ARIZONA MEDICAID SCHOOL-BASED CLAIMING

TIME STUDY IMPLEMENTATION GUIDE FOR DIRECT SERVICES AND ADMINISTRATIVE CLAIMING EFFECTIVE: July 1, 2011

Prepared by AHCCCS

VISION

The Arizona Health Care Cost Containment System (AHCCCS) is committed to providing an efficient and effective Medicaid School-Based Claiming (MSBS) program. The program is comprised of Direct Services and Administrative components designed to ensure the optimum delivery of services to our clients. In keeping with this vision, AHCCCS implemented a statewide Random Moment Time Study (RMTS) methodology to support proper Medicaid reimbursement for delivered services.

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.

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".

Schools are often involved in informing families of their potential eligibility for Medicaid or in helping them arrange medical appointments for children. These activities are considered "administrative," and schools are able to receive reimbursement through Medicaid.

Both types of claiming must comply with federal and state guidelines related to provider qualifications, covered services, claiming requirements, and documentation.

LEA participation in the Medicaid School-Based Claiming program is voluntary. If school districts wish to participate in the MAC program they are required to also participate in the Direct Service claiming program. School districts cannot participate solely in MAC.

Purpose of Guide

The purpose of the Medicaid School-Based Claiming Time Study Implementation Guide is to inform our Third Party Administrator and school districts of the appropriate methods for claiming federal reimbursement for the cost of Medicaid direct services and administrative activities performed in the school setting. This Guide replaces the prior approved MAC Time Study Guide beginning July 1, 2011.

Particularly, the guide will:

- Help schools and school districts prepare appropriate claims for both direct medical services and administrative costs and under the Medicaid program;
- Ensure that the Medicaid program pays only for appropriate school-based services and 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 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 the Medicaid School-Based program;
- Serve as the single point of contact for LEAs that are either interested in participating or are participating in the MSBC;
- Help LEAs prepare appropriate claims under the Medicaid program;
- Ensure that the Medical program pays only for appropriate Medicaid 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 the MSBC program;
- 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 such as the administration of the RMTS and cost collection;
- Distribute LEA payments; 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 time spent performing medical direct services allowable under the direct service program and the 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 provision of direct medical services, administrative and outreach, and some of which are not. Sorting out the portion of staff activity that is related to direct medical services, MAC activities 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 MSBC program will be required to participate in the RMTS methodology of time study.

Random Moment Time Study (RMTS) Methodology

The RMTS, sometimes referred to as Random Moment Sampling, is a federally accepted method for tracking employee time and activities within school districts. According to OMB Circular A-87 (revised 5/10/04), and its accompanying implementation guide ASMB C-10, "Substitute systems for allocating salaries and wages to federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to, random moment sampling…."

RMTS is particularly useful, because:

- It uses a verifiable, statistically valid random sampling technique that produces accurate labor distribution results, and
- It greatly reduces the amount of staff time needed to record an individual time study participant's activities.

The RMTS method polls participants on an individual basis at random time intervals over a quarterly (three month) time period and totals the results to determine work effort for the entire population of eligible staff over that same 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.

SAMPLING REQUIREMENTS

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

As stated, the AHCCCS RMTS sampling methodology is designed to permit a level of precision of +/- 2% (two percent) with a 95% (ninety-five percent) confidence level for activities. Statistical calculations show that a minimum statewide sample of 2,401 completed moments each quarter, per cost pool, is adequate to obtain this precision when the total pool of moments is greater than 3,839,197. Additional moments are selected each quarter to account for any invalid moments. Invalid moments are observations that cannot be used for analysis, i.e., moments selected for staff who are no longer at the school district, or who changed jobs and are no longer in an allowable position and their old position has not been filled.

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

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

WHERE:

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

CORRECTION FOR FINITE POPULATION

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

Prior to the beginning of each quarter, participating districts should 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 three "cost pools." There will be three 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 School Calendar Year. The quarterly RMTS will be utilized for both the Direct Service and MAC program. The following are are defined as:

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

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

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

Each quarter, 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 (July – September), 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

Each quarter the State audits a 5% sub-sample of coded moments to ensure coding completeness, accuracy, and consistency. The Third Party Administrator will randomly select a 5% sample of centrally coded responses which will be submitted to the State each quarter for validation. The State's validation process 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 discuss any disagreements with the coding staff quarterly. The State may choose to broaden the sub-sample based on results of their review. Based on these discussions, additional guidance and training for centralized coding will occur. The RMTS results are finalized upon completion of the State's sub-sample review and approval.

