Medicaid Administrative

Claiming Program Guide

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INTRODUCTION

Medicaid School- Based Claiming

Medicaid School-Based Claiming is a joint federal-state program that offers reimbursement for both the provision of covered medically necessary school-based services and for the costs of administrative activities, such as outreach, which support the Medicaid school-based program. Schools can provide a wide range of health care and related services to their students, which may or may not be reimbursable under the Medicaid program.

SCHOOLS ARE OFTEN INVOLVED IN INFORMING FAMILIES OF THEIR POTENTIAL ELIGIBILITY FOR MEDICAID OR IN HELPING THEM ARRANGE MEDICAL APPOINTMENTS FOR THE CHILDREN. THESE ACTIVITIES ARE CONSIDERED "ADMINISTRATIVE," AND SCHOOLS ARE ABLE TO RECEIVE REIMBURSEMENT THROUGH MEDICAID.

Many children receive covered Medicaid services through their schools. Medicaid will reimburse schools for documented medically necessary services that are provided to children who are both Medicaid eligible and who have been identified as eligible under the Individuals with Disabilities Education Act (IDEA) *34 CFR 300 et seq*. Currently, the schools can receive reimbursement for physical therapy, occupational therapy, speech therapy, nursing services, health aides, certain transportation, and behavioral health services. These activities are considered "direct medical services".

Both types of claiming must comply with federal and state guidelines related to provider qualifications, covered services, claiming requirements, and documentation. This guide will discuss in detail the requirements for the Medicaid Administrative Claiming program only.

Medicaid Administrative Claiming

The Medicaid Administrative Claiming (MAC) program is one of two federally funded program endorsed by the Arizona Department of Education (ADE) and the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid Agency. The MAC program allows a Local Education Agency (LEA), which includes school districts, charter schools not sponsored by a school district, and the Arizona School for the Deaf and Blind, to be reimbursed for certain costs associated with health and outreach activities which are not claimable under other Medicaid programs. In general, the types of health and outreach activities funded under MAC are the referral of students/families for Medicaid eligibility determinations, the provisions of health care information and referral, coordination and monitoring of health services and interagency coordination. A key focus of the MAC program is the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, which is used to ensure a comprehensive, preventative health care program for Medicaid eligible children ages three to twenty-one years of age.

Purpose of Guide

The purpose of the Medicaid Administrative Claiming (MAC) Guide is to inform our Third Party Administrator and schools of the appropriate methods for claiming federal reimbursement for the cost of Medicaid administrative activities performed in the school setting.

Particularly, the guide will:

- Help schools and school districts prepare appropriate claims for administrative costs under the Medicaid program;
- Ensure that the Medicaid program pays only for appropriate school-based administrative activities and that such activities are carried out effectively and efficiently;
- Protect the fiscal integrity of the Medicaid program by providing a clear articulation of the requirements for school-based administrative claiming;
- Help ensure consistency in the application of federal administrative claiming requirements across school districts;
- Assist our Third Party Administrator to implement operational and oversight functions;
- Provide technical assistance for the intended audience.

AHCCCS

AHCCCS operations are funded substantially from federal, state and county resources**.** AHCCCS is the agency that develops the policies and administers the Medicaid School Based Claiming Program through a Third Party Administrator and in collaboration with the Arizona Department of Education. AHCCCS is the only entity that may submit claims to CMS to receive federal financial participation (FFP) for allowable Medicaid costs.

Third Party Administrator

AHCCCS contracts with a single entity or organization to act as a third party administrator to:

- Develop a participation agreement for the LEA to sign that includes the requirements for participate in the MAC program;
- Serve as the single point of contact for LEAs that are either interested in participating or are participating in the Medicaid School-Based Program;
- Help LEAs prepare appropriate claims for the MAC costs under the Medicaid program;
- Ensure that the Medical program pays only for appropriate MAC activities and that such activities are carried out effectively and efficiently;
- Protect the fiscal integrity of the Medicaid program by providing a clear articulation of the requirements for MAC;
- Help ensure consistency in the application of federal school-based claiming requirements;
- Assist in the implementation of operational and oversight functions;
- Educate all LEAs throughout the State about Medicaid school-based claiming;
- Train and provide technical assistance to all participating LEAs;
- Perform certain key claims functions related to the submittal and payment of LEA claims; and
- Conduct compliance reviews of all participating LEAs.

RANDOM MOMENT TIME STUDY METHODOLOGY

Arizona conducts a time study on a quarterly basis for those school districts that are participating in this program. The purpose of the time study is to identify the proportion of administrative time allowable and reimbursable under the MAC program.

In most school districts, it is uncommon to find staff whose activities are limited to just one or two specific functions. Staff members normally perform a number of activities, some of which are related to the direct covered services and some of which are not. Sorting out the portion of staff activity that is related to these direct covered services and to all other functions requires an allocation methodology that is objective and empirical (i.e., based on documented data). Staff time has been accepted as the basis for allocating staff cost. The federal government has developed an established tradition of using time studies as an acceptable basis for cost allocation.

A time study reflects how staff time is distributed across a range of activities. A time study is not designed to show how much of a certain activity staff perform; rather, it reflects how time is allocated among different activities. As stated previously, the state will utilize a Random Moment Time Study (RMTS) methodology at which time all LEAs who participate in the MAC program will be required to participate in the RMTS methodology of time study.

Time Study Participants

All school districts that participate in the time study will identify allowable Medicaid direct service and administrative costs within a given district by having staff who spend their time performing those activities participate in a quarterly time study. These districts must certify that any staff providing services or participating in the time study meet the educational, experiential and regulatory requirements.

The following categories of staff have been identified as appropriate participants for Arizona School-Based time studies. Additions to the list may be dependent upon job duties. The decision and approval to include additional provider types would necessitate an amendment to this Program Guide.

This does not include individuals such as parents or other volunteers who receive no compensation for their work; this would include in-kind “compensation.” For purposes of this implementation plan, individuals receiving compensation from school districts for their services are termed “school district staff.” Beginning with the October-December 2009 Quarter, Arizona will begin using the two cost pool methodology. All staff will be reported into one of two cost pools: a Direct Service and Administrative Providers” cost pool and an “Administrative Services Provider Only” cost pool. **The two cost pools are mutually exclusive, i.e., no staff should be included in both pools.** The following provides an overview of the eligible categories in each cost pool. As a part of their regular job functions the staffs listed in this cost pool are eligible to provide Direct School-Based Services as well as activities reimbursable under the MAC Program. The individuals listed in this cost pool will meet the provider credential and license requirements necessary to provide direct School-Based services.

Cost Pool 1 (Direct Service & Administrative Providers)

- Guidance Counselors
- Licensed professional Counselors (LPC)
- Licensed Marriage and Family Therapists
- Speech-Language Pathologists
- Audiologists
- Occupational Therapists
- Physical Therapists
- Occupational Therapy Assistants
- Physical Therapy Assistants
- Speech-Language Pathology Assistants (2-1-2010)
- Social Workers
- Psychologists
- Psychiatrists
- Registered Nurses, Licensed Practical Nurses and School Health Aides

Cost Pool 2 (Administrative Service Providers Only)

- Audiology Assistants
- Interpreters
- Bilingual Specialists
- Administrators for Exceptional Student Education
- Special Education Teachers
- Program and Staffing Specialists
- Student Services Personnel
- Augmentative Specialists
- Dietitians
- Liaisons and Certain Teachers for Exceptional Student Education
- And other groups/individuals that may be identified by the school district

Staff with these job titles, are not automatically included in the time study. A district must determine whether they meet all requirements above and if they are less than 100% federally funded. Individuals that are 100% federally funded will be excluded from the time study as none of their costs are reimbursable. All criteria must be met in order to be included in the time study.

