with federal and state Medicaid regulations,

policies and guidelines, the CMS *Medicaid School-Based Administrative Claiming Guide* of May 2003, this Guide, and any federal or state revisions hereto.

- Claims must be accurate and complete when submitted for payment, pursuant to the Medicaid Provider Participation Agreement and as required of all Medicaid providers, prior to submission of the claim to HSD/MAD, and according to this Guide.

X. Monitoring, Oversight & Technical Assistance

To ensure that MSBS participating LEAs, RECs or SFEAs understand the program and have in place the requisite guidelines and procedures for administering the program, the HSD/MAD School Health Office includes several key methods of monitoring and overseeing the MSBS program, and for providing technical assistance to LEAs, RECs or SFEAs as indicated. These include:

- State level desk audits are conducted on the quarterly administrative claims. This comprises a review of the LEA's, REC's or SFEA's submitted time study questionnaires, calculation and supporting documentation, and a determination of the appropriateness of the claim.

- Periodic on-site visits to assess implementation of the RMS time study methodology and the results reported on the administrative claim, and to provide technical assistance as needed.

- Identification of trends based on day-to-day telephone calls and e-mail inquiries from participating LEAs, RECs or SFEAs. Follow-up trainings will be tailored to correspond with these trends, and technical assistance will be provided as needed. HSD/MAD School Health Office staff will also use trends apparent from official grievances and appeals to coordinate trainings and direct the focus of on-site visits.

- Provider experience and program understanding will be assessed through pre- and post-tests collected at training sessions.

- HSD/MAD School Health Office staff, together with their counterparts at the Department of Health (DOH) and Public Education Department (PED), will maintain open lines of communication and a willingness to resolve problems, address issues and concerns, and provide technical assistance as indicated.

XI. Provider Compliance

The measures for monitoring and oversight listed in Section IV, Part X are designed to ensure that participating LEAs, RECs and SFEAs comply with program guidelines, policies and regulations, in accordance with the CMS *Medicaid School-Based Administrative Claiming Guide* of May 2003, this Guide, and other program requirements. However, in the instance that a participating LEA, REC or SFEA is found through a desk audit or other means of oversight to be out of compliance, the following principles shall apply:

- The claim for the quarter may be recalculated by HSD/MAD, based on the audit, and approved for payment;
- The claim for the quarter may be denied;
- The LEA, REC or SFEA will be required to submit a Corrective Action Plan to HSD/MAD within 30 working days of receipt of letter from HSD/MAD to remedy the immediate noncompliance issue;
- The LEA, REC or other SFEA may be directed to submit a Directed Plan of Correction to HSD/MAD within 30 working days to remedy multiple or systemic noncompliance issues;

- If indicated, funds owed may be recouped from the LEA, REC or SFEA;
- In all cases, the LEA, REC or SFEA has the option to appeal through HSD/MAD's administrative hearing process pursuant to the Medicaid provider hearing regulations.
- If indicated, the LEA, REC or SFEA may be terminated from participation in the MSBS program, as set forth in Medicaid General Provider Policies, 8.302.1 (refer to **Appendix E**).

XII. Conclusion

New Mexico's MSBS program is reflective of extensive collaboration between HSD/MAD, PED, DOH and many of New Mexico's LEAs, RECs and SFEAs, and is the product of numerous discussions that took place over the course of 2003 and 2004 on how best to reimplement administrative claiming. This collaborative approach has proven essential, not only as a means of strengthening both interagency and state/school district relationships, but also for informing and guiding decision-making about the MSBS program's optimal organizational structure, needed policy revisions, areas in need of clarity, and overall operation on both state and school district levels. It is believed that this Guide outlines an improved structure for the MSBS program that will help to ensure its success in New Mexico.

Questions about this Guide, requests for technical assistance, or additional information about the MSBS program may be obtained by contacting the HSD/MAD School Health Office. Contact information for HSD/MAD School Health Office staff may be found in the Appendix section of this Guide at **Appendix O**.