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.

Time Study Participants

The purpose of the Arizona statewide time study is to identify the proportion of direct medical service and administrative and outreach time allowable and reimbursable under Medicaid. This information is used for direct service cost reporting to enable the State of Arizona to conduct a cost settlement at the end of the fiscal year for the MSBC program. The MAC time study results are applied to the allowable administrative costs of the participating districts to calculate the quarterly Medicaid Administrative Claim. Staff performing Medicaid related activities in a school district seeking reimbursement are required to participate in the statewide time study using the approved RMTS methodology.

All school districts that participate in the time study must identify allowable Medicaid direct service and administrative costs within a given school district. The staff members who perform direct medical services and administrative and outreach activities are required to participate in a quarterly time study. School districts must certify that any staff providing services or participating in the time study meets the educational, experiential and regulatory requirements. Staff pool lists will be updated quarterly to reflect staff changes at the school district level. If a staff person leaves the school district and the position is then filled, the school district must notify the third party administrator to update the contact information associated with that replacement position. In the event that a new position is created or a district does not include that position on the staff pool list created at the beginning of the quarter, which is used to generate the statewide sample, the district will have to wait until the next quarter to add that staff person/position. Staff rosters will not be modified once the sample has been generated and the quarter has started with the exception of replacement positions. Costs cannot be claimed for a position unless that position is included in the sample pool list. Therefore, only positions included on the staff pool list for potential RMTS sampling can have costs included in the cost pool for Direct Service and MAC claiming purposes.

Although some staff may perform any combination of direct service and Administrative related activities, depending on their qualifications and role, they will only be allowed to participate in one of the three following cost pools:

- The first cost pool is comprised of Direct Service staff, including those who conduct direct services and administrative activities as well as direct service staff only 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 Personal Care Direct Service Providers who provide direct services and the respective costs for these staff.
- The third cost pool is comprised of Administrative service staff only and the respective costs for these staff.

Personal care providers were separated from the other direct service providers as their training, background, and role in the district is significantly different from traditional direct service providers. In order to ensure that the most accurate time study results are captured for these two groups of service providers, it was determined that two separate cost pools would be most appropriate.

The three 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 three cost pools above.

Staff may report into one of three cost pools: a “Direct Service Provider”, “Personal Care Provider”, or “Administrative Service Provider” cost pool. The three cost pools are mutually exclusive, i.e., a staff person cannot be included as a participant in more than 1 (one) cost pool.

The following provides an overview of the eligible categories in each cost pool as approved in Arizona’s State Plan Amendment (SPA). Only qualified providers in the approved Arizona State Plan can be included in Direct Service pools. 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.”

The following categories of staff have been identified as appropriate participants for the Arizona statewide RMTS. Additions to the list may be made depending upon job duties. The decision and approval to include additional staff will be made on a case-by-case basis, and participants subsequently approved by CMS from additional State Plan Amendments will be included in the list during future updates.

The individuals listed in cost pools 1 and 2 will meet the provider credential and license requirements necessary to provide Direct School-Based Services. As a part of their regular job functions the staff listed in cost pools 1 are eligible to provide

Direct School-Based Services as well as activities reimbursable under the MAC Program. Individuals listed in cost pool 3 are eligible to provide activities reimbursable under the MAC Program only.

Cost Pool 1 (Direct Service Providers)

- 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 and Licensed Practical Nurses

Cost Pool 2 (Personal Care Providers)

- School Health Aides

Cost Pool 3 (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
- Guidance Counselors
- School Based Psychologists
- And other groups/individuals that may be identified by the school district that perform administrative outreach activities that do not bill Medicaid for school-based direct medical services

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.

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.

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 MSBC program updates, process modifications and compliance issues.

Central Coding Staff Training (Activity Coding)

The State ensures that all coding is accurate through an intensive quality assurance process. All coding is conducted centrally by the State's Third Party Administrator. The coders refer to the time study codes and activity descriptions outlined in this Implementation Guide. Every valid response is coded initially by one Central Coder and verified by a second Central Coder. This provides a check on the accuracy of each code before it is finalized. If there is not enough information to determine the code the coder will contact the participant. If the participant does not respond to the coders request then the coded response will default to non-Medicaid. If a discrepancy is encountered, the coders will discuss the code before coming to a final decision.