Two mutually exclusive time studies, described below, will be conducted each quarter. Although some staff may perform both direct services and MAC-related activities, they will only be allowed to participate in one of the two time studies**.** For Direct Service staff who also perform MAC activities, the Direct Services time study will be used to identify the claimable activities. MAC claimable time will only be included on a MAC cost report and will not be reimbursed through the Direct Services Program. Each quarterly time study has two (2) cost pools that are made up as follows:

- The first cost pool is comprised of direct service staff, including those who conduct both direct services and administrative claiming activities as well as direct service only staff, and the respective costs for these staff. These costs include staff time spent on billing activities related to direct services.
- The second cost pool is comprised of administrative claiming staff only and the respective costs for these staff.

Therefore, the two universes of time study participants and associated cost pools are mutually exclusive and the only direct costs that can be claimed under Medicaid related to this program are derived from the two cost pools described above.

Part of the AHCCCS review process is to ensure that all of the staff who will be submitted are included in the sample universe. The school districts will send in a roster of participants. All of those staff members are loaded into the appropriate cost pool. The entire list of staff from all participating districts in a particular cost pool is included in the sample universe. At the end of the quarter, a financial schedule is sent to the districts to report allowable costs for staff. The list sent to the districts will only include the staff/positions which were reported at the beginning of the quarterly RMTS process. Districts are instructed that they can only claim costs for participants that were submitted the roster process and thus included in the sample universe. AHCCCS can compare the lists of submitted staff against the list used in the sample universe. This list should be a match since all staff submitted by the districts are included in the sample universe.

Random Moment Time Study (RMTS)

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

Time Study Start and End Dates

Each calendar quarter, the dates that school districts will be in session and for which their staff members are compensated will be determined. District staff members are paid to work during those dates that districts are in session: as an example, districts may end the school year sometime in May each year. All days including and through the end of the school year would be included in the potential days to be chosen for the time study. Each quarter, district calendars will be reviewed to determine those dates that the schools pay for their staff to work, and those dates will be included in the sample. Since school calendars change on an annual basis, the school calendars will be evaluated on an annual basis and the sample dates will be determined and documented.

Sampling Requirements (RMTS)

In order to achieve statistical validity, maintain program efficiencies and reduce unnecessary district administrative burden, a consistent sampling methodology for all activity codes and groups will be used. The RMTS sampling methodology is constructed to achieve a level of precision of +/- 2% (two percent) with a 95% (ninety-five percent) confidence level for activities.

Statistical calculations show that a minimum sample of 2,401 completed moments each quarter, per cost pool, is adequate to obtain this precision when the total pool of moments is greater than 3,839,197.

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

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

WHERE:

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

CORRECTION FOR FINITE POPULATION

Where: N = population

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

N=	Sample Size Required	Sample Size plus 15% Oversample
100,000	2,345	2,697
200,000	2,373	2,729
300,000	2,382	2,739
400,000	2,387	2,845
500,000	2,390	2,849
750,000	2,393	2,852
1,000,000	2,395	2,854
3,000,000	2,399	2,859
>3,839,197	2,401	2,860

RMTS Process & Notification

The RMTS process is described here as four steps:

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

Identify Total Pool of Time Study Participants

At the beginning of each quarter, participating districts submit a staff roster (Participant List) providing a comprehensive list of staff eligible to participate in the RMTS time study. This list of names is subsequently grouped into job categories (that describe their job function), and from that list all job categories are assigned into one of two "cost pools". There will be two mutually exclusive cost pools.

Identify Total Pool of Time Study Moments

The total pool of "moments" within the time study is represented by calculating the number of working days in the sample period, times the number of work hours of each day, times the number of minutes per hour, and times the number of participants within the time study. The total pool of moments for the quarter is reduced by the exclusion of weekends, holidays and hours during which employees are not scheduled to work.

Randomly Select Moments and Randomly Match Each Moment to a Participant

Once compiled, each cost pool is sampled to identify participants in the RMTS time study. The sample is selected from each cost pool, along with the total number of eligible time study moments for the quarter.

Using a statistically valid random sampling technique, the desired number of random moments is selected from the total pool of moments. Next, each randomly selected moment is matched up, using a statistically valid random sampling technique, with an individual from the total pool of participants.

Each time the selection of a minute 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 minute and each person are available to be selected each time a selection occurs. This step guarantees the randomness of the selection process.

Each selected moment is defined as a specific one-minute unit of a specific day from the total pool of time study moments and is assigned to a specific time study participant. Each moment selected from the pool is included in the time study and coded according to the documentation submitted by the staff person.

The sampling period is defined as the three-month period comprising each quarter of the Calendar Year. The following are the quarters followed for the MAC program:

- Quarter 1 = January 1 – March 31
- Quarter 2 = April 1 – June 30

- Quarter 3 = July 1 – September 30
- Quarter 4 = October 1 – December 31

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

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

Each quarter, dates that school districts will be in session and for which their staff members are compensated will be identified. District staff members are paid to work during those dates that districts are in session; as an example, districts may end the school year sometime in May each year. All days including and through the end of the school year would be included in the potential days to be chosen for the time study. It is important to understand that although districts may end the school year prior to the close of the quarter staff members are paid for services provided through the end of the federal fiscal quarter. Districts typically spread staff compensation over the entire calendar year even when staff members are not working. The district considers this compensation reimbursement for time when staff members actually work rather than compensation for the staff members time off during the summer months.

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

"*…the results of the time studies performed during the regular school year would be applied to allocate the associated salary costs paid during the summer. In general, this is acceptable if administrative activities are not actually performed during the summer break, but salaries (reflecting activities performed during the regular school year) are prorated over the year and paid during the summer break."*

Notify Participants about their Selected Moments

Email is the standard method by which time study participants are notified of their requirement to participate in the time study and of their sampled moment. For those participants without access to e-mail, an alternative method for notification will be used (i.e.: via mail). Sampled participants will be notified of their sampled moment no more than five (5) days prior to the sampled moment. At the prescribed moment, each sampled participant is asked to record and submit his/her activity for that particular moment. Additionally, if the moment is not completed the participant receives a late notification email 24 hours after their selected moment. Throughout this entire process, the district RMTS coordinators have real-time access in the online system to view their sampled staff, the dates/times of their sampled staff moments, and whether or not the moment has been completed. The time study questionnaire or survey forms are not kept open more than 5 business days after the end of the time study period to ensure the accuracy of the time. As explained later in this document, if the return rate of valid moments is less than 85% then, non-returned moments will be included and coded as non-allowable code.

RMTS Return Compliance

Compliance reports are run weekly by the RMTS administrator and sent to the districts. The school districts also have the ability to run compliance reports on a daily basis. A validity check of the time study results is completed each quarter prior to the calculation of the claim. The validity check ensures that the minimum number of responses is received each quarter to meet the required confidence level. The number of completed and returned time study moments is analyzed to confirm that the confidence level requirements have been met. Once the validity of the sample has been confirmed, the time study results are calculated and prepared for the calculation of the quarterly claim.

Centralized Coding

Arizona has chosen to utilize a centralized coding methodology. Under that methodology the sampled staff member does not code his or her moment using RMTS activity codes. The sampled staff member is asked to document their activity by providing specific narrative examples. At the end of the documentation, the sampled staff member is asked to certify their documentation.

