
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 vision, core beliefs, and goals of the MSBS program 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 health care for children and youth.
- 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 access to needed care for students and their families 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 to make comprehensive health services available at or 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 youths 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 between schools, families, community providers, and state agencies, so that 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 comprehensive health services through the schools.

5. To develop and implement a long-range plan to ensure the sustainability of a comprehensive MSBS program.
6. To enroll students in the Medicaid Program.

Multiple resources were used in developing New Mexico's MSBS program, including, but not limited to 42 CFR, Part 43, Centers for Medicare and Medicaid Services (CMS) *Medicaid School-Based Administrative Claiming Guide* of May 2003; the New Mexico State Plan; New Mexico Medicaid School-Based Services for MAP (Medicaid Assistance Program) Eligible Recipients Under 21 Years of Age, 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) was developed to provide MSBS program guidance.

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 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. These issues included the codes, cost allocation methodology and time study model. An effective, accurate, and efficient administrative claiming program was reinstated as part of the MSBS program on November 1, 2004.

In 2006, the CMS Regional Office conducted a funding review of the MSBS program for the 2005 federal fiscal year (October 1, 2004 – September 30, 2005). The purpose of this review was to examine the MSBS funding flow, sources of the non-Federal share, and to verify if the mechanism for transferring the state share used to fund the MSBS program met federal requirements. In response to the findings of the CMS review, HSD/MAD implemented several changes to the MSBS program. These changes included:

- Changing the process for providing the required non-federal share of funding to ensure that state general funds are being provided by the participating LEAs, RECs, and SFEAs.
- Implementation of a monitoring, oversight, and technical assistance program to ensure that LEAs, RECs, and SFEAs participating in the MSBS program are in compliance with state and federal requirements. This process includes a 4-year cycle of on-site reviews of direct service claims as well as desk audit reviews of administrative claims.

In 2011, CMS approved the implementation of a web-based administrative claiming program to improve the random moment sample process and provide a more compliant and efficient administrative claiming process. The random moment sampling and administrative claiming process were transitioned to the current web-based format in January 2011

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 **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 *Centennial Care* (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 *Centennial Care* managed care organizations (MCOs) that have developed collaborative relationships with these community providers and programs. By working to develop relationships with the *Centennial Care* 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

The *Centennial Care* MCOs are contractually obligated 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 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 *Centennial Care* MCOs to achieve these goals, since many times the schools are the first point of contact for 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. 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.

LEAs, RECs, and SFEAs may be reimbursed in the MSBS program for both direct services and administrative activities. The rates for direct and administrative claims are different, as are the billing and reimbursement processes.

Direct Services

Direct medical services that are provided by qualified, professional personnel can be reimbursed according to the current NM Medicaid Fee for Service CPT Code Fee Schedule if an appropriate level of state (non-federal) funds is available to provide the services. The state share is calculated annually and participating LEAs, RECs, and SFEAs are responsible for reimbursing this portion to the state via quarterly payments from their state general funds. The state share for NM is generally around 30% leading to a federal match of approximately 70%.

Administrative Services

Participating LEAs, RECs, and SFEAs are also reimbursed for administrative activities provided in support of the Medicaid program. 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.

Administrative activities are reimbursed through a time study model agreed upon by HSD/MAD and CMS; this model allows for reimbursement of expenses at a rate of 50% federal funds. Participating LEAs, RECs, and SFEAs must certify that the remaining 50% of their expenses come from state general funds.

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, including 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 or 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 Medicaid program.

Other key issues addressed in this guide include:

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

Section II - Steps to Becoming an MSBS Provider

There are five steps that a LEA, REC or other SFEA must take to become a MSBS program provider. These steps include: submission of a letter of intent; entering into a Governmental Services Agreement (GSA) with HSD/MAD; establishing a Collaborative Plan; and completing a provider participation application through the Medicaid fiscal agent, Xerox. 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, LEA, REC, or SFEA a letter of intent, should be written to HSD/MAD and should be signed by the district superintendent, president of the school board, 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, an electronic link to this Guide, a Medicaid provider participation agreement, and a checklist for the Collaborative Plan will be sent to the LEA, REC, or SFEA. HSD/MAD staff will begin drafting a GSA between the agency and the LEA, REC, or SFEA.

II. Governmental Services Agreement

For an LEA, REC, or SFEA to become approved as an 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 **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 be mailed back to the LEA, REC, or SFEA for its records.