Sampled Staff Training

Arizona implements a centralized coding methodology so training around the activity codes is not required as sampled staff members do not code their moments. However, the RMTS documentation system includes an online tutorial containing information about the program, the participant's role in the program, as well as, how to complete their sampled moment in the system. The sampled staff member must visit these screens prior to being able to document their moment. For these reasons, training of sampled staff members on Medicaid allowable activities and non-Medicaid activities is not a required element 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?
- Describe why you were doing this activity.
- Is the service you provided listed on the child's IEP?

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. All valid moments completed and returned will be included in the calculation of the RMTS results. 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 all 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. If the statewide compliance rate for a quarter does not achieve at least 90%, AHCCCS will send out a non-compliance warning letter to each LEA that did not achieve an 85% compliance rate. AHCCCS will continue to monitor those LEAs to ensure compliance is achieved. AHCCCS may prohibit participation by LEAs that continue to fall below an 85% return rate compliance.

Time Study Activities/Codes

Time study codes assist in the determination of time and associated costs related to and reimbursable under the Medicaid program. The time study codes have been designed to reflect all of the activities performed by time study participants.

The time study codes are assigned indicators that determine its 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:

Code	Description
U	Unallowable – refers to an activity that is unallowable under the Medicaid program. This is regardless of whether or not the population served includes Medicaid eligible individuals.
TM	Total Medicaid – refers to an activity that is 100 percent allowable under the Medicaid program.
PM	Proportional Medicaid – refers to an activity, which is allowable under the Medicaid program, but for which the allocable share of costs must be determined by the application of the IEP Ratio.
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 General Administration.

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

Code	Code Text	Activity	Direct Service Program	MAC Program
	Prov Svcs	**PROVISION OF SERVICES**		
1A	Outreach	Non-Medicaid Outreach	U	U
1B	Outreach	Medicaid Outreach	U	TM/50%
2A	Enrollment	Facilitating Non-Medicaid Eligibility Determination	U	U
2B	Enrollment	Facilitating Medicaid Eligibility Determination	U	TM/50%
3	Educational Services	School Related and Educational Services	U	U
4A	DirNonIEP	Direct Medical Services-Not Covered as IDEA/IEP Services	U	U
4B	DirMedIEP	Direct Medical Services-Covered as IDEA/IEP Services	PM	U
5A	Transportation	Transportation Non-Medicaid	U	U

5B	Transportation	Medicaid Transportation	U	PM/50%
6A	Translation	Non-Medicaid Translation Services	U	U
6B	Translation	Medicaid Translation	U	PM/50%
7A	Planning	Non-Medical Program Planning, Policy Development, and Interagency Coordination	U	U
7B	Planning	Medical Program Planning, Policy Development, and Interagency Coordination	U	PM/50%
8A	Training	Non-Medical/Medicaid Related Training	U	U
8B	Training	Medical/Medicaid Related Training	U	PM/50%
9A	Referral	Referral, Coordination, and Monitoring of Non-Medicaid Services	U	U
9B	Referral	Referral, Coordination, and Monitoring of Medicaid Services	U	PM/50%
10	GA	General Administration	R	R
11	Unallowable	Not Paid/Not Worked	U	U

These activity codes represent 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.

Medicaid Eligibility Rate Development

Participating school districts are required to regularly submit claims to AHCCCS for direct medical services rendered, according to the guidelines in the AMPM and AHCCCS Billing Manual. At the end of each fiscal year, the school district must submit a Medicaid cost report, participate in the time study, and provide information for the Medicaid Special Education Ratio in order to complete the cost settlement process as outlined in Attachment 4.19B of the approved Arizona Medicaid State Plan.

The Direct Service Claiming Program uses a Medicaid Special Education Ratio as one of the steps in determining total allowable costs, as described in Section 4.19B of the approved Arizona Medicaid State Plan. A Medicaid Special Education Ratio is determined for each participating school district. When applied, this Ratio discounts the Direct Service and Personal Care cost pools by the percentage of Medicaid Special Education students. The names and birthdates of students with a health related Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) are identified from the December 1 Count Report each year filed annually by each school district and matched against the December 1st Medicaid eligibility file from AHCCCS to determine the percentage of students eligible for Medicaid. The numerator of the rate is the students with an IEP or IFSP that are eligible for Medicaid and the denominator is the total number of students with a health-related IEP or IFSP.