Coding Validation

The Third Party Administrator will randomly select a 10% sample of centrally coded responses which will be submitted to the State each quarter for validation. The validation will consist of reviewing the participant responses and the corresponding code assigned by the Third Party Administrator to determine if the coding was completed correctly. The State has a representative from AHCCCS who will separately review the subsample of responses and coding and identify any

disagreements with the coding staff. After that discussion on coding, coding instructions would be modified to document those coding decisions so that they can be consistently applied in future quarters.

At the end of each quarter, once all random moment data has been received and time study results have been calculated, statistical compliance reports will be generated to serve as documentation that the sample results have met the necessary statistical requirements.

Training Types & Overview

LEA RMTS Coordinator Training

AHCCCS will review and approve all RMTS training material used by the Third Party Administrator. Once the training material has been approved by AHCCCS, the Third Party Administrator will provide initial training for the LEA RMTS coordinators which will include an overview of the RMTS software system and information on how to access and input information into the system. It is essential for the LEA RMTS coordinators to understand the purpose of the time studies, the appropriate completion of the RMTS, the timeframes and deadlines for participation, and that their role is crucial to the success of the program. Participants are to be provided detailed information and instructions for completing and submitting the time study documentation of the sampled moment. All training materials will be accessible to LEA RMTS coordinators. In addition, annual training will be provided to the LEA coordinators to cover topics such as MAC program updates, process modifications and compliance issues.

Central Coding Staff Training (Activity Coding)

Central Coders are employed by the Third Party Administrator and 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 may contact the individual LEA and request submission of additional information about the moment. 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.

Sampled Staff Training

In the past, the primary purpose of staff training was to educate the sampled staff member on MAC Program activity codes so he or she could accurately determine the appropriate activity code for the activity they were performing at the sampled moment. Since Arizona has implemented a centralized coding methodology, the training regarding activity codes is no longer required since the sampled staff member will not have to code their moment. The RMTS documentation system includes training information on the program and their role in the program as well as how to complete the moment. The sampled staff member must visit these screens prior to being able to document their moment. For these reasons, training of sampled staff members will no longer be a requirement for completion of their moment.

Documentation (RMTS)

All documentation of sampled moments must be sufficient to provide answers to the time study questions needed for accurate coding:

- Who were you with?
- What were you doing?
- What was the purpose or end result of this activity?
- Is this activity a referral?
- Who was the referral made to?
    - If referral was made outside of your school district, please indicate if this provider is a Medicaid provider.

In addition, sampled staff will certify the accuracy of their response prior to submission—sampled staff members are assigned a unique user name and password that is only sent to them. They must use this unique user name and password to login and document their moment. After answering the documentation questions they are shown their responses and asked to certify that the information they are submitting is accurate. Their moment is not completed unless they certify the accuracy of the information. Since the sample staff member only has access to their information, this conforms to electronic signature policy and allows them to verify that their information is accurate.

Additional documentation maintained by the Third Party Administrator includes:

- Sampling and selection methods used,
- Identification of the moment being sampled, and
- Timeliness of the submitted time study moment documentation.

Time Study Return Compliance

AHCCCS will require an 85% return rate. Non-responsive moments, moments not returned or not accurately completed and subsequently resubmitted by the school district, will not be included in the results unless the return rate for valid moments is less than 85%. If the return rate of valid moments is less than 85% then, non-returned moments will be included and coded as a non-allowable. To ensure that enough moments are received to have a statistically valid sample, Arizona will over sample at a minimum of fifteen percent (15 %) more moments than needed for a valid sample size. To assure that districts are properly returning sample moments, the district's return percentage for each quarter will be analyzed. Sanctions AHCCCS may impose include placing schools on "payment hold", conducting more frequent monitoring reviews, recoupment of funds, and ultimately, cancellation of the school's Participation Agreement.

Time Study Activities/Codes

The time study codes are assigned indicators that determine allowability, federal financial participation (FFP) rate, and Medicaid share. A code may have one or more indicators associated with it. These indicators should not be provided to time study participants.

The time study code indicators are:

Application of FFP rate	50 percent	Refers to an activity that is allowable as administration under the Medicaid program and claimable at the 50 percent non-enhanced FFP rate.
Allowability & Application of Medicaid Share	U	Unallowable – refers to an activity that is unallowable as administration under the Medicaid program. This is regardless of whether or not the population served includes Medicaid enrolled individuals.
	TM	Total Medicaid – refers to an activity that is 100 percent allowable as administration under the Medicaid program.
	PM	Proportional Medicaid – refers to an activity, which is allowable as Medicaid administration under the Medicaid program, but for which the allocable share of costs must be determined by the application of the proportional Medicaid share (the Medicaid enrollment rate). The Medicaid share is determined as the ratio of Medicaid enrolled students to total students.
	R	Reallocated – refers to those general administrative activities which must be reallocated across the other activity codes on a pro rata basis. These reallocated activities are reported under Code 10, General Administration.

The following time study codes are to be used for the Random Moment Time Study:

Code	Activity	MAC Indicator(s)
1.a	Non-Medicaid Outreach	U

1.b	Medicaid Outreach	TM/50%
2.a	Facilitating Non-Medicaid Eligibility	U
2.b	Facilitating Medicaid Eligibility Determination	TM/50%
3	School Related & Educational Activities	U
4	Direct Medical Services	U
5.a	Transportation Non-Medicaid	U
5.b	Medicaid Transportation	PM/50%
6.a	Non-Medicaid Translation	U
6.b	Medicaid Translation	50%
7.a	Program Planning, Development and Interagency Coordination Non-Medical	U
7.b	Program Planning, Development and Interagency Coordination Medical	PM/50%
8.a	Non-Medical/Non-Medicaid related Training	U
8.b	Medical/Medicaid related Training	PM/50%
9.a	Referral, Coordination, and Monitoring Non-Medicaid Services	U
9.b	Referral, Coordination, and Monitoring of Medicaid Services	PM/50%
10	General Administration	R
11	Not Paid/Not Worked	U

These activity codes represent administrative and direct service activity categories that are used to code all categories of school-based provider activity. For all activity codes and examples, if an activity is provided as part of, or an extension of, a direct medical service, it may not be claimed as Medicaid Administration. The detailed code definitions and examples may be found in Appendix A.

Submitting a Claim for Medicaid Administration

The MAC Program cost calculation has five components:

- Cost pool construction
- Allowable Medicaid administrative time
- The Medicaid Enrollment Rate (MER)
- The FFP
- Indirect cost rate (ICR)

Calculating the Claim

In general terms, the federal share of the claim for Medicaid administration is calculated by:

Item	Function
1. Cost Pool Total	Multiplied by
2. Percent (%) time claimable to Medicaid administration	Multiplied by
3. The Medicaid Enrollment Rate (MER) (where applicable)	Multiplied by
4. 1 + Indirect Cost Rate (this percent is added to the value of the calculation at this stage in the process) equals the amount of the claim request	Multiplied by
5. Percent (%) FFP (50%)	

a) **Cost pools**

Cost pools have previously been explained beginning on page _3_

b) **% Time Claimable to Medicaid Administration**

The time study results are utilized to determine the amount or percent of time spent by school district personnel on the identified outreach, care and coordination functions**.**

c) **The Medicaid Enrollment Rate (MER)**
The amount of the claim is affected by the MER. This factor is a critical component of the claim. The MER is calculated annually The MER is applied to the total claimable percentage (Codes 1b, 2b, 5b, 6b, 7b, 8b & 9b).

d) **Federal Financial Participation (FFP) Rate**
After the results of the time study are multiplied by the cost pool total, they are then multiplied by the 50% FFP rate.

e) **Indirect Cost Rate (ICR)**
Indirect costs will be claimed as a part of the MAC Program. The State will use a consistent method to calculate the unrestricted ICR as outlined in OMB Circular A-87. Claims for the school district's indirect costs are only allowable when the cognizant agency has an approved indirect cost rate. These indirect rates are developed by the LEA state cognizant agency, Arizona Department of Education, and are updated annually.