III. Collaborative Plan

One of the most important steps that an LEA, REC, or SFEA must take to become an MSBS program provider is to develop a Collaborative 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 Plan should be designed to identify community health needs and list strategies for meeting those needs. It must accompany the signed GSA in order for the GSA to be processed for final signatures at HSD. Collaborative Plans must be reviewed, amended as necessary, and submitted to HSD/MAD every two years.

An effective collaborative plan must include, but is 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-term, 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 hinder the 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 that must include:
 - An explanation of how the LEA, REC, or other SFEA will inform, assess and enroll families seeking Medicaid coverage.
 - Identify the individual(s) who will maintain active Presumptive Eligibility/Medicaid On-Site-Application-Assistance (PE/MOSAA) certification and perform PE/MOSAA activities for the LEA, REC, or SFEA;
 - Establish a goal number of PE/MOSAA applications per year, based on the LEA's, REC's, or SFEA's student population and health insurance demographics; and
 - Describe the LEA's, REC's or SFEA's commitment to reporting Medicaid outreach and enrollment statistics to HSD annually, as set forth in VIII below.

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

IV. National Provider Identifier

The National Provider Identifier (NPI) is a federally-mandated identification number issued to health care providers. All HIPAA-covered individual and organizational health care providers must obtain an NPI to identify themselves on billing transactions. MSBS related service providers must 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 and Collaborative Plan an LEA, REC, or SFEA must submit a provider participation application to HSD/MAD thru the fiscal agent, Xerox. A template copy of the provider participation application form and process can be found in **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, Xerox. After the district has received approval and a group provider number, applications for rendering providers may be processed.

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 and speech-language pathology clinical fellows, social workers (LISW and LMSW), psychologists, audiologists, and case managers.

Rendering providers should submit their provider participation agreements with a copy of their certification(s) or license(s). Licenses for all providers should be kept on file.

The following provider types must submit a copy of both their board license **and** PED license:

- Occupational therapists
- Physical therapists
- Speech-language pathologists
- Licensed master's level independent social worker (LISWs) and licensed master's level social worker (LMSWs)

The following provider types are required to submit **only** their board license:

- Audiologists
- Speech-language pathology clinical fellows
- Licensed marriage & family therapists (LMFTs)
- Licensed professional clinical counselors (LPCCs)
- Licensed mental health counselors (LMHCs)
- Licensed psychiatric clinical nurse specialists
- Licensed nutritionists, and registered dieticians

The following provider type is required to submit **only** their PED license:

- School psychologists.

Some providers do not require a rendering provider number. 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. These providers include:

- Occupational and physical therapy assistants
- Speech-language pathology apprentices

- Licensed bachelor's level social worker (LBSWs)
- Licensed registered nurses and licensed practical nurses

Provider participation applications can be completed online through the Xerox Web Portal at: <https://nmmedicaid.acs-inc.com/webportal/enrollOnline>.

Many rendering providers may already have a Medicaid number and 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, Xerox, 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 to:

XEROX, Inc.
Attn: Provider Enrollment
1720-A Randolph Rd, SE
Albuquerque, NM 87106
Or
P.O. Box 27460
Albuquerque, NM 87125

The Medicaid number and NPI will be used by the LEA, REC, or SFEA to bill Medicaid for services provided only by that individual. 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 XEROX at the address listed above.

Once the LEA, REC, or SFEA becomes an MSBS program provider, it must notify XEROX 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 XEROX 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 XEROX to maintain an active Medicaid enrollment status. The new license must be submitted to XEROX within 90 days of the expiration date of the last license. The license should be sent to XEROX at the address listed above or faxed to XEROX/Provider Enrollment at (505) 246-9085. Failure to submit the license will result in termination of the provider's Medicaid number.

A re-verification document for each enrolled provider must be completed and returned to XEROX every two years. XEROX will send the document to be completed and signed by the provider. The document will be sent to the most current mailing address affiliated with the provider; providers who are affiliated with more than one LEA, REC, or SFEA will only receive one re-verification document. Failure to submit the re-verification 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 an 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 **Appendix C**.

CMS is 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 other primary and preventive services that are given cost-free to all students..

VII. Identification of Medicaid Eligible Children

Each MSBS-participating LEA, REC, or SFEA is expected to confirm 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, 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 XEROX 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 the XEROX 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://nmhsd.sks.com/LookingForAssistance/Field_Offices_1.aspx.

Because the approval process is not immediate, LEAs, RECs, or SFEAs should 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 only be done once every twelve months. School districts who wish to receive training for their employees to become PE/MOSAA determiners should call the School Health Office for information.