Costs associated with several Medicaid administrative activities performed by the school districts are adjusted by the school district's Medicaid Eligibility Rate (MER). The MER reduces these counts to the amount for services specific to Medicaid eligible individuals. The MER for the MAC program is calculated on an annual basis. The names and birthdates of students are identified from the October 1st Student Count Report each year filed annually by each school district and matched against the October 1st Medicaid eligibility file from AHCCCS to determine the percentage of students eligible for Medicaid. The numerator of the MER is the total number of Medicaid eligible students in the district and the denominator is the total number of students enrolled in the district.

Financial Data

The financial data to be included in the calculation of the MAC claim are to be based on accrued expenditures during the quarter. These costs must be obtained from detailed expenditure reports generated by the provider'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
    - Salaries and benefits for district staff
    - Contracted staff costs for contractors that are eligible to participate in the program
- Staff training and professional development
- Travel expenses incurred

Indirect Costs

Indirect costs included in the claim are computed by multiplying the costs by the school districts approved unrestricted indirect cost rate. These indirect rates are district specific and developed by the school district's 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 non-special education 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 MSBC Program. LEAs must maintain and have available upon request by state or federal entities the contract with the state to participate in the MSBC 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 MSBC 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 school-based services programs. This oversight and monitoring must be done at both the LEA and state level.

State Level Oversight and Monitoring

The state is charged with performing appropriate oversight and monitoring of the time study and MSBC Program for 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 School-Based Claiming. The IGA clearly state all parties' responsibilities. Please see IGA attached as Appendix B.

AHCCCS will monitor and review various components of the Medicaid School-Based Claiming 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 5% 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 Medicaid School-Based Claiming 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 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.

Third Party Administrator Level Oversight and Monitoring

Quarterly Tasks

Training Regarding RMTS

- 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.

Roster Updates

- 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
- Review data submitted by district and conduct follow up, if needed
- 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 Medicaid School Based Claiming update meetings
- Answer general questions from districts throughout the quarter
- Collect annual indirect cost rate (ICR) from ADE

- Calculate annual Medicaid Enrollment Rate (MER) for MAC\
- Calculate annual Medicaid Special Education Ratio per LEA
- 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 LEA and AHCCCS
- Conduct LEA monitoring as delegated by AHCCCS

Local LEA Level Oversight and Monitoring

Each LEA participating in the School-Based Services Program must take appropriate oversight and monitoring actions that will ensure compliance with 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 Medicaid School Based Claiming 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.

ATTACHMENT A: TIME STUDY CODING INSTRUCTIONS

After RMTS participants log their moment, it is the "coders" responsibility to categorize the response. The coding structure below will determine whether the activities logged are claimable, non-claimable, an allocated expense or a cost that can be claimed in the MAC program.

All time study results are aggregated statewide and applied equally to school districts participating in the MSBC Program.

The table below summarizes the codes, the activities associated with that code and the claimable status of the code.

Code	Code Text	Activity	Direct Service Program	MAC Program
	Prov Svcs	**PROVISION OF SERVICES**		
1A	Outreach	Non-Medicaid Outreach	U	U
1B	Outreach	Medicaid Outreach	U	TM/50%
2A	Enrollment	Facilitating Non-Medicaid Eligibility Determination	U	U
2B	Enrollment	Facilitating Medicaid Eligibility Determination	U	TM/50%
3	Educational Services	School Related and Educational Services	U	U
4A	DirNonIEP	Direct Medical Services-Not Covered as IDEA/IEP Services	U	U
4B	DirMedIEP	Direct Medical Services-Covered as IDEA/IEP Services	PM	U
5A	Transportation	Transportation Non-Medicaid	U	U
5B	Transportation	Medicaid Transportation	U	PM/50%
6A	Translation	Non-Medicaid Translation Services	U	U
6B	Translation	Medicaid Translation	U	PM/50%
7A	Planning	Non-Medical Program Planning, Policy Development, and Interagency Coordination	U	U
7B	Planning	Medical Program Planning, Policy Development, and Interagency Coordination	U	PM/50%
8A	Training	Non-Medical/Medicaid Related Training	U	U
8B	Training	Medical/Medicaid Related Training	U	PM/50%
9A	Referral	Referral, Coordination, and Monitoring of Non-Medicaid Services	U	U
9B	Referral	Referral, Coordination,	U	

		and Monitoring of Medicaid Services		PM/50%
10	GA	General Administration	R	R
11	Unallowable	Not Paid/Not Worked	U	U