MAC CLAIM DEVELOPMENT

The Third Party Administrator will submit quarterly claims on behalf of participating LEAs directly to AHCCCS. After reviewing each claim, AHCCCS will process the claim for payment. The claims will be based on the quarterly costs, the time study, the Medicaid eligibility rate, the indirect cost rate (ICR) and the FFP.

MAC Medicaid Enrollment Rate (MER)

The costs associated with several Medicaid administrative activities performed by school districts must be adjusted by the district's Medicaid enrollment rate. The Medicaid Enrollment Rate (MER) reduces these costs to the amount for services specific to Medicaid enrolled individuals. The MER for the MAC Program is calculated on an annual basis. For example, referring an individual student to a Medicaid provider in the community is allowable only to the extent that the student is Medicaid enrolled. The costs of these activities are claimable as administrative activities but only to the extent that they are directed toward the Medicaid enrolled population.

To determine the MER for each participating school district, Arizona will use the following method to calculate the quarterly rate. The district student roster is submitted for a match against the statewide file to determine the number of Medicaid enrolled students in the district. The MER is calculated by dividing the total number of Medicaid enrolled students in a district by the entire district enrollment.

Financial Data

The financial data to be included in the calculation of the MAC claim are to be based on actual expenditures incurred during the quarter. These costs must be obtained from actual detailed expenditure reports generated by the district's financial accounting system.

OMB Circular A-87 specifically defines the types of costs: direct costs, indirect costs and allocable costs that can be included in the program. Sections 1 through 42 provide principles to be applied in establishing the allowability or unallowability of certain items of cost. These principles apply whether a cost is treated as direct or indirect. The following items are considered allowable costs as defined and cited below by A-87.

Direct Costs

Typical direct costs identified in A-87 include:

- Compensation of employees

Indirect Costs

Indirect costs included in the claim are computed by multiplying the costs by the LEA approved unrestricted indirect cost rate. These indirect rates are developed by the LEA state cognizant agency, Arizona Department of Education, and are updated annually. The methodology used by the respective state cognizant agency to develop the indirect rates has been

approved by the cognizant federal agency, as required by the CMS guide. Indirect costs are included in the claim as reallocated costs.

Unallowable Costs

Costs that may not be included in the claim are:

- Direct costs related to staff that are not identified as eligible time study participants (i.e., costs related to teachers, cafeteria, transportation, and all other non-School Based administrative areas)
- Costs that are paid with 100 percent federal funds
- Any costs that have already been fully paid by other revenue sources (federal, state/federal, recoveries, etc.)

Revenue Offset

Expenditures included in the MAC claim are often funded with several sources of revenue. Some of these revenue sources require that expenditures be offset, or reduced, prior to determining the federal share reimbursable by Medicaid. These "recognized" revenue sources requiring an offset of expenditures are:

- Federal funds (both directly received by the district and pass through from state or local agencies)
- State expenditures that have been matched with federal funds (including DSC). Both the state and federal share must be used in the offset of expenditures.
- Third party recoveries and other insurance recoveries

Claim Certification

LEAs will only be reimbursed the federal share of any MAC claims. The Chief Financial Officer (CFO), Chief Executive Officer (CEO), Executive Director (ED), Superintendent (SI) or other individual designated as the financial contact by the LEA will be required to certify the accuracy of the submitted claim and the availability of matching funds necessary. The certification statement will be included as part of the invoice and will meet the requirements of 42 CFR 433.51.

LEAs will be required to maintain documentation that appropriately identifies the certified funds used for MAC claiming. The documentation must also clearly illustrate that the funds used for certification have not been used to match other federal funds. Failure to appropriately document the certified funds could result in non-payment of claims.

DOCUMENTATION AND RECORDKEEPING REQUIREMENTS

It is required that all LEAs maintain documentation supporting the claims filed through the MAC Program. LEAs must maintain and have available upon request by state or federal entities the contract with the state to participate in the MAC Program. Documentation must be maintained quarterly in support of claims. This information must be available upon request by state or federal entities. Each participating LEA will maintain a quarterly audit file containing, at a minimum, the following information:

- A roster of eligible staff, by category, submitted for inclusion in the participant sample pool
- Financial data used to develop the expenditures and revenues for the claim calculations including state/local match used for certification
- Documentation of the district's approved indirect cost rate (if applicable)
- A copy of the completed and signed certification form

The State requires LEAs to maintain complete copies of all MAC Program claims and supporting documentation including time study results.

Retention period

Documentation must be retained for the minimum federally required time period. Federal guidelines (42 CFR 433.32) state the retention period is three years unless there is an outstanding audit. The State's requirement is for LEAs to maintain MAC Program documentation for five years or until such time all outstanding audit issues and/or exceptions are resolved.

Oversight and Monitoring

Federal guidelines require the oversight and monitoring of the administrative claiming programs. This oversight and monitoring must be done at both the LEA and state level.

<u>State Level Oversight and Monitoring</u>

The state is charged with performing appropriate oversight and monitoring of the time study and MAC Program to ensure compliance with state and federal guidelines. AHCCCS is the responsible agency for this required monitoring and oversight effort. AHCCCS has an Intergovernmental Agreement (IGA) with the Arizona Department of Education for Medicaid administrative claiming. The IGA clearly state all parties' responsibilities. Please see IGA attached as Appendix B.

AHCCCS will monitor and review various components of the MAC program operating in the state. The areas of review include, but are not limited to:

- Participant List – ensure only eligible categories of staff are reported on the participant list based on the approved RMTS categories in the implementation plan
- RMTS Time Study – sampling methodology, sample, and time study results
- RMTS Central Coding – review at a minimum a 10% sample per quarter of the completed coding
- Training – Compliance with training requirements: program contact and central coder
- Financial Reporting – Costs are only reported for eligible cost categories and meet reporting requirements
- Documentation Compliance

Frequency of Monitoring

All LEAs will be monitored at least once every three (3) years. This monitoring will consist of either an on-site, desk, or combination review. For this monitoring process, one quarter will be selected for in-depth review. Participating LEAs will be required to fully cooperate in providing information and access to necessary staff in a timely manner to facilitate these efforts. LEAs that do not fully cooperate in the review process may be subject to sanctions.

The State will pursue sanctions for LEAs that fail to meet MAC Program requirements or fail to correct problems identified during review. Examples of actions that will cause implementation of sanctions include, but are not limited to:

- Repeated and/or uncorrected errors in financial reporting, including failure to use the Third Party Administrator-provided financial reporting worksheets
- Failure to cooperate with state and/or federal staff during reviews or other requests for information
- Failure to maintain adequate documentation
- Failure to provide accurate and timely information to the Third Party Administrator as required

Sanctions the state may impose include suspending payment of MAC claims, conducting more frequent reviews, and the recoupment of funds. Once an LEA has been notified of the need for remedial action, the LEA will submit a corrective action plan to the State, and the State will approve or amend the corrective action plan on an agreed upon time frame.