The LEA, REC, SFEA will detail their plan for PE/MOSAA activities in their Collaborative Plan and document PE/MOSAA efforts in their annual Medicaid Outreach- Enrollment Site Summary Report as follows: Report Medicaid outreach and enrollment statistics to HSD by quarter, 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.

Section III – Billing for Direct Services

I. Covered Direct Services

In accordance with MSBS program regulations at 8.320.6 (which can be found in **Appendix C**), an LEA, REC, or other 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 PCP;
- The services must be necessary to the treatment of the recipient's specifically identified medical condition and meet the needs specified in the IEP or 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 and agrees in writing. CFR 300.154 (Code of Federal Regulations) and NMAC 6.31.2.9 (New Mexico Administrative Code) require parental consent. For more information about IDEA requirements, contact the Special Education Bureau of the New Mexico Public Education Department (PED) at (505) 827-1457.

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, audiological, and speech language pathology therapies 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** 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 an individual 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 MCO if the recipient is enrolled in the *Centennial Care* 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 by or under contract with the LEA, REC, or SFEA, the LEA, REC, or SFEA must coordinate with the case manager in the development of the 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 **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 HSD/MSD 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 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 sign 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 **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 **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 RLD and who meet licensure requirements of the 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 the RLD and who meet licensure requirements of the PED. Occupational therapy assistants must work under the supervision of a licensed occupational therapist.
- **Speech-language pathologists, speech-language pathology clinical fellows, speech language pathology apprentices, and audiologists** who are licensed by the Board of Speech-Language Pathology and Audiology under the RLD and who meet licensure requirements of PED as applicable. Speech-language pathology clinical fellows and 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 as a bachelor's or master's level social worker 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 and supervised by a psychiatrist or Ph.D., Psy.D., or Ed.D. who is licensed by the New Mexico Psychologist Examiners Board
 - School Psychologists who meet licensure requirements of PED. Level One School Psychologists must be supervised by a Ph.D., Psy.D., Ed. D, or Level Three School Psychologist. Level 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 have two years of direct experience in serving medically at-risk children or adolescents.
 - Case managers must be registered as Case Managers with XEROX.
- **Licensed professional clinical counselors** who are licensed by the New Mexico Counseling and Therapy Practice Board under RLD.
- **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 dietitians** who are licensed by the New Mexico Nutrition and Dietetics Practice Board **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 **Appendix G**.

Contact information for RLD may be found at www.rld.state.nm.us. The PED Licensure Unit may be reached at (505) 827-5821.

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 the *Centennial Care* 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 annually review and sign 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 Obtaining Primary Care Provider Authorization and Completing the Good Faith Effort*, which can be found in **Appendix H**.

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, Xerox, 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 (CMS-1500) may be purchased at any office or forms supply location. Paper billing is only allowed in certain circumstances such as re-bills and adjustments and prior approval may need to be obtained from Xerox. 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 XEROX. XEROX provider services staff may be reached at 1-800-299-7304.

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, 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 Re-Submission 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, XEROX.

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 XEROX using the Adjustment or Void Request forms. Specific instructions can be obtained from the fiscal agent by contacting XEROX 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 XEROX 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 XEROX provider services.

IX. 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 Program Policy and Integrity Bureau for a prospective and/or retrospective audit. The following may occur after an audit by the Medicaid Program Policy and Integrity 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 LEAs, RECs, and SFEAs for direct health services that are part of a child's IEP or IFSP, the MSBS program also reimburses them 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:

- The LEA, REC, or SFEA submits their 40-day count to the Medicaid School Health Office annually. The 40-day count plus any confidential student information **must** be submitted through the MOVEit 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 Claim Time Study

An 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, an 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 along with Fairbanks administer New Mexico's RMTS system. In summary, the RMTS system works as follows:

- **Forty-five days prior** to the beginning of each quarter, participating LEAs, RECs, or SFEAs submit a staff roster (Participant List) providing a comprehensive list of staff eligible to participate in the RMS time study. 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 RMS period begins the submitted roster of eligible staff cannot be updated or changed. . The NM MAC program Participant List Guide may be found in **Appendix L**.
- 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, 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.
- Once compiled statewide, each cost pool is sampled to identify participants in the RMS 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 with an individual from the total pool of participants using a statistically valid random sampling technique..
- 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.

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 three days 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 will remain open for seven (7) calendar days after the specific moment has occurred. The participant will receive reminders three (3) business days before and then on the second, third, fourth, and fifth business days after the sampled moment has occurred. After the seventh calendar day the participant’s login will not work.