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 2B 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 4A: Direct Medical Services- Not Covered as IDEA/IEP Services

The "coder" uses this code when the participant is providing direct client care services that are not IDEA and/or not IEP services. This code includes the provision of all non IDEA/IEP medical services reimbursed through Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. This code includes pre and post activities associated with the actual delivery of the direct client care services, e.g., paperwork or staff travel required to perform these services.

All non IDEA and/or non-IEP direct client care services:

Examples:

- Providing health/mental health services.
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports.
- Providing personal aide services.
- Performing developmental assessments.
- Developing a treatment plan (medical plan of care) for a student if provided as a medical service.
- Performing routine or mandated child health screens including but not limited to vision, hearing, dental, scoliosis, and EPSDT screens.
- Administering first aid or prescribed injection or medication to a student.
- Providing counseling services to treat health, mental health, or substance abuse conditions.
- Making referrals for and/or coordinating medical or physical examinations and necessary medical evaluations as a result of a direct medical service.
- Immunizations and performance of routine or education agency mandated child health screens to the student enrollment, such as vision, hearing and scoliosis screens.
- Nursing services and evaluations including skilled nursing services and time spent administering/monitoring medication when the service is not included on the student's IEP. For example, medication for a short-term illness or recent injury would not normally be included in an IEP. Time spent administering/monitoring medication that is not included as part of the IEP and not documented in the IEP such as administration/monitoring of maintenance drugs (example 1: insulin for a diabetic if the insulin administration/monitoring is not in the IEP; example 2: anti-seizure medication for a child if the anti-seizure medication is not in the IEP) and administration/monitoring of non-routine medications for acute conditions when the administering/monitoring of the medication is not included as part of the IEP and not documented in the IEP

Code 4B. Direct Medicaid Services – Covered as IDEA/IEP Services

This "coder" uses this code when school district staff (employees or contracted staff) provide direct client services as covered services delivered by school districts under the Direct Care or FFS Program. These direct client services may be delivered to an individual and/or group in order to ameliorate a specific condition and are performed in the presence of the student(s). This code includes the provision of all IDEA/IEP medical (i.e. health-related) services. It also includes functions performed pre and post of the actual direct client services (when the student may not be present), for example, paperwork, or staff travel directly related to the direct client services. Note, some of the following activities may be subject to the free care principle:

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

- Providing health/mental health services as covered in the student's IEP.
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports as covered in the student's IEP.

Examples:
- Audiologist services including evaluation and therapy services (only if included in the student's IEP).
- Physical Therapy services and evaluations (only if included in the student's IEP).
- Occupational Therapy services and evaluations (only if included in the student's IEP).
- Speech Language Therapy and evaluations (only if included in the student's IEP).
- Psychological services, including evaluations and assessment (only if included in the student's IEP). [Assessment services are not in the client's IEP because assessments are performed before the students IEP is developed.]
- Counseling services, including therapy services (only if included in the student's IEP).
- Providing personal aide services (only if included in the student's IEP).
- Nursing services and evaluations (only if included in the student's IEP), including skilled nursing services on the IEP and time spent administering/ monitoring medication only if it is included as part of an IEP and documented in the IEP. [For example, administration of a medication such as Ritalin would only be included as an IEP-Related Service if the student IEP's actually contained a requirement for its provision; administration/monitoring of anti-spasmotic drugs for children with cerebral palsy, such as baclofen, that is included as part of an IEP and documented in the IEP; insulin for a diabetic if the insulin administration/monitoring is in the IEP.]

This code also includes pre and post time directly related to providing direct client care services when the student is not present. Examples of pre and post time activities when the student is not present include: time to complete all paperwork related to the specific direct client care service, such as preparation of progress notes, translation of session notes, review of

evaluation testing/observation, planning activities for the therapy session, travel to/from the therapy session, or completion of billing activities.

Examples:

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

Code 5A: Transportation for Non-Medicaid Services

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 5B 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 6A 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 6B 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 7A: 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 7B: 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 8A 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 8B 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 9A: 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 9B: 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, inter-periodic 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.