<u>Third Party Administrator Level Oversight and Monitoring</u>

Quarterly Tasks

<u>Training Regarding RMTS</u>

- Ensure districts have participated in required RMTS training in order to participate in RMTS
- Review of RMTS compliance rate, ensure each district meets the 85% compliance level requirement
- Ensure LEA RMTS coordinator understands how critical response rate is per district and that he/she is aware of applicable sanctions for non-compliance.

<u>Roster Updates</u>

- Prepare roster update and email to district contact
- Receive updated roster from district

- Review and QC updated roster
- Upload individual district rosters into database with all other participating districts

Time Study Tasks

- Randomly select time study participants from database
- Notify district contact of staff from their district who were selected for the quarter
- Notify selected participants no more than 5 days prior and 1day prior to their selected moment and send reminders one day after the moment if it has not been completed with a copy to the supervisor and/or district coordinator
- Review documented responses and code time study received from selected participants; conduct follow-up if necessary for the determination of the appropriate time study code
- Quality check received and coded time study data
- Follow up with participants who submitted incomplete data, correcting the data so it can be used
- Scan all data and prepare it for the claim

Financial Tasks

- Conduct financial training with district
- Prepare quarterly financial workbook and email workbook to designated financial contact
- Receive completed workbook and QC for errors
- If necessary, resubmit to contact for revisions
- Prepare financial information for the MAC claim
- Prepare Certification of Public Expenditure (CPE) form and send to financial contact for completion
- Receive completed CPE forms from district and submit to AHCCCS

Miscellaneous Tasks

- Participate in quarterly MAC update meetings
- Answer general questions from districts throughout the quarter
- Collect annual indirect cost rate (ICR) from district
- Obtain quarterly Medicaid Enrollment Rate (MER) from the State
- Run quarterly MAC claim and submit to AHCCCS
- Send copy of claim to district for their records
- Conduct quality assurance reviews, as needed
- Serve as liaison between district and AHCCCS
- Conduct LEA monitoring as delegated by AHCCCS

Local LEA Level Oversight and Monitoring

Each LEA participating in the MAC Program must take appropriate oversight and monitoring actions that will ensure compliance with MAC program requirements. Actions must be taken to ensure, at a minimum, that:

- The time study is performed correctly
- The financial data submitted is correct
- RMTS training requirements are met
- Appropriate documentation is maintained to support the time study and the claim

Required Personnel

Each LEA will designate an employee as the LEA RMTS coordinator or MAC Program contact. This single individual is designated within the LEA to provide oversight for the implementation of the time study and to ensure that state policy decisions are implemented appropriately. The LEA must also designate an Assistant LEA RMTS coordinator to provide back-up support for time study responsibilities.

APPENDIX A

Medicaid Administrative Claiming Program Time Study Activity Codes

Code 1a. Non-Medicaid Outreach

Use this code when performing activities that inform eligible or potentially eligible individuals about non-Medicaid social (Food Stamps and Title IV-E), vocational, general health and educational programs (including special education) and how to access them; describing the range of benefits covered under these non-Medicaid social, vocational and educational programs and how to obtain them. Both written and oral methods may be used. Includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Scheduling and promoting activities which educate individuals about the benefits of healthy life-styles and practices;
- Conducting general health education programs or campaigns addressed to the general population;
- Conducting outreach campaigns directed toward encouraging persons to access social, educational, legal or other services not covered by Medicaid;
- Assisting in early identification of children with special medical/dental/mental health needs through various child find activities;
- and Outreach activities in support of programs that are 100 percent funded by State general revenue.

Code 1b. Medicaid Outreach

Use this code when performing specific activities to inform eligible individuals about Medicaid and EPSDT benefits and how to access the program. Information includes a combination of oral and written methods that describe the range of services available through Medicaid and EPSDT, the cost (if any), location, how to obtain services, and the benefits of preventive healthcare. Includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Interpreting materials about Medicaid to persons with children within the school district boundaries who are illiterate, blind, deaf, or who cannot understand the English language;
- Informing foster care providers of foster children residing within school district boundaries about the Medicaid and EPSDT program;
- Informing Medicaid eligible pregnant students about the availability of EPSDT services for children under the age of 21 (including children who are eligible as newborns);
- Utilizing brochures approved by the Division of Medical Services, designed to effectively inform eligible individuals about the benefits Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and services, and about how and where to obtain services;
- Providing information about EPSDT in the schools that will help identify medical conditions that can be corrected or ameliorated by services covered through Medicaid;
- Informing children and their families about the early diagnosis and treatment services for medical/mental health conditions that are available through the Medicaid program; and
- Facilitating access to Medicaid when a staff member knows that a child does not have appropriate health care, this does not include child find activities directed to identifying children with educational handicapping conditions.

Code 2a. Facilitating an Application to Non-Medicaid Programs

Use this code when assisting an individual or family to make application for programs such as TANF, Food Stamps, WIC, day care, legal aid, and other social or educational programs and referring them to the appropriate agency to make application. Both written and oral methods may be used. Include related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Explaining the eligibility process for non-Medicaid programs;
- Assisting the individual or family in collecting/gathering information and documents for the non-Medicaid program application;
- Assisting the individual or family in completing the application
- Developing and verifying initial and continuing eligibility for the Free and Reduced Lunch Program. When a school district employee is verifying a student's eligibility or continuing eligibility for Medicaid for the purpose of developing, ascertaining or continuing eligibility under the Free and Reduced Lunch program, report that activity under this code; and
- Providing necessary forms and packaging all forms in preparation for the Non-Medicaid eligibility determination.

Code 2.b Facilitating Medicaid Eligibility Determination

Use this code when assisting children and families in establishing Medicaid eligibility, by making referrals to the Division of Family Services for eligibility determination, assisting the applicant in the completion of the Medicaid application forms, collecting information, and assisting in reporting any required changes affecting eligibility. Includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Referring an individual or family to the local assistance office to make an application for Medicaid benefits;
- Explaining the Medicaid eligibility process to prospective applicants;
- Providing assistance to the individual or family in collecting required information and documents for the Medicaid application; and
- Assisting the individual or family in completing the Medicaid application.

Code 3: School Related and Educational Activities

Use this code when performing any other school-related activities that are not Medicaid related, such as social services, educational services, teaching services; employment and job training. These activities include the development, coordination, and monitoring of a student's education plan. Include related paperwork, clerical activities, or staff travel required to perform these activities.

Examples:

- Providing classroom instruction (including lesson planning);
- Testing, correcting papers;
- Developing, coordinating, and monitoring the Individualized Education Plan (IEP) for a student, which includes ensuring annual reviews of the IEP are conducted, parental sign-offs are obtained, and the actual IEP meetings with the parents;
- Compiling attendance reports;
- Reviewing the education record for students who are new to the school district;
- Providing general supervision of students (e.g., playground, lunchroom);
- Providing individualized instruction (e.g., math concepts) to a special education student;
- Conducting external relations related to school educational issues/matters;
- Activities related to the immunization requirements for school attendance;
- Enrolling new students or obtaining registration information;
- Conferring with students or parents about discipline, academic matters or other school related issues;
- Participating in or presenting training related to curriculum or instruction (e.g., language arts workshop, computer instruction);
- Providing Individuals With Disabilities Education Act (IDEA) mandated child find activities.