- Fairbanks’ Central Coders will review the documentation of participant activities performed during the selected moments and determine the appropriate activity code. In a situation when insufficient information is provided to determine the appropriate activity code, the central coder will contact the sampled participant and request submission of additional information about the moment. In addition, the program coordinator at the applicable LEA, REC, or SFEA is copied on that follow-up email so that they are aware that a request for additional

information has been made. Once the information is received, the moment will be coded and included in the final time study percentage calculation. All moments will be coded separately by at least two coders as part of a quality assurance process. The moments and the assigned codes will be reviewed for consistency and adherence to the state-approved activity codes. *Administrative Activity Time Study Codes* may be found in **Appendix J**.

- 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 returns less than 85% of their sampled moments, HSD may enforce 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 GSA.
- HSD/MAD will perform the following validity checks to ensure that all districts complete at least 85% of valid random moment samples. HSD/MAD will also review 5% of valid coded responses and coding on a quarterly basis.
- Once all quarterly random moment data has been received and Time Study results have been calculated, statistical compliance reports will be generated to serve as documentation that the sample results have met the necessary statistical requirements.
- The cost allocation methodology and financial data used for the MSBS administrative claiming program are consistent with the requirements of OMB Circular A-87 and generally accepted accounting standards.
- Participating LEAs, RECs, and SFEAs will submit quarterly claims to HSD. These claims will be based on the quarterly costs, time study results, the Medicaid eligibility rate, the provider participation rate, and the FFP.

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.

All LEA, REC, or SFEA employees involved in administrative activities are assigned to one of two previously defined cost pools. Financial expenditures related to these employees are reported on a quarterly basis by the LEA, REC, or SFEA. Costs are broken down as follows:

Cost Pool 1: Direct Service Staff

Staff in Cost Pool 1 are direct service staff that have direct responsibilities related to the MSBS program that include the regular performance of one or more Medicaid allowable administrative activities.

Cost Pool 2: Other Health and Health-Related Staff

Staff in Cost Pool 2 include other health and health-related staff involved in direct administrative activities.

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

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;
- Program and staffing specialists; and
- Allowable staff whose salaries are paid from MSBS funds.

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

- Principals;
- Coaches;
- Non-special education teachers;
- Transportation staff;
- Janitorial staff;
- Cafeteria workers; and
- 100% federally funded staff

IV. Coding the Time Study

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

- CODE 1A Non-Medicaid Outreach – U
- CODE 1B Medicaid Outreach – TM/50 Percent FFP
- CODE 2A Facilitating Application for Non-Medicaid Programs – U
- CODE 2B Facilitating Application for Medicaid Programs – TM/50 Percent FFP
- CODE 3 School-Related and Education Activities – U
- CODE 4A Direct Medical Services, Not Covered as IDEA/IEP Service – U
- CODE 4B Direct Medical Services, Covered as IDEA/IEP Service - U
- CODE 5A Transportation for Non-Medicaid Programs – U
- CODE 5B Transportation for Medicaid Programs – PM/50 Percent FFP
- CODE 6A Non-Medicaid Translation – U
- CODE 6B Translation Related to Medicaid Services – PM/75 Percent FFP
- CODE 7A Program Planning, Policy Development, and Interagency Coordination Related to Non-Medical Services – U
- CODE 7B Program Planning, Policy Development, and Interagency Coordination Related to Medicaid Services – PM/50 Percent FFP
- CODE 8A Non-Medical/Non-Medicaid Training – U
- CODE 8B Medical/Medicaid Related Training – PM/50 Percent FFP
- CODE 9A Referral, Coordination, and Monitoring of Non-Medicaid Services – U
- CODE 9B Referral, Coordination, and Monitoring of Medical Services – PM/50 Percent FFP
- CODE 10 General Administration – R
- CODE 11 Not Paid/Not Worked – U

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 (1B and 2B) 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 **Appendix J**.

V. Completing the Claim Form

The claim form, which can be found in **Appendix M**, includes several components. 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 **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 which have 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 is in **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, and Technical Assistance

To ensure LEAs, RECs, or SFEAs participating in MSBS 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. These are 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.
- Assessment of provider experience and program understanding through pre- and post-tests collected at training sessions.
- Maintenance of open lines of communication by HSD/MAD School Health Office staff, together with their counterparts at the Department of Health (DOH) and PED 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 event that a participating LEA, REC, or SFEA is found to be out of compliance through a desk audit or other means of oversight, 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 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;
- Funds owed may be recouped from the LEA, REC, or SFEA;
- The LEA, REC, or SFEA has the option to appeal through HSD/MAD's administrative hearing process pursuant to the Medicaid provider hearing regulations.
- 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. 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. 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 is found in **Appendix O**.