Code 4:Direct Medical Services

Use this code when providing direct health care, treatment, and/or counseling services including mental health assessments and evaluations to an individual in order to correct or ameliorate a specific condition. This code also includes administrative activities that are an integral part of or extension of a medical service (e.g., patient follow -up, patient assessment, patient

counseling, patient education, parent consultations, billing activities). This code also includes all related paperwork, clerical activities, or staff travel required to perform these activities.

Examples:

- Providing health/mental health services contained in an IEP;
- Medical/health assessment and evaluation as part of the development of an IEP;
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports;
- Providing health care/personal aide services;
- Providing speech, occupational, physical and other therapies;
- Administering first aid, or prescribed injection or medication to a student;
- Providing direct clinical/treatment services;
- Providing counseling services to treat health, mental health, or substance abuse conditions;
- Performing routine or mandated child health screens including but not limited to vision, hearing, dental, and EPSDT screens;
- Providing immunizations;
- Targeted Case Management provided or covered as a medical service under Medicaid; and
- Activities, which are services or components of services, listed in the State's Medicaid plan.

Code 5.a: Transportation for Non-Medicaid Services

This code should be used by school staff when assisting an individual to obtain transportation to services not covered by Medicaid, or accompanying the individual to services not covered by Medicaid. Include related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

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

Code 5.b Transportation-Related Activities in Support of Medicaid Covered Services

School staff when assisting an individual to obtain transportation to services covered by Medicaid should use this code. This does not include the provision of the actual transportation service or the direct cost of the transportation, but rather the administrative activities involved in providing transportation. Include related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Scheduling or arranging transportation to Medicaid covered services.

Code 6.a Non-Medicaid Translation

School staff when providing translation service for non-Medicaid activities should use this code. Include related paperwork, clerical activities or staff travel required to perform the activities.

Examples:

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

Code 6.b Translation Related to Medicaid Services

This code should be used by school staff when it is not included and paid for as part of a medical assistance service and must be provided with by separate units or separate employees performing solely translation functions for the school and it must

facilitate access to Medicaid covered services. Please note that a school district does not need to have a separate administrative claiming unit for translation. Include related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

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

Code 7.a: Program Planning, Policy Development, and Interagency Coordination Related To Non-Medical Services

School staff should use this code when performing activities associated with the development of strategies to improve the coordination and delivery of non-medical services to school age children. Non-medical services may include social services, educational services, and state or state education mandated child health screenings provided to the general school population. Only employees whose position descriptions include program planning, policy development, and interagency coordination may use this code. Include related paperwork, clerical activities or staff travel required to perform these activities.

Examples

- Identifying gaps or duplication of non-medical services to school age children and developing strategies to improve the delivery and coordination of these services;
- Developing strategies to assess or increase the capacity of non-medical school programs;
- Monitoring the non-medical delivery systems in schools;
- Developing procedures for tracking families' requests for assistance with non-medical services and providers;
- Evaluating the need for non-medical services in relation to specific populations or geographic areas;
- Analyzing non-medical data related to a specific program, population, or geographic area;
- Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical problems;
- Defining the relationship of each agency's non-medical service to one another;
- Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services and state mandated health screening to the school populations;
- Developing medical referral sources; and
- Coordinating with interagency committees to identify, promote and develop non-medical services in the school system.

Code 7.b: Program Planning, Policy Development, And Interagency Coordination Related To Medical Services

This code should be used by school staff when performing activities associated with the development of strategies to improve the coordination and delivery of Medicaid covered medical/dental/mental health services to school age children, and when performing collaborative activities with other agencies and/or providers. Only employees whose position descriptions include program planning, policy development, and interagency coordination should use this code. Include related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Developing strategies to assess or increase the capacity of school medical/dental/mental health programs;
- Monitoring the medical/dental/mental health delivery systems in schools;
- Developing procedures for tracking family's requests for assistance with medical/dental/mental health services and providers, including Medicaid. (This does not include the actual tracking of requests for Medicaid services);
- Evaluating the need for medical/dental/mental health services in relation to specific populations or geographic areas;
- Analyzing Medicaid data related to a specific program, population, or geographic area;
- Working with other agencies providing medical/dental/mental health services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligible, and to improve collaboration around the early identification of medical problems;
- Working with other agencies and/or providers to improve collaboration around the early identification of medical/dental/mental problems;
- Developing strategies to assess or increase the cost effectiveness of school medical/dental/mental health

programs;

- Working with Medicaid resources, such as the Medicaid agency and Medicaid managed care plans, to make good faith efforts to locate and develop EPSDT health services referral relationships;
- Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services to the school populations;
- Developing medical referral sources such as directories of Medicaid providers and managed care plans, who will provide services to targeted population groups, e.g., EPSDT children;
- Coordinating with interagency committees to identify, promote and develop EPSDT services in the school system;
- Identifying gaps or duplication of medical/dental/mental health services to school age children and developing strategies to improve the delivery and coordination of these services; and
- Working with Division of Medical Services to identify, recruit and promote the enrollment of potential Medicaid providers.

Code 8.a Non-Medical/Non-Medicaid Related Training

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

Examples:

- Participating in or coordination training that improves the delivery of services for programs other than Medicaid; and
- Participating in or coordinating training that enhances IDEA child find programs.

Code 8.b Medical/Medicaid Related Training

This code should be used by school staff when coordinating, conduction, or participating in training events and seminars for outreach staff regarding the benefit of medical/Medicaid related services, how to assist families to access such services, and how to more effectively refer students for those services. Include related paperwork, clerical activities, or staff travel required to perform these activities.

Examples

- Participating in or coordination training that improves the delivery of medical/Medicaid related services;
- Participating in or coordinating training that enhances early identification, intervention, screening and referral of students with special health needs to such services (e.g., Medicaid EPSDT services); and
- Participating in training on administrative requirements related to medical/Medicaid services.

Code 9.a: Referral, Coordination, And Monitoring Of Non-Medicaid Services

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

Examples

- Making referrals for and/or coordinating access to social and educational services such as child care, employment, job training, and;
- Making referrals for, coordinating, and/or monitoring the delivery of state education agency mandated child health screens;
- Making referrals for, coordinating, and/or monitoring the delivery of scholastic, vocational, and other non-health related examinations;
- Gathering any information that may be required in advance of these non-Medicaid related referrals;
- Participating in a meeting/discussion to coordinate or review a student's needs for scholastic, vocational, and non-health related services not covered by Medicaid; and
- Monitoring and evaluating the educational components of the IEP as appropriate.

Code 9.b: Referral, Coordination, And Monitoring Of Medicaid Services

THIS CODE SHOULD BE USED WHEN MAKING REFERRALS FOR, COORDINATING, AND/OR MONITORING THE DELIVERY OF MEDICAL (MEDICAID COVERED) SERVICES. REFERRAL, COORDINATION AND MONITORING ACTIVITIES RELATED TO SERVICES IN AN IEP ARE REPORTED IN THIS CODE. ACTIVITIES THAT ARE PART OF A DIRECT SERVICE ARE NOT INCLUDED IN THIS CODE. INCLUDE RELATED PAPERWORK, CLERICAL ACTIVITIES, OR STAFF TRAVEL NECESSARY TO PERFORM THESE ACTIVITIES.

Examples

- Identifying and referring adolescents who may be in need of Medicaid family planning services;
- Making specific medical referrals for and/or coordinating medical or physical examinations and necessary medical/dental/mental health evaluations;
- Making referrals for and/or scheduling EPSDT screens, interperiodic screens, and appropriate immunization, but not to include the state-mandated health services;
- Referring students for necessary medical health, mental health, or substance abuse services covered by Medicaid;
- Arranging for any Medicaid covered medical/dental/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/mental health condition;
- Gathering information that may be required in advance of these medical/dental/mental health referrals;
- Participating in a meeting/discussion to coordinate or review a student's needs for health-related services covered by Medicaid;
- Providing follow-up contact to ensure that a child has received the prescribed medical/dental/mental health services;
- Coordinating the completion of the prescribed services, termination of services, and the referral of the child to other Medicaid service providers as may be required for continuity of care;
- Providing information to other staff on the child's related medical/dental/mental health services and plans;
- Monitoring and evaluating the Medicaid service components of the IEP as appropriate; and
- Coordinating the delivery of community based medical/dental/mental health services for children with special/severe health care needs.

Code 10: General Administration

USE THIS CODE WHEN PERFORMING ACTIVITIES THAT ARE NOT DIRECTLY ASSIGNABLE TO PROGRAM ACTIVITIES. INCLUDES RELATED PAPERWORK, CLERICAL ACTIVITIES OR STAFF TRAVEL REQUIRED TO PERFORM THESE ACTIVITIES.

Examples:

- Taking lunch, breaks, leave, or other paid time not at work;
- Establishing goals and objectives of health-related programs as part of the school's annual or multi-year plan;
- Attending or facilitating school or unit staff meetings training, or board meetings;
- Reviewing school or district procedures and rules;
- Reviewing technical literature and research articles;
- Providing general supervision of staff, including supervision of student teachers or classroom volunteers, and evaluation or employee performance; and
- Performing other administrative or clerical activities related to general building or district functions or operations.

Code 11: Not Paid / Not Worked

This code should be checked if the RMS moment occurs at a time when a part-time, temporary or contracted employee is not scheduled to be at work or when a full-time individual takes a non-paid day off or leave of absence.

APPENDIX B

INTERGOVERNMENTAL AGREEMENT BETWEEN

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION (Administration)
AND
ARIZONA DEPARTMENT OF EDUCATION (ADOE)
FOR
SCHOOL-BASED MEDICAID SERVICES

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the date and year specified below.

Arizona Department of Education

____
Signature

____
Typed Name

____
Title

____
Date

Attorney General Contract No.__________, which is an Agreement between public agencies, has been reviewed pursuant to A.R.S. §11-952 by the undersigned Assistant Attorney General who has determined that it is in the proper form and is within the powers and authority granted under the laws of the State of Arizona to those Parties to the Agreement represented by the Attorney General.

Dated this __ day of _____, 2000
JANET NAPOLITANO, THE ATTORNEY GENERAL
By _______________________________
Assistant Attorney General

Secretary of State filing information:

Arizona Health Care Cost Containment System Administration

____
Signature

Michael Veit
Typed Name

Contracts & Purchasing Administrator
Division of Business and Finance
Title

____
Date

In accordance with A.R.S. §11-952, this Agreement is in proper form and is within the power and authority granted to the Administration under A.R.S. §§36-2903 et seq. and 36-2932 et seq.

____
Legal Counsel for the Administration

Agreement Period:
This Agreement shall become effective on the date it is filed with the Secretary of State, pursuant to A.R.S. §11-952(F), or on July 1, 2000, whichever occurs first.

This Agreement shall:

Remain in effect until terminated as provided herein.

Whereas, the AHCCCS Administration has, pursuant to Title 36, Chapter 29 of the Arizona Revised Statutes, a statutory obligation to provide Medicaid services to eligible persons including children with special education needs;

Whereas, the ADOE has, pursuant to Title 15, Chapter 7, Article 4 of the Arizona Revised Statutes, statutory obligations to ensure a free appropriate public education to students with special education needs;

Whereas, the Individuals with Disabilities Education Act (20 U.S.C. 1412(a)(12)(A)) requires each state to ensure that an interagency agreement or other mechanism for interagency coordination is in effect between the state educational agency and the state Medicaid agency;

Whereas, the AHCCCS Administration operates the State's Medicaid program under a waiver pursuant to section 1115 of Title XIX of the Social Security Act, which waiver permits the State, among other things, to limit the free choice of providers and deliver care through a system of capitated managed care organizations;

Whereas, the AHCCCS Administration and the Arizona Department of Education have determined that, at present, it is most advantageous to the State to meet its obligations under Part B of the IDEA by making payments to local educational agencies on a fee-for-service basis for a limited set of Medicaid covered services provided on-site by schools while designing and implementing a system that can be expanded to include a broader scope of services for which local educational agencies will be directly reimbursed on a fee-for-service basis for services provided by the local educational agency;

Whereas the AHCCCS Administration and ADOE have the authority to enter into intergovernmental agreements pursuant to ARS 11-952;

Therefore the parties agree to the following:

I. Definitions

A. "Administration" means the AHCCCS.

B. "ADOE" means the Arizona Department of Education.

C. "AHCCCS" means the Arizona Health Care Cost Containment System as defined by ARS § 36-2903(A).

D. "AHCCCS Covered Services" means those services set forth in ARS §§ 36-2907 and 36-2939 and Arizona Administrative Code Title 9 Chapter 22 Article 2 and Chapter 28 Article 2.

E. "Contractor" means Contractor as defined by AAC R9-22-101 and R9-28-101 as well as the Children's Rehabilitative Services Program and Regional Behavioral Health Authorities under contract with ADHS to the extent that the Children's Rehabilitative Service Program and the Regional Behavioral Health Authorities are obligated by contract with the Administration to provide services to Title XIX eligible children.

F. "EVS/IVR system" means Eligibility Verification System/Integrated Voice Response that is AHCCCS' automated electronic eligibility verification system.

G. "HCBS" means Home and Community Based Services as defined by ARS § 36-2939(B)(2) and (C).

H. "IEP" means an individualized education program as defined at ARS § 15-761(10).

I. "LEA" means the local education agency as defined by 20 U.S.C. § 1402(15).

J. "PCP" means primary care provider as defined by A.A.C. R9-22-102(18).

K. "Qualified Child" means a child between the ages of 3 and 22 years of age who has been determined by AHCCCS to be eligible under Title XIX of the Social Security Act and who has been determined by the LEA to be eligible for special education and related services.

L. "Qualifying Service" means an AHCCCS covered service that is medically necessary for a qualified child and is also a related service included in the qualified child's IEP.

M. "Related service" means those services defined by 34 CFR 300.24.
N. "Special Education service" means those services defined by 34 CFR 300.26.

II. Financial Responsibility

In General. As set forth in this Agreement, the financial responsibility of the AHCCCS shall precede the financial responsibility of the LEA with respect to the provision of qualifying services.

B. Fee for Service Payments to LEAs.
1. For dates of service on or after July 1, 2000, the Administration, through the Third Party Administrator designated by the Administration, shall reimburse participating LEAs the federal Medicaid contribution, less an administrative fee established by the Administration, for the qualifying services specifically described in Appendix A of this Agreement.
2. The Administration, in consultation with the ADOE, will identify on an on-going basis additional appropriate qualifying services that can be added to the direct fee-for-service payment methodology described in this Agreement. Additions to qualifying services eligible for direct fee-for-service reimbursement to LEAs will be made through revisions to the AHCCCS Medical Policy Manual.

C. Services Provided through Contractors. With respect to qualifying services other than those identified in Section II Paragraph B and Appendix A (and any additional services identified through amendments to the AHCCCS Medical Policy Manual concerning Medicaid services in public schools), the Administration, through its Contractors, shall provide all other qualified services to qualified children.

D. Limitations on Financial Responsibility.
Service Effecting HCBS Eligibility: Neither the Administration nor any Contractor is responsible to provide or reimburse the LEA for any AHCCCS covered related service that, if provided in addition to the AHCCCS covered services received by the member, would render the member ineligible for HCBS because the cost effectiveness requirements of AAC R9-28-510 as implemented through AHCCCS Medical Policy Manual, were exceeded.

III. Conditions and Terms of Reimbursement to LEAs

A. In General
1. Every provider of qualified services shall meet applicable licensure requirements, shall be registered with the Administration, and shall sign a Provider Agreement as required by the Administration.
2. All claims shall be submitted in accordance with State and Federal law and the Fee-For-Service Provider Manual.
3. All qualifying services shall be medically necessary as set forth in Arizona Administrative Code R9-22-101(B)(37).
4. All qualifying services shall be ordered or prescribed by either a physician licensed pursuant to A.R.S. Title 32, Chapters 13 or 17, or by other licensed practitioners who are authorized in accordance with federal and state laws and who are recognized by AHCCCS.
5. Qualifying services shall be prescribed and provided in accordance with the AHCCCS Medical Policy Manual.
6. All qualifying services shall be provided on school grounds unless the IEP specifies an alternative setting where educational services are also provided.

B. Fee for Service. On and after January 15, 2001, claims shall be submitted by school districts and individual charter schools that are not affiliated with a school district that are registered as group billing entities for registered providers employed by or contracted with the LEAs, subject to the following terms:

1. **Claims may be submitted for the services identified in Section II, Paragraph B.**
2. **Claims shall be submitted to and paid through the Third Party Administrator designated by the Administration.**
3. **The LEA shall be reimbursed an amount equal to the appropriate Federal Medical Assistance Percentage multiplied by the lesser of the fee-for-service rate adopted by the Administration for the qualifying service or the amount billed by the provider, less an administrative fee as set forth in the contract between the Administration and the Third Party Administrator.**
4. **LEAs and providers under contract with LEAs shall comply with the provisions of 42 CFR 433.139 relating to the third party liability. The financial obligation of AHCCCS to cover qualifying services does not precede the obligation of potentially liable third parties. Failure on the part of LEAs or their contracted providers to pursue third party liability as required by federal law will result in the denial of the claim.**
5. **The LEA shall ensure that for each service rendered documentation, consistent with the requirements of the AHCCCS Medical Policy Manual and the AHCCCS Fee-For-Service Provider Manual, is maintained to establish the date of service, the type of service, the identity of the provider and the medical necessity of the service.**

Fee for Service Reimbursement for Services Provided Prior to July 1, 2000. The Administration will pursue approval from the U.S. Department of Health and Human Services, Health Care Financing Authority ("HCFA") for a methodology for payments to LEA's on a fee-for-service basis for Medicaid services rendered prior to July 1, 2000. Once approved by HCFA, the Administration will establish a payment methodology for such services.

D. Reimbursement from Contractors. In compliance with 20 U.S.C. 1412(a)(12)(B)(ii), if a Contractor fails to provide a medically necessary qualifying service to a qualified child (other than the services set forth in Section II Paragraph B) after a request for the service has been made, and the LEA provides or pays for these services, an LEA may file a claim for reimbursement with the responsible Contractor. If the Contractor denies payment of the claim, the LEA may grieve the denial in accordance with Section IV of this Agreement.

Payment Recoupment. LEAs shall reimburse the Administration upon demand or the Administration may deduct from future payments to the LEA any amount:

1. **For which the LEA's books, records, and other documents are not sufficient to clearly confirm that those amounts were used by the LEA to deliver qualifying services listed in Appendix A (or amendments to the AHCCCS Medical Policy Manual related to Medicaid Services in the public schools) to qualified children or which fail to conform with federal requirements as specified in 45 CFR Part 74;**
2. **Sustained as an audit exception resulting from a financial statement audit or an audit conducted in accordance with the Single Audit Act of 1984; or**
3. **Determined by the federal government to be unallowable, deferred or disallowed for any reason.**

IV. Disputes

The LEA may grieve the denial of a claim for reimbursement or recoupment of an overpayment by the Administration, the Third Party Administrator, or a Contractor, in accordance with AAC R9-22-801 et seq.

V. Responsibilities for Coordination of Services

A. ADOE: The ADOE is responsible for ensuring that:
   1. LEAs are aware of the terms and conditions of this IGA; and
   2. The State maintains the level of financial effort as required by 34 CFR 300.153 and 34 CFR 300.154.

B. LEA: The LEA is responsible for:
   1. Verifying whether the child has been determined eligible for Title XIX services through the Administration's EVS/IVR system and for any cost associated with the use of the EVS/IVR system;
   2. Coordinating the delivery of care with other health care providers treating the qualifying child in accordance with the AHCCCS Medical Policy Manual; and
   3. Ensuring compliance with the Federal Education Rights and Privacy Act and obtaining any necessary consent to release information to the Administration, the Contractor, and other treating health care providers.
   4. Ensuring that any services terminated, suspended or reduced by the LEA are continued pending a hearing decision, if a request for an expedited hearing and for continuation of services pending the hearing is filed by or on behalf of a qualifying child, pursuant to Arizona Administrative Code R9-22-1301 *et seq.*

Miscellaneous Terms

A. Documentation and Records. Each LEA and each provider shall maintain books and records relating to qualifying services provided. Records shall include but not be limited to financial records, records relating to quality of care, medical records, and other records specified by the Administration. Each LEA and each provider shall preserve and make available all records for a period of five years from the date of service except that for records related to a grievance, dispute, litigation or settlement of claims arising out of this Agreement, or costs, claims, or expenses of this Agreement to which exception has been taken by the Administration shall be retained for five years from the final disposition or resolution thereof.

B. Confidentiality. Each LEA and each provider shall maintain the confidentiality of medical records and other member specific information received through the AHCCCS Administration in accordance with applicable State and Federal laws and regulations and the AHCCCS Medical Policy Manual.

C. Audit and Inspection. Each LEA and each provider shall make available at its office at all reasonable times during the period set forth in paragraph A of this Section any of its records for inspection, audit or reproduction by any authorized representative of the Administration, or the State of federal government.

D. Amendments. Amendments to this Agreement shall be in writing and signed by the parties.

E. Non-discrimination. The parties shall comply with State Executive Order 99-4, which mandates that all persons, regardless of race, color, religion, sex, national origin or political affiliation, shall have equal access to employment opportunities, and all other applicable federal and state laws, rules and regulations, including the Americans with Disabilities Act.

F. Termination. This Agreement may be terminated by any party to the Agreement upon 90 days notice; however, the parties recognize that in the absence of this agreement some other mechanism shall be in place to assure compliance with the terms of IDEA as they relate to the coordination of special education and Medicaid services.

G. Termination for Conflict of Interest. Either the Administration or the ADOE may cancel this contract without penalty or further obligation if any person significantly involved in initiating, negotiating,

securing, drafting or creating this Agreement is in effect any employee of, or a consultant to, any other party to this agreement with respect to the subject matter of this Agreement. The cancellation shall be effective when the party receives written notice of the cancellation unless the notice specifies a later time.

H. Duration. This Agreement becomes effective on the date it is signed by all parties and filed with the Secretary of State's Office and continues on a year to year basis unless terminated by one of the